The critical care area

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Critical care nurses have been working for a long time to move the organisation of nursing care away from that based on the typical clinical areas of anaesthesia, resuscitation and intensive care. Their role is more appropriately oriented to the 'care of the person in a critical condition' regardless of the place in which he or she is being cared for. The critically ill patient may be a person of any age group who is in an unstable or critical condition: consequently the health/illness concept in this case assumes a natural emphasis on the illness of the cared-for person.

Critical care area nurses work in a complex environment: they have to act quickly and often without the information necessary to be able to make decisions for care congruent with need. In fact the intervention is often so rapid that it is independent from the analysis of cause.

The nursing interventions in the critical care area are determined on the basis of the model that considers the logic of the obtainable result, which activates the intervention. On the basis of the result, we look for the causes. So the attainable results, and the concepts of the obtained result are fundamental, which can improve in quality and quantity with constant and critical revision of the abilities and performances of nurses. The carrying out of procedures is based on the undertaking of responsibility consequent to actions autonomously carried out and interdependent actions with the doctor. Undertaking of responsibility is, in any case, a dynamic process strictly related to experience and developed ability and therefore to acquired capacity.

The aim of this report is to define – in relation to the critical care area – the key words which are the theme of the 11th IPASVI (Italian National Federation of Colleges of Nurses, Health Visitors and Paediatric Nurses) National Congress. The definition of the chosen words is preceded by a short introduction and the word 'discipline' is articulated in its paradigmatic components.

All this aims to facilitate the presentation and the analysis of the issue, even though we are aware of the strict interconnection of the chosen words and the related difficulty in separating the subtended concepts.

INTRODUCTION

The term 'critical care area' was created in the nursing sphere, specifically by nurses working in anaesthetics and in general or specialised intensive care units, gathered together in association. This type of care has been characterised by the treatment of an organ or system affected following acute illness; exacerbation of chronic illness; or as a consequence of trauma: there can be a severe pathological syndrome evolving in a short time to a life-threatening situation.

Nurses based in these units, with responsibility for extremely sick people, have worked to find a way of overcoming the clinical divisions, and moving towards more holistic care, with the sick person and his or her relatives being at the centre of this care. We have arrived at a way of thinking that no longer considers the organisation of the service or the ward as a fundamental determinant for care, but instead focuses on the uniqueness of the person who is being cared for, i.e. the person whose life is at risk.

So in this way the concept of the critical care area was born. The basic definition of the concept, which could seem insignificant, nevertheless describes an important innovation in the concept of nursing care and in the organisation models within it:

- it is the critical/unstable condition of the sick person that determines the logistic organisation of the critical care area and not the simple sum total of pre-defined wards/services
- it is the kind of intervention and medical/nursing services provided in this area which characterise the specific and unique type of care and not the designation of the ward
- consequently, following this logic, even the ordinary ward where a patient for whatever reason may be found in a life-threatening or unstable situation, is a critical care area.

KEY WORD: DISCIPLINE

All nurses, regardless of their professional work area, consider themselves to be part of the nursing discipline. The unique features of a situation or a cared-for person determine the choice of the specific conceptual models which support the consequent nursing care.

The centrality of the person is implicit in every conceptual model. This is particularly important in an area like critical care, which is characterised not only by the severity and unpredictability of the patient's condition, but by the constant use of highly complex technology, which becomes rapidly obsolescent and is frequently renewed.

The characterising elements in the critical care area lead to a

contextual definition of concepts on which the nursing discipline is founded: man/person, health/illness, environment/society, and nursing.

KEY WORD: MAN-PERSON

The critical care patient is a person in a critical situation of life instability 'with a precarious physical and psychological balance, subject to continuous clinical/care changes, sometimes difficult to be foreseen and controlled in their evolution' (ANIARTI).

The patient's experience of life in the critical care area is significant because it is experienced by people:

- at the beginning of their life (premature or newborn babies in threatening life conditions)
- who pass from complete autonomy to a situation of dependence upon care following an unexpected event (e.g. a road traffic or work accident, a myocardial infarction)
- already sick who undergo a worsening of their condition (chronic and invalid patients)
- who are waiting for an organ transplant or have a newly transplanted organ, and are hoping to reconstruct their own life.

The experience of life in the critical care area – for all the protagonists in nursing relationships, i.e. the patients, significant others and workers – heightens awareness of the irrepressibility of the force that maintains life and simultaneously the fragility of its elements.

The constant precariousness of life's pathway; the effort needed to 'redirect' oneself; and the inevitable moments of abandonment and discouragement – including sometimes the desire to die – are all elements that typically impact on the patient's well-being in the critical care area. Awareness of these is an important part of the caring relationship.

It is not just a high level of skill and technical ability that is needed in the caring relationship but also the structured ability to understand and explain the meaning of life, survival and death to oneself and to others. The cultural, social and spiritual components, implicit in the concept 'man-person', express and specify the delineation of the disciplinary paradigm in the critical care area.

KEY WORD: HEALTH/ILLNESS

Western society has developed a concept of health, which – despite numerous critical and re-defining interventions – basically tends to consider it as 'an absence of illness, handicap or physical–psychological limitations'; health, therefore, is being conceived as a synonym of efficiency, vitality and productivity. It is in that context that hospital services, and particularly services oriented to the care of the serious ill, were developed, with the aim of shifting the borderline between life and death further and further ahead, trying to distance death from life.

Progress in the therapeutic and diagnostic fields has created an increased incidence of 'limit situations', not long ago unimaginable, which present society and in particular the health professions with new ethical questions. Assisted fertility procedures, euthanasia, and aggressive or excessive therapy are only a few examples of situations, in which social discussion is confronted with individual and group values, originating from new possibilities on the beginning of life, on its quality and on death.

In the critical care area the definition of the health–illness concept, in contrast to what happens in other area settings, takes not health, but the illness of the cared-for person, as a starting point.

The person in a critical or unstable life condition is, by definition, a seriously ill person for whom initial care is not even aimed at restoring partial health, but towards the stabilisation of the condition so that it becomes a 'manageable illness'. This process, a continuum which starts from illness and moves towards health, is inescapable because the results of intensive or resuscitation interventions cannot always be foreseen. Nor can the re-planning potentiality of the individual and of the people who are a reference point for him be foreseen. However, it is certain that without these interventions there would not be any possibility of re-planning.

KEY WORD: ENVIRONMENT/SOCIETY

The Italian Constitution considers care for the citizen's health as part of the fundamental values of the Republic.

Health is seen as a dyad of individual and collective values:

- individual welfare, characterised by individual rights
- group welfare, characterised by social rights.

The State provides prevention, cure and rehabilitation services by way of the firm foundations of the contribution of the citizens. The dedication of the State as far as health value is concerned has created, among other things, a national health service and, more recently, the introduction of public company hospitals.

The evident need to keep costs under control, at the same time maintaining at least minimal levels of care based on epidemiological priorities, has induced an organised rationalisation and redistribution of productive factors. Achieving a constant balance of congruence between 'health response – demand – induced demand' is strategic in needs assessment and the definition of the appropriateness of the health service. The activation of homogeneous functional areas and departments, provided for by the 1992 Legislative Decree (no. 502) and its following modifications, derives from the evaluation of the appropriateness and rationality of health structures, and also supports the analysis and integrated actions for the resolution of nursing care cases.

For a long time now critical care nurses, and the nursing profession in general, have put the person in the centre of the health system and have chosen inter- and intradisciplinary integration as a strategic element of a nursing care process which consolidates methodological attention towards the quality of the result and to the appropriate use of resources.

The critical care area organisation, as outlined above, guarantees the acceptance of responsibility of the person in a logical process which includes different phases – synthesised in Figure 1 – and can be developed both inside or outside hospital.

KEY WORD: NURSING CARE

One of the particular characteristics of caring for a person in a critical condition is the complexity arising from the necessity to act in a short space of time, with few, if any, of the deciding elements necessary to implement a congruent answer to the request.

Frequently the critical nature of the situation necessitates rapid intervention, while analysis of the original causes is left aside.

From this, the classic model by which care services are generally defined is derived:

cause → intervention → expected result

In this context it becomes modified as follows:

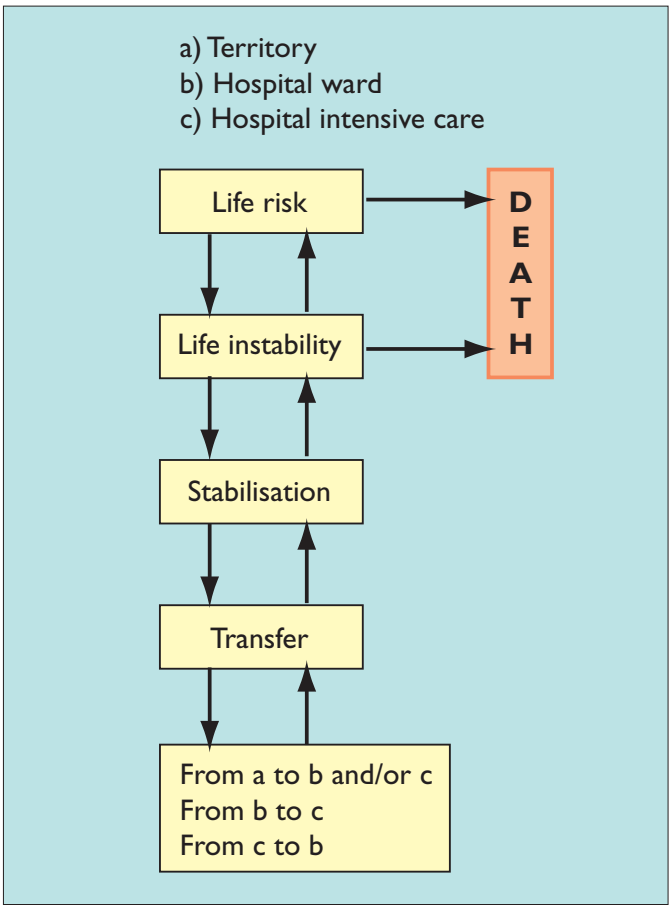

Figure 1. The critical event.

pursuable result → intervention → obtained result → search for causes

Elements that guide the carrying out of nursing, both in and out of hospital, are:

- *time* within which to act – intended as an independent variable for the work process, considering that lack of intervention will, within a few minutes, even if breathing and circulation restart, cause irreversible brain damage
- *place* in which event happens
- *data* available – intended as a variable, dependent on the time and interaction for the decision and carrying out of the intervention
- *technologies* available
- *professionalism* of the team.

'Place' among the dependent variables, is concluded to have the most effect on the others, as is shown in Figure 2.

Outside hospital or general wards		Intensive care wards
Scarce and/or unobtainable in medium-long term	DATA	Sufficient and obtainable in short term
Limited medium complexity	TECHNOLOGY	Numerous, high complexity
Nurses: few Doctors: on call Workers (nonsanitary): few	PROFESSIONALITY	Nurses: sufficient Doctors: Sufficient Workers (nonsanitary): few

Figure 2. The critical care area.

The nursing care of people in critical life-threatening situations frequently uses and elaborates standards for processes and for resources, to facilitate obtaining the desired result or the nearest possible. Although the above mentioned variables are often used as a reference point, the nurse still retains a high level of decision-making. Agreement on what, when, how and how much to do, is achieved within the team and then expressed in the form of procedures, care protocols and guidelines.

These instruments, although standardising the reference framework on which care can be planned, leave space for analysing the situation and for choosing the best method of intervention, taking into consideration the situation and the individual. In this way it is possible to respect the individuality of the person, and maintain his or her dignity, life projects and social–affective links.

KEY WORD: 'SKILL'

The nurse working in the critical care area demonstrates her or his skill by being:

- rapid and expert in acute clinical and emergency situations
- careful and thorough in analysing and interpreting care situations and the organisational context
- discrete and empathetic in interpersonal relationships
- precise and capable in management of the technology which substitutes for the function of vital organs, and of the materials and instruments used in care support
- aware and careful in storing, preparing and administering drugs
- cautious and rational in the choice of material to use
- supportive and trustworthy in advisory and tutorial activity
- communicative and responsible in the planning of specialised nursing care.

In order to maintain such a high level of performance, constant updating of personal knowledge, behavioural and operative models is necessary, focusing particularly on:

- the emergence of new challenges in care
- critical revision of intervention strategies
- scientific community comparison.

Following this line of thought, to be a basic nurse is a necessary but not sufficient condition to express fully the professional capabilities specific to the operative field of the critical care area. Specialisation is the obtaining of greater skills and knowledge in one part of the discipline and makes the specialised nurse a competent professional and a recognised 'teacher-trainer'.

KEY WORDS: AUTONOMY AND RESPONSIBILITY

The implementation of nursing care and the explication of the skills of a critical care nurse and of specialised critical care nurses are based on the assumption of responsibility for actions carried out autonomously and interdependently.

The taking on of responsibility in the critical care area is a dynamic process, strictly related to the experience and the skills developed and therefore the acquired ability. The unpredictability of urgent emergency situations, the rapid evolution of diagnosis and therapy and the equally rapid obsolescence of biotechnology and of health equipment, make the logic of con-

Table 1. Double entry table for critical re-reading of a case related to the pursuable, and the obtained, result

Independent variable:	Time		
Dependent variable:	Actions (data/decisions) Human resources (professionalism and number of operators) Technology (material and technical sources)		
TIME	SHORT <7 min	MEDIUM 7–20 min	LONG > 20 min
Work process	⇓	⇓	⇓
Actions	Basic Life Support	Advanced Life Support	protocols, guidelines, nursing care plans
Human resources	registered nurse	nurse and doctors	care team
Technology	low complexity	medium-high complexity	high complexity
	⇓	⇓	⇓
Result	restoration of life functions	maintenance of life functions, no pharmacological damages	no pharmacological damages with possibility of redefining one's own project of life both for the person and his family

straining nurse's actions on a list, something that cannot be proposed, even if it is continuously extendable.

What should guide the nurse in the definition of her or his area of autonomy – and therefore the assumption of responsibility – is the dialectic confrontation with the scientific and social community on standards of process and of results obtained and obtainable, both autonomously and in interdependence. Nursing care results obtained from a close collaboration between nurses, doctors and other operators are numerous. The collaboration expresses itself prevalently in the diagnostic process, in the laying down of therapeutic protocols and in the highly intensive nursing-medical interventions as for example: cardiopulmonary resuscitation (CPR); extrication of a polytrauma patient; nursing of a brainstem dead patient for organ extraction.

Just as numerous and significant are the nursing care results which are achieved in the autonomous carrying out of work procedures. Some examples are:

- mobilisation of coma patients attached to ventilators, the choice of splints and positions with the aim of preventing bedsores, and facilitating ventilation and secretions drainage with minimal suction trauma
- repositioning patients at intervals, darkening the room at night, letting patients listen to music, natural sounds and the family's voices, with the aim of restoring relationships and space-time orientation
- use of tactile (e.g. heat/cold, gloved hand/bare hand) or olfactory (e.g. use of their usual perfume or after-shave) stimulation with the aim of eliciting a sensory response.

KEY WORD: RESULT

Previously, the model which subtends the critical care nurse's work has been presented thus:

pursuable result → intervention → obtained result → search for causes

On this basis the definition of the result is strictly related to two elements:

- the pursuable result: on account of the drama of the situation, the great variety of interactive elements and standardisation of the actions
- the obtained result: because of the possibility of using protocols, guidelines, and nursing plans as well, after procedures (CPR or forced ventilation).

The constant review of one's personal skills and of performance indexes increases the potential to really reaching the 'pursuable result' and the 'obtained result'. This occurs using instruments of critical re-reading of experience like the one showed below which, using efficacy and efficiency criteria, can be evaluated by a care team, the scientific community and the society.

The double entry table (Table 1) for critical re-reading of a case crosses the independent variable, time, with:

- actions which have to be carried out and performance indexes which have to be pursued and achieved in consolidating the actions in that given time
- minimal human resources necessary to obtain the result in the given time
- the minimum material and technology resources for operators to achieve the result in that given time.

The validation of the work process implemented by the team for achievement of results implies:

- re-examination of the process
- internalisation of methodology
- moving ahead of achievable result/quality levels
- consolidation and growth of professional knowledge.

CONCLUSIONS

In the presentation, the constituents of the subtended concepts of discipline, competence, autonomy, responsibility and result have been dismantled and then recomposed in the light of what characterises and makes nursing care special in the critical care area.

This 'special' quality, even though made evident by processes, methods and actions used for taking responsibility of a person in a critical/unstable condition, leads again on a logical line to the disciplinary construction, which determines the basic notions of the profession and nursing, not only in theory but also in practice.

The whole professional group will have as a reference from now on its own discipline, the critical care area; this will attribute a positive sense of membership to the profession, making the debate between the different professional groups constructive and dialectic, opening new horizons to research and to the qualitative redefinition of care with the possibility of confrontation within the profession.

On this logic the elaboration of a part will become the thought of the whole professional group, the amplification of each member's own culture and the heritage of the community in which that group is inserted. ■