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Nurses and Acute Care

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Abstract

Acute care is provided in acute hospitals and in emergency departments. The acute condition occurs suddenly and lasts for a certain period of time. It should be noted that the signs of the disease include rashes, redness, swelling, etc. The syndrome is a set of different symptoms and signs that appear as one clinical picture.

Keywords: *Acute Care, Medicine, Health, Nurse.*

Introduction

Assessment is a complex process that requires knowledge and skills of the nurse to interpret findings and give meaning in relation to patient care [1]. The nursing assessment has a direct impact on patient safety and well-being and when done ineffectively can lead to delivery of suboptimal care.

It is also important that community nurses have expertise in managing care across the lifespan and are cognisant of the anatomical and physiological variances. Nurses require a good understanding of anatomy and physiology of the human body relevant to their specific role within the community team, and should have or be developing consultation, physical and psychological assessment and history-taking skills.

When presented with an acute situation and/or deteriorating patient a systematic approach to assessment is vital. A detailed approach initially is inappropriate for acutely unwell patients and indeed may be detrimental to their well-being. Lifesaving rapid assessment and intervention are required thus treating the patient before holistic assessment and diagnosis are complete. It is acknowledged that this is in direct opposition to traditional theories of nursing assessment and can be initially challenging.

Acute care nurse practitioners are advanced practice nurses who specialize in providing care for acutely ill patients in a variety of settings [2]. The environment in which acute care nurse practitioners function is very intense and dramatic. Some of the characteristics of an acute care nurse practitioner's work include coordinating patient care, assessing the patient's health history, ordering diagnostic tests, performing therapeutic procedures, and prescribing medications. Possibilities for work exist in these settings:

- Emergency rooms
- Operating rooms
- Critical care units
- Transplant units

Most patients who present to the ED (Emergecy Department) are not critically ill and do not require the resources and equipment needed in the critical care area [3]. The majority of ED rooms are appropriate for caring for acute patients. Typical complaints cared for in this area include cardiac, abdominal, neurological, and other complaints and injuries.

EDs can be designed in a variety of ways. Some departments have pods or zones where several similar patient rooms surround a central station. At this station, care providers gather for recordkeeping and sharing information. This nurses' station area is generally off limits to patients and families, although conversations may be overheard by visitors and staff, which creates concerns about violations of privacy standards. When designing the ED, carpeting in the central area to absorb noise or glass partitions around the central area can help protect privacy. In the absence of these precautions, it's incumbent that you monitor what is said to reduce the flow of private health information to people who should not be hearing it.

A nurse who is involved in acute care situations such as an emergency room or intensive care unit often deals with clients who are exposed to severe threats to physiological integrity [4]. The conservation of structural integrity is often the immediate priority in these acute care situations. For example, when a nurse in an emergency room is dealing with a client who has been in a severe motor vehicle accident, the client's structural integrity is at risk. When the client's structural integrity has been damaged, the client must put all available energy into healing the self. The nurse tries to provide care for that client so that energy can be conserved for the processes of healing. In addition to experiencing a threat to structural integrity, this client has other needs as well. The client has social relationships and these relationships are also disrupted by the accident. The nurse is concerned with the client's spouse and family who are part of the social unit. Even in this time of crisis in the emergency room, the client's social integrity is of concern. Finally, the nurse is also concerned about the client's personal integrity because the traumatic experience and necessary treatment can be frightening and dehumanizing. As the nurse strives to maintain the client's structural, social, and personal integrity, the nurse recognizes that the client is a person who is a unique individual.

Critical Care

Critical care nurses care for patients who are critically ill [2]. They have a great deal of one-on-one contact with the patients and are often the main source of information for the family members. They are responsible for constantly monitoring the patient's condition, as well as recognizing any subtle changes. These nurses use a great amount of technology within their practice, and function as integral members of the multidisciplinary health care team. Critical care nurses must possess the ability to collaborate with other members of the health care team such as physicians, case managers, therapists, and, especially, other nurses. They are responsible for all care given to the patient, from medication administration to tracheotomy and other ventilator care, as well as constant monitoring of the patient for any alterations in status. Responsibilities include monitoring, assessment, vital sign monitoring, ventilatory management, medication administration, intravenous insertion and infusion, central line care, Swan–Ganz catheters, and maintenance of a running record of the patient's status. They must be prepared at all times to perform cardiopulmonary resuscitation and other life-saving techniques.

Acute Intoxication

Acute intoxication frequently occurs in persons who have more persistent alcohol - or drug - related problems [5]. It is a transient condition following the administration of alcohol or other psychoactive substance, resulting in disturbances in level of consciousness, cognition, perception, affect or behaviour, or other psycho - physiological functions and responses. Intoxication is highly dependent on the type and dose of drug and is infl uenced by an individual ' s level of tolerance and other factors. Acute intoxication is the term used in the World Health Organization (WHO) International Classification of Diseases 10 (ICD - 10) for intoxication of clinical significance. Acute intoxication is usually closely related to dose levels and the intensity of intoxication lessens with time, and effects eventually disappear in the absence of further use of the psychoactive substance. The symptoms of intoxication do not always reflect the desired or expected effects of the psychoactive substance.

Many psychoactive substances are capable of producing different types of effect at different levels. For example, alcohol may have apparently stimulant effects on behaviour at lower dose levels, then may lead to agitation and aggression with increasing dose levels, and produce clear sedation at very high levels. The cultural and personal expectations regarding the effects of the drug will also influence the level of intoxication. The common features of psychoactive intoxication include disinhibition, euphoria, lack of coordination, risk of harm and impaired judgment. However, it is important to recognise the symptoms of alcohol or drug intoxication not only to confi rm the presence and severity of the effects of psychoactive substance(s), but also to be able to differentiate the symptoms from other conditions.

Nursing interventions are based on the urgency and seriousness of the individual with acute intoxication. When an individual is acutely intoxicated, first aid procedures are implemented in relation to:

- A: airway.
- B: breathing.
- C: circulation/cardiac.

Pain Management

The inadequacies of the management of pain have been reported consistently for over 30 years [6]. Despite improvements in acute pain management through the introduction of 'acute pain' teams and new technology such as patientcontrolled analgesia, the management of acute pain following surgery has long been reported as problematic in the UK, USA and Europe. In the community the picture is worse with chronic pain estimated to have a prevalence rate between 2 and 40%, and it is particularly problematic for those who are older or have difficulty communicating. In Europe it has been found that chronic pain of moderateto-severe intensity occurs in 19% of adults, seriously affecting the quality of their social and working lives. Many people with chronic pain often report poorer self-rated health, mental well-being and social functioning as well as greater levels of depression and work loss.

The challenges of managing pain have been well documented, and it would be fair to say that whilst the management of acute pain and particularly that associated with surgery have shown radical improvement in recent years, many people continue to experience unrelieved chronic or persistent pain which is tremendously debilitating in terms of their function and quality of life. It is interesting that several of the contributors in this book chose to focus the development and delivery of a service for people whose pain was challenging to manage.

Stress in Pregnancy

Acute and chronic stressors can occur due to life events such as the death or serious illness of a loved one, previous traumatic event, or any social or economic stressors [7]. Stress in either the acute or chronic form affects pregnancy outcomes. When the body experiences stress, there is a physiological reaction. Chronic stress results in physiological dysfunction over time that impairs the immune response and produces metabolic and cardiovascular changes that produce illness. Increased stress during pregnancy can result in normal stress reactions causing increased physiological response, which is harmful to the pregnancy. A woman may be entering her pregnancy unknowingly in a poor physiological state at risk for hypertension and diabetes due to these changes. Maternal exposure to severe life events, such as death or serious illness in close relatives, witnessing or experiencing physical violence as a child or adult, or having experienced an adverse birth outcome previously, can place the woman at risk for adverse pregnancy outcomes. Labor and delivery may trigger a response in women who suffer from posttraumatic stress disorder (PTSD) resulting from prior adverse pregnancy outcome or sexual assault. Healthcare providers should evaluate all patients who exhibit signs of depression in pregnancy to rule out PTSD so the patient receives the proper psychologic support. PTSD has been identified in women who have had a diversity of acute traumatic events in their life. The diagnosis and effect on pregnancy outcomes can be found in all countries, ethnic groups, and socioeconomic levels. Intimate partner violence has been identified as a chronic stressor and as a cause of PTSD in women, which can have a negative impact on pregnancy and result in LBW and preterm delivery.

Major stressors such as life events, major catastrophes, chronic strain, neighborhood stress, and multiple stressors may contribute to PTB, gestational age, or gestational length. The exact mechanism by which maternal stress causes preterm labor is not fully understood, but it is thought to occur by one of two mechanisms. Corticotropin-releasing hormone released as a by-product of maternal stress could stimulate neuroendocrine pathways within the maternal–fetal–placental unit that trigger labor; or maternal stress could cause increased maternal and fetal susceptibility to inflammation and infection, triggering labor through an immune-inflammatory pathway. These interactions between neuroendocrine, immune, and behavioral processes may be tempered by maternal resilience resources (ego strength, personality, social, coping, cultural values, and worldview). Hardiness, resilience, and social support might act as stress buffers in some women, lessening the impact of stress.

Not all women are affected in the same way by stress, which could account for difficulty with prediction of outcomes. Critical periods may occur during pregnancy where there is altered vulnerability to the effects of prenatal stress. The cumulative effects of lifetime exposure to acute stress and experiences of chronic day-to-day stress increase the risk of stress-related disease during pregnancy and may help explain some ethnic disparities in birth outcomes. Just as it is difficult to predict the outcomes related to stress, it is imperative to assess for the methods pregnant women may use to cope with stress prenatally

Hollistic Health Assessment

A key component of the advancing nursing role is that of holistic health assessment [8]. Holistic health assessment aims to capture data in a systematic and comprehensive format and includes all aspects of the patient's well being, including: physical and mental health, psychological status, social circumstances, beliefs and aspirations for their health and well being. It is important that repeated assessment is avoided, and for this reason the multidisciplinary team must develop a shared assessment document that can be used by all members of the team. Also, it must be agreed who will be responsible for what aspects of collecting data, to avoid either repeating or missing important information and to maximise the full potential of the team. The shared assessment document should form an integral part of the patient's pathway of care and treatment, and so there should be the ability to build upon information elicited during the acute phase of the patient's journey. Integrated care pathways are an ideal framework to foster both seamless integration of the acute and rehabilitative phases and interdisciplinary working. There are various methods of collecting data during holistic health assessment, including:

- Observation – sensing, seeing or smelling
- Interview – including history taking
- Listening
- Consultation with other members of the multidisciplinary team, family members, patient's notes and hand-held records, etc.
- Physical examination, e.g. inspection, palpation, percussion and auscultation
- Assessing physical function, range of movement, gait and mobility, etc.
- Judicious use of clinical investigations
- Self-report measures of health and disease

A significant number of rehabilitation patients have communication difficulties, either due to problems with speech or cognitive dysfunction. Specialist support from the speech and language therapists should be used as appropriate, while liaison with family members can be useful to supplement information elicited from the patient.

Long-Term Care

Elders who need long-term care suffer from chronic conditions that are not curable [9]. Risks and benefits cannot be readily ascertained and, in any event, clearly involve elements that are not necessarily excluded by the much more diffuse model of long-term care. For example, the sick role concept underlying acute care assumes that the sick person will cooperate with health professionals to restore premorbid functioning, indeed, has the obligation to do so. Longterm care by definition precludes a return to premorbid, normal functioning, so personal or idiosyncratic considerations that would otherwise be trumped by the obligation to getwell retain their validity. Long-term care needs also tend to involve multiple, overlapping physical, psychological, and social dimensions that cannot all be readily conceptualized, much less managed, in strict medical terms.

Even for clear medical needs there is often greater uncertainty and a wider range of possible interventions. Because the goal cannot be cure, the diagnostic therapeutic certainty of the acute care model finds little to grip. Lacking the traction provided by the goal of curing as the main ingredient of patient welfare, patient preferences and values become far more important. In the acute care context, especially in hospitals, the foreign environment intimidates patients. In contrast, home care is delivered on the patient's own turf and institutional care occurs where the patient resides, so patient autonomy is in a more fertile environment. Despite these environmental differences, long-term care, especially nursing home care, seems to efface rather than enhance the residual autonomy of elders.

Patient

Specialty services focus on providing care to a specific area of the patient's body, mind, and soul [10]. Behavioral health, cardiology, gastroenterology, neurosurgery, and pulmonology are all examples of specialty services. Specialty services often require specific data and information from the patient in order to decide on the best treatment options. The specific data and information often are the result of specific questions asked of the patient, tests, exams, and other evaluative measures that otherwise might not be conducted on every patient.

In addition to the patient population and specialty service, the level of care is another differentiator for selecting an EHR (Electronic Health Records). Patients have varying needs when seeking health care. The needs may be routine, acute, emergent, surgical, life

threatening, or rehabilitative. The type of care needs for the patient will determine the level of care needed for the patient. Ambulatory outpatient, acute care, emergency, operative care, intensive care, and long-term or skilled care services are all different levels of care. Many health care organizations can care for patients across several levels of care. However, some are only focused on one level of care.

During the acute phase, keep the patient safe [11]. Use strategies for continuous monitoring of airway, breathing, and circulation, and implement emergency measures as needed to support life. Monitor for seizure activity and place the patient on the seizure precautions regimen. Examine the environment for safety risks such as falls from the bed or self-discontinuation of tubes. Assess the potential for a suicide attempt, and if necessary, initiate suicide precautions and never leave the patient unattended.

Meet the self-care deficits related to hygiene, nutrition, and elimination. Promote a sense of security: approach the patient in a calm, nonthreatening, and nonjudgmental way. Building a trusting relationship with the patient provides a foundation for addressing the more long-term goals that are associated with becoming drug-free.

Following the acute phase, initiate the process of rehabilitation, and implement a treatment plan to maintain abstinence. The first goal is to work toward getting the individual to break through the denial of drug abuse and take responsibility to begin the recovery process. Provide educational materials and arrange a consultation with a chemical abuse counselor to begin the process before discharge from an acute care setting. Often, individuals are admitted from an acute care setting to an inpatient or outpatient treatment facility where nursing staff and other healthcare providers can begin specialized treatment programs. These programs include peer group programs in which confrontation, support, and hope are part of the treatment process. Treatment goals for the individual include development of a healthy self-concept, self-discipline, adaptive coping strategies, strategies to improve interpersonal relationships, and ways of filling leisure time without the use of drugs.

Patient transfers to the community nursing services centred on delimited issues, such as wound care, and were nurse-to-nurse handovers [12]. The challenges of boundary crossing are further magnified when the responsibilities in question are more diffuse, where professional boundaries must be crossed and the departments on either side of the boundary are unknown to each other. Health and social care in the community is provided by a mixed economy of services; a patchwork quilt of private carers, local authority teams and nursing and residential homes. As we have seen, all have different referral criteria, the details of which are often opaque. Moreover, as social science has shown us, individuals' requirements for care are context dependent. The arrangements necessary to support someone in their own home are quite different from those that suffice in the acute care setting. As well has having an uncertain understanding of the requirements of the receiving service and the needs of patients in a new context, very often transfers of care have to be undertaken when there are few opportunities for face-to-face interaction. Thus, while the post-anaesthetic recovery nurse takes the patient back to the ward and hands over to the nurse who will be responsible for their continuing care, when a patient is transferred to a nursing or residential home they are accompanied by the ambulance service who have had no ongoing trajectory involvement. In such circumstances boundary crossing is heavily dependent on artefacts and, if documents are to travel between distant social worlds, then considerable elaboration is necessary and this can be a source of exasperation to the original community. In the study site, transfers of care from the hospital to the community, where input from social care agencies was required, were mediated by the unifi ed assessment form. This was a lengthy document which was almost universally despised by hospital staff. Different providers had responsibility for completing different sections on the form but nurses were charged with the lion's share of this work.

Acute Care Hospitals

Hospital-based acute care nursing practice will always have an important place in any health-care system [13]. Highly skilled acute care nurses will always find a place to practice. It is generally accepted that the older population requires more health care of all types— acute, chronic, and community based.

Paradigm shifting in nursing education does not need to be an either/or proposition. It is sometimes felt that nursing education is either acute care focused or it is community focused. Nursing education needs to

combine the two so that the graduate can practice with competence in either or both settings. The skills are similar, but the emphasis may be different. Although some hospital skills are being done by non-nurses at a cheaper cost, nursing education must still teach such important skills as critical thinking, therapeutic relationship, primary care and case management, as well as how to be comfortable with a consumer-driven health-care system.

Once the integrative nurse collects the appropriate biopsychosocial measures that indicate the degree of distress anxiety is causing, she/he can develop a plan either with or for a patient, based on his/her preferences and current medical condition [14]. First, the integrative nurse will need to consider the physiological status of any patient for whom anxiety management interventions may be suggested. Patient safety and acceptability are of the utmost importance. For example, a patient hospitalized for an acute illness may have a needle phobia. For this patient, acupuncture would not be an acceptable intervention, given the use of needles to deliver the treatment. Likewise, meditation may conflict with some individuals' religious beliefs and preferences.

Nurses working in acute care or critical care hospital settings as well as home health and public health, should review the medication administration record, noting any medications that have the potential to alter heart rate, respiratory rate, or blood pressure. Many of the interventions used to manage anxiety can also promote relaxation, sleep, and alterations in cardiovascular status, which is why the nurse needs to have an in-depth understanding of all medications, their actions, and potential side eff ects.

Acute care hospitals are legally obligated to offer families of potential organ donors the option of organ and tissue donation [15]. Approaching a grieving family about donation can be difficult. But research reveals that when the conversation is sincere and sensitive, the majority of families experience important short- and longterm benefits whether or not they choose to donate. In fact, families can become angry and frustrated when denied the opportunity to donate. Research on public attitudes and family experience of donation repeatedly have come to the same conclusion: the manner in which the donation request is made is the main factor in a family's ultimate decision, regardless of preexisting attitudes.

Approaching a family about donation requires coordinated efforts among the physician, hospital staff, and the OPO coordinator. The physician has the responsibility to inform the family of their relative's death. Time must be allowed for the family to accept the reality of death before raising the question of donation. The person who is most comfortable and knowledgeable about donation should discuss donation with the family, and that individual is usually the OPO coordinator. OPO coordinators bring knowledge, experience, and a confidence in their ability to handle all aspects of the donation process. They know firsthand the benefits that the process offers the family. Donation is a process. Obtaining consent does not consist of simply asking the family if they wish to donate, in essence, "popping the question." Informed consent takes time; OPO staff members have the time that busy physicians and nurses do not have. OPO staff members spend significant time, often many hours, with families during the donation process. An investment of the time of bedside nurses and physicians is not possible in today's environment of limited healthcare resources.

Conclusion

Acute diseases occur suddenly and last for a certain period of time, while the onset of chronic diseases is usually gradual and they can last for a long time, sometimes a lifetime. The transition between these two forms is made by subacute diseases. The disease is accompanied by subjective disturbances or symptoms and signs. Symptoms are shared into general and specific. The general are common to a wide range of diseases, while the specific occur only in smaller number of diseases.

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