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Un Paziente Con Emorragia Cerebrale Intrattabile In Ventilazione Artificiale

La storia clinica

Nazzareno Fagoni, Marta Laganà

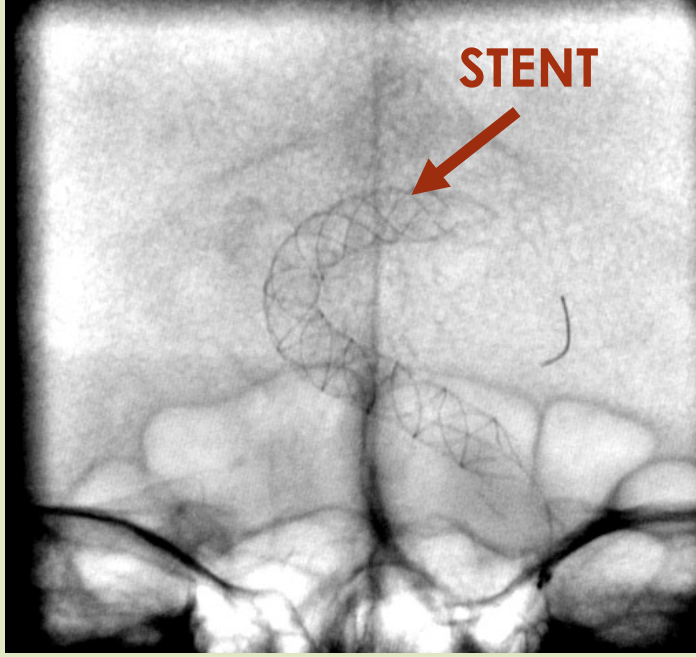
4 settembre 2014

- Il sig. Giorgio, **68 anni**, viene ricoverato in Stroke Unit per aneurisma dell'arteria basilare noto da tempo.

  Programma: **posizionamento di stent** (esclusione dell'aneurisma)

- Anamnesi patologica remota:
  - Cardiopatia ischemica (Bypass Ao-Coronarico nel 2000)
  - Esiti di ictus nel territorio vertebro-basilare (2009 e 2010).
  - Paziente in doppia antiaggregazione e EBPM

La scelta del trattamento



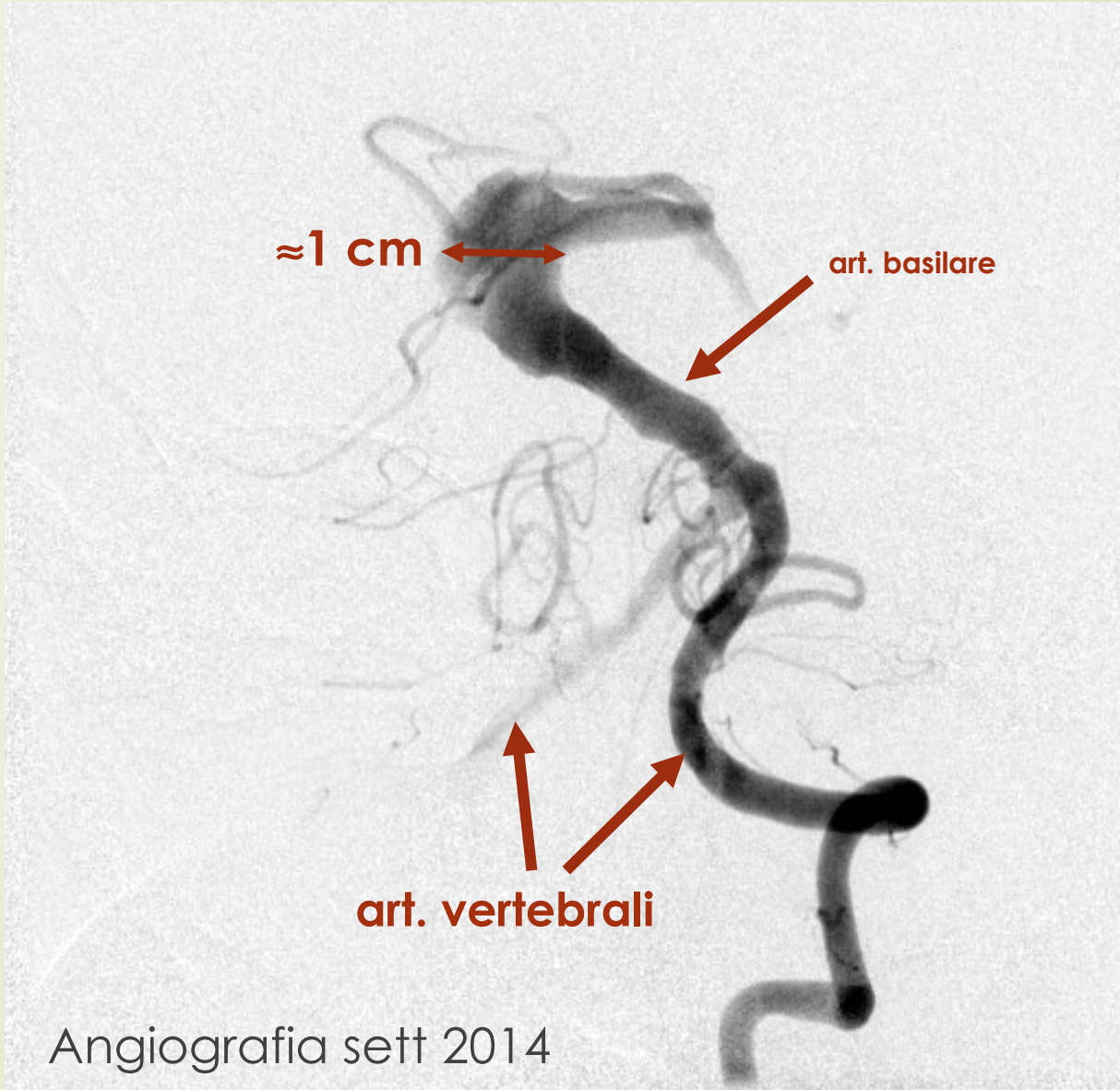
- 10 agosto 2014:

il sig. Giorgio era stato ricoverato in Stroke Unit per ischemia del peduncolo cerebrale sinistro complicata da polmonite.

E' stato deciso di **procrastinare la procedura (stent)** angiografica **per ridurre il rischio di sanguinamento**.

Aneurisma della arteria Basilare

- Gigante, fusiforme e parzialmente trombizzato, di **31,5 mm** (RMN di agosto 2014)
- Notevole **incremento** dell'aneurisma **rispetto** all'angiografia del **2011**.



Angiografia sett 2014

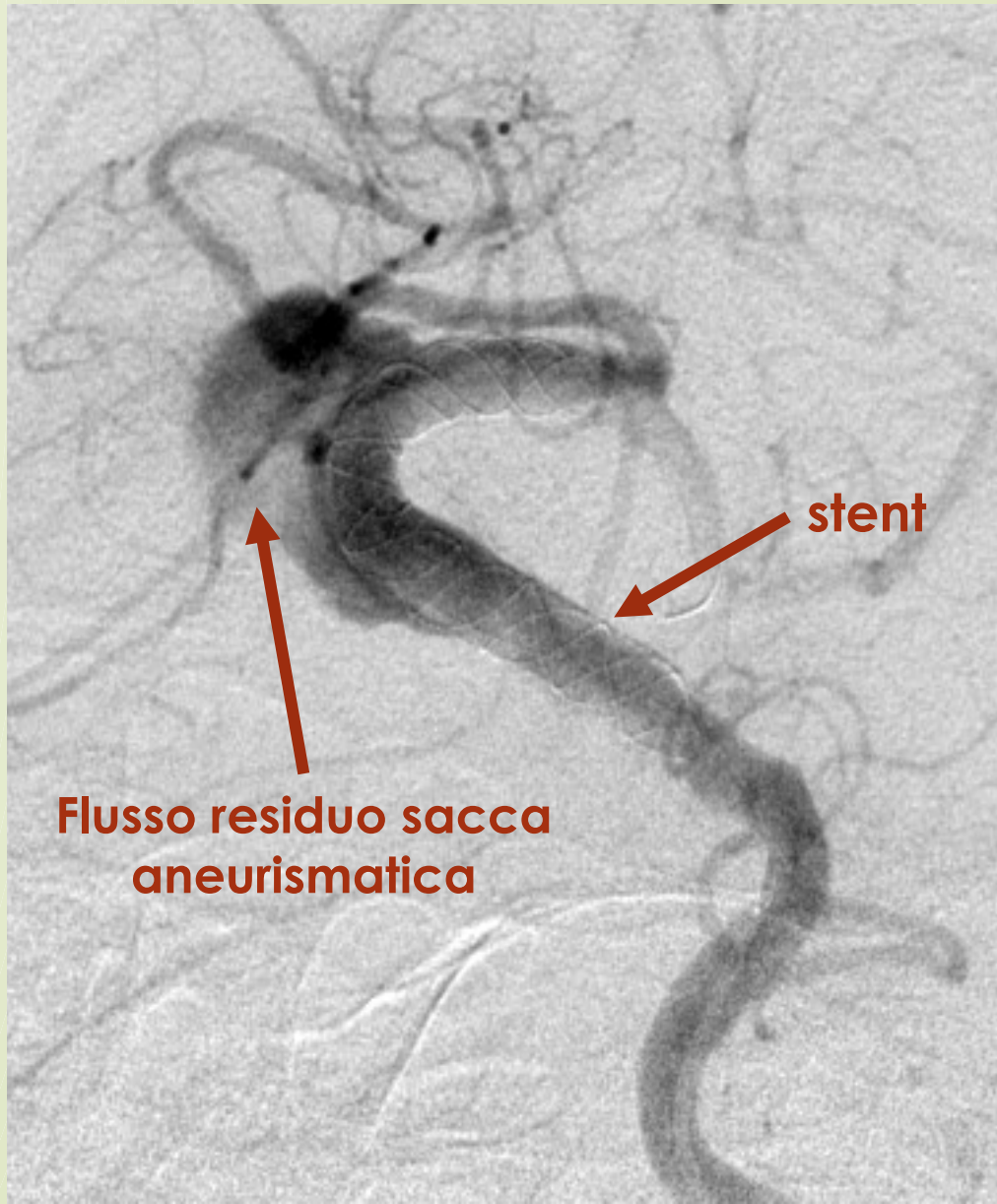
5 settembre 2014

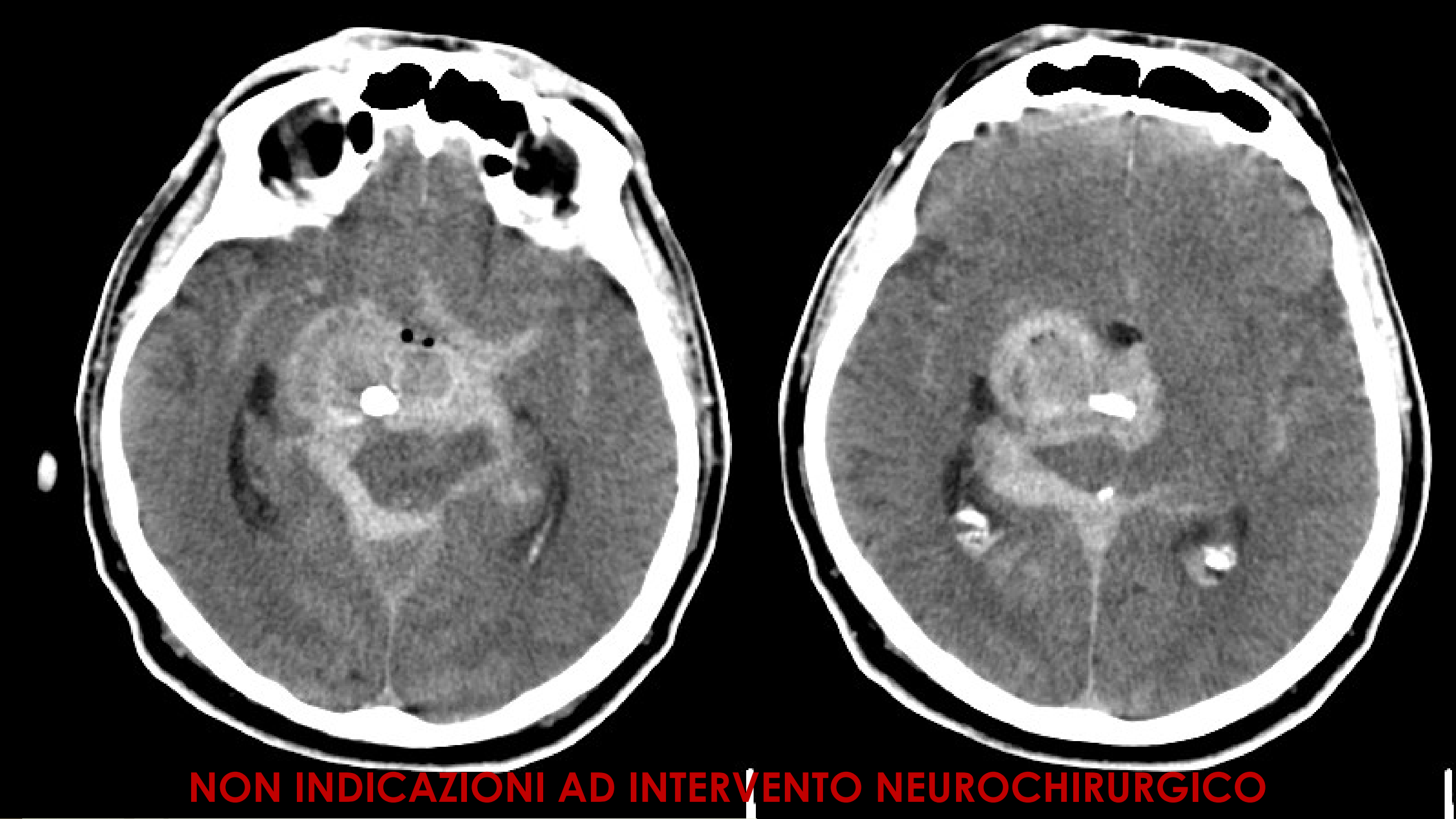
- Posizionato stent → monitoraggio postoperatorio

- Risvegliato nel pomeriggio senza complicanze.

Nel tardo pomeriggio: cefalea, vomito, successivo COMA.

Esegue TAC encefalo




NON INDICAZIONI AD INTERVENTO NEUROCHIRURGICO

I giorni seguenti…

	5 settembre ore 13:15	5 settembre ore 17:40	8/9/2014	10/9/2014	12/9/2014
GCS	4+6+5	1+1+1	1+3+1	1+3+1	1+1+1
Fotomotore	+	-	-	-	-
Corneale	+	-	-	+ dx - sin	-
Carenale	+	-	+	+	-
Oculo-vestibolare	+	-	+ dx - sin	-	-
Drive respiratorio	+	-	+	+	-

DNR order

STOP ventilazione

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End Of Life Nursing

Un Paziente Con Emorragia Cerebrale Intrattabile In Ventilazione Artificiale

12 MARZO 2015

INF. ORSINI MICHELE

Discrepancies between Perceptions by Physicians and Nursing Staff of Intensive Care Unit End-of-Life Decisions

Edouard Ferrand, François Lemaire, Bernard Regnier, Khaldoun Kuteifan, Michel Badet, Pierre Asfar, Samir Jaber, Jean-Luc Chagnon, Anne Renault, René Robert, Frédéric Pochard, Christian Herve, Christian Brun-Buisson, and Philippe Duvaldestin for the French RESSENTI Group

RESULTS

Of the 320 ICUs canvassed for the study, 157 (49%) agreed to participate. Of these 157, only the 133 units with more than 10% of the personnel returning completed questionnaires were included in the study.

Of these 133 ICUs, 90 (67.7%) were mixed medical–surgical, 22 (16.5%) were surgical, and 21 (15.8%) were medical. Ninety-eight (73.6%) ICUs were in university hospitals and 35 (26.4%) in general hospitals. Questionnaires with answers to more than 90% of the items were returned by 3,156 of the 6,341 (49.8%) nursing staff members (Table 1) and by 521 of the 915 (56.9%) physicians (Table 2) working in the 133 ICUs.

Ninety-one percent (n = 2,875) of the 3,156 nursing staff members and 99% (n = 517) of the 521 physicians had personal experience with DFLSTs as part of their work in the ICU. Tables 3 and 4 show how caregivers perceived DFLSTs and the place of these decisions in the ICU.

Decision-Making

The overwhelming majority of caregivers agreed on what should be done theoretically concerning collaborative decision-making processes but strongly differed in their perceptions tice. A large majority of both nursing staff memb cians (91 and 80%, respectively) stated that decisi collaborative, but only 27% of nurses and 50% of lieved that this occurred in actual practice.

Among physicians, 79% (n = 418) believed that, before making a DFLST, they considered the opinion of the nursing staff regarding the course of the patient's treatment in the ICU, as compared with only 31% of nursing staff members (n = 953) ($p < 0.001$). Furthermore, 32.2% of physicians (n = 170) and

TABLE 6. DAY- AND NIGHT-SHIFT NURSING STAFF MEMBERS' PERCEPTIONS OF THE DECISION-MAKING PROCESS

	Day-Shift Nursing Staff n (%)	Night-Shift Nursing Staff n (%)	p Value
Commitment of the ICU to high ethical standards	1,892 (60)	294 (68)	< 0.001
Feel they are not involved in the ICU's commitment to ethics	431 (34)	138 (47)	< 0.008
Feel their opinions are not taken into account	228 (18)	259 (60)	< 0.0001
Feel they receive inadequate information about patients	230 (18)	328 (76)	< 0.0001
Satisfied with decision-making procedures	419 (33)	95 (22)	< 0.001

Sixty-five percent of nursing staff members (n = 2,036) and 78% of physicians (n = 415) believed that their ICU was committed to high ethical standards. Physicians were more likely than nursing staff members to believe that the nursing staff was involved in this commitment (75% of physicians [n = 396] vs. 43% of nursing staff members [n = 1,360]; $p < 0.001$) with no differences between ICUs of university and general hospitals (data not shown). Nursing staff members in surgical ICUs were more likely to believe that they were not sufficiently involved by physicians

OR CRITERIA USED TO MAKE DECISIONS TO SUSTAINING TREATMENT

	Nursing Staff n (%)	Physicians n (%)
	1,536 (43)	378 (72)
s	343 (10)	13 (2)
	567 (16)	16 (3)
	52 (2)	2 (0.4)
Economic cost	4 (0.1)	0 (0)
No prior quality of life	186 (5)	34 (6)
No hope for future quality of life	796 (22)	71 (13)
Age	92 (3)	4 (0.8)

ClinicalArticle

Advance Directives and End-of-Life Decision Making

Survey of Critical Care Nurses' Knowledge, Attitude, and Experience

Yvonne Scherer, RN, EdD
Mary Ann Jezewski, RN, PhD
Brian Graves, RN, MS, ACNP
Yow-Wu Bill Wu, PhD
Xiaoyan Bu, RN, DNS

CRITICAL CARE NURSE Vol 26, No. 4, AUGUST 2006

Table 4 Scores on and percentage agreement for selected attitudes regarding advance directives and end-of-life issues*

Item/statement	Score Mean	Score SD	% Agreement
Nurse is responsible for conferring with the doctor if a patient's rights have not been considered	5.58	0.86	97.6
Nurses should help inform patients of the patients' condition and treatment options	5.44	1.01	96.2
Appropriate to give pain medication even if it hastens death	5.56	0.89	96.1
Uphold patients' wishes when nurses' view conflicts with patients' view	5.54	0.95	94.8
Nurses should actively help patients complete advance directives	5.10	1.30	89.0
Actively assisting some patients to die should be made legal	3.20	1.61	42.2
Starting or stopping life support is ethically the same	2.88	1.63	31.7
Acceptable for healthcare providers not to offer treatment to the terminally ill	2.00	1.42	16.7
Advance directives lead to acceptance of euthanasia	2.06	1.34	12.4

*Scores are based on a 6-point Likert scale (1 = strongly disagree to 6 = strongly agree); % agreement = sum of Likert scale scores 4-6 divided by the total responses per question; reliability coefficient (Cronbach α) = .57. Because of the length of the instrument used, only items for which some level of conclusion can be drawn are given in this table.

EfCCNa survey: European intensive care nurses' attitudes and beliefs towards end-of-life care

Jos M Latour, Paul Fulbrook and John W Albarran

ABSTRACT

Background: Available literature suggests that critical care nurses have varied experiences in relation to end-of-life (EOL) care. Few studies have examined the involvement of European intensive care nurses' involvement in EOL care decisions and the extent to which their nursing practice is based on shared beliefs, experiences and attitudes.

Aim: To investigate experiences and attitudes of European intensive care nurses regarding EOL care.

Methods: Using a survey method, delegates ($n = 419$) attending an international critical care nursing conference were invited to complete a self-administered questionnaire about their involvement with EOL care practices. The questionnaire composed of 45 items and was available in three European languages.

Results: A total of 164 questionnaires were completed, yielding a response rate of 39%. The majority of respondents (91·8%) indicated direct involvement in EOL patient care, while 73·4% reported active involvement in decision-making process. 78·6% of respondents expressed commitment to family involvement in EOL decisions, however only 59·3% of the participants said that this was routinely undertaken ($p < 0·0005$, $Z = -4·778$). In decisions to withdraw or withhold therapy, 65% would decrease the flow of inspired oxygen, 98·8% provide continuous pain relief and 91·3% endorse open visiting. The majority (78%) disagreed that dying patients should be transferred to a single room. A division of views was observed in relation to 44% agreeing that patients should be kept deeply sedated and equal numbers contesting the continuation of nutritional support (41·6% versus 42·3%).

Conclusions: The involvement of European intensive care nurses in EOL care discussions and decisions is reasonably consistent with many engaged in initiating dialogue with coworkers. In general, views and experiences of EOL care were similar, with the exception of the provision of nutrition and use of sedation.

Relevance to practice: Use of formal guidelines and education may increase nurses' involvement and confidence with EOL decisions.

Key words: Attitudes • Decision-making • End-of-life care • Ethics • Intensive care • Nursing

Table 5 Nurses' beliefs of EOL care practice

	n	Strongly agree or agree [*n* (%)]	Do not know [*n* (%)]	Strongly disagree or disagree [*n* (%)]
During EOL care, the patient *should not* continue to receive fluids to maintain hydration	158	27 (17·1)	12 (7·6)	118 (74·7)
The family and friends of the patient *should* be permitted to visit at any time, day or night	161	147 (91·3)	4 (2·5)	10 (6·2)
During EOL care, oro/endotracheal suction *should* be continued to maintain the airway of the patient	161	131 (81·4)	7 (4·3)	23 (14·3)
The patient *should not* be kept deeply sedated	156	56 (35·9)	29 (18·6)	69 (44·2)
The patient *should* always be given the opportunity to receive last rituals that are appropriate to the religious and spiritual beliefs of the patient and their family	160	155 (96·9)	4 (2·5)	1 (0·6)
The patient *should not* continue to receive all interventions to prevent pressure sores	159	53 (33·3)	7 (4·4)	97 (61)
The patient *should* continue to receive care from nurses who know the patient and family	157	121 (77)	10 (6·4)	26 (16·6)
The patient *should* be provided with effective pain relief	161	159 (98·8)	1 (0·6)	1 (0·6)

	n	Strongly agree or agree [*n* (%)]	Do not know [*n* (%)]	Strongly disagree or disagree [*n* (%)]
Timing of EOL discussion often too early	156	11 (7)	4 (2·6)	141 (90·4)
Timing of EOL discussion just right	154	56 (36·4)	16 (10·4)	82 (53·2)
Timing of EOL discussion often too late	155	91 (58·7)	18 (11·6)	46 (29·7)
Asked by medical colleagues to participate in EOL decisions	157	60 (38·2)	12 (7·6)	85 (54·1)
Always actively involved in EOL discussions with physicians	157	69 (44)	7 (4·5)	81 (51·6)
Often initiated EOL discussion with doctors	154	98 (63·6)	16 (10·4)	38 (24·6)
Patient and/or family is always involved in EOL discussions	155	92 (59·3)	8 (5·2)	55 (35·5)
Patient and/or family always need to be consulted before EOL decision is made	159	125 (78·6)	2 (1·3)	32 (20·1)
Involvement in EOL decisions positively influences job satisfaction	156	112 (71·8)	18 (11·5)	26 (16·7)

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Review Article

Nursing Roles and Strategies in End-of-Life Decision Making in Acute Care: A Systematic Review of the Literature

Judith A. Adams, Donald E. Bailey Jr., Ruth A. Anderson, and Sharron L. Docherty

Duke University School of Nursing, 307 Trent Drive, Durham, NC 27710, USA

Table 2: Summary of roles, strategies, and outcomes.

Information broker	Supporter	Advocate	Patient and family outcomes
Give information to physicians	Build trust	Advocate to physicians	Accept that patient is dying
(i) Patient and family preferences	(i) Introduce self and oncoming nurse	(i) Speak out in meetings	(i) Prepare
(ii) Emotional readiness	(ii) Practical needs	(ii) Question or coach	(ii) Help let go
(iii) Clinical condition of patient	(iii) Provide details about patient and daily care	(iii) Plant seeds	
	(iv) Accept decisions	(iv) Time discussions around physician seen as most open	
	(v) Explain equipment		
	(vi) Willing to talk		
	(vii) Rituals		
	(viii) Storytelling and life review		
	(ix) Help maintain hope		
	(x) Prepare for bad news		
	(xi) Assess readiness		
	(xii) Negative: ignore family and focus on technical details		
Give information to family	Empathy	Advocate to family	Make better decisions
(i) Educate about disease process	(i) Emotional support	(i) Give clear information	(i) Get the truth from nurses
(ii) Explain equipment	(ii) Acknowledge feelings	(ii) Interpret information	(ii) Understanding of prognosis
(iii) Translate/interpret medical terms	(iii) Take time to listen	(iii) Explore goals	(iii) Trusting relationships, allowed family to ask more questions
(iv) Clarify	(iv) Support physicians as well as family members	(iv) Explain implications of decisions	(iv) Move along in decision making process
(v) Educate	(v) Allow family time to process information	(v) Encourage to consider what patient would want	(v) Good death
(vi) Give information only without interpretation		(vi) Describe how patient is responding to treatment	(vi) Fear that families carry burden of guilt
(vii) Provide meaningless information		(vii) Explain prognosis	(vii) Satisfaction with care
		(viii) Blunt at times	
		(ix) Tell family patient is dying	
		(x) Sometimes vague and not involved	
Mediate		Extent of nursing advocacy:	
(i) Coordinate family meetings		(i) 75% actively involved in EOL decisions	
		(ii) 42%–54% discuss EOL decisions with patient or family members	
(ii) Consult other disciplines			
(iv) Request ethics consult			
(iii) Facilitate communication between family and medical team			
(iv) Ask physician to speak to family			
(v) Coach family in what to ask physicians			

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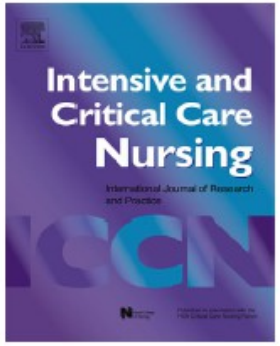

ANNIVERSARY SERIES: THE STATE OF THE SCIENCE

Caring for the dying patient in the ICU — The past, the present and the future

Isabell Fridh*

School of Health Sciences, Borås University, S-501 90 Borås, Sweden

as problems or obstacles when caring for dying patients (Espinosa et al., 2008). The most common problems ICU nurses report are lack of involvement in the care planning and in EOL decisions, disagreement among physicians and other healthcare team members, unrealistic expectations from families, lack of experience and education, lack of support from superiors, too low staffing levels and an environment not designed for EOL care (Espinosa et al., 2010; Zomorodi and Lynn, 2010).

Follow-up meetings after a loved one's death in an ICU are requested and wished for by bereaved families (Downar et al., 2014; van der Klink et al., 2010; Williams et al.,

of-life care (Coombs et al., 2012). In conclusion, the major problems ICU nurses report concerning EOL care are related to issues about when to stop futile medical care and to the insufficient dialogue with the medical profession about end-of-life decisions. To move forward there is a need for more research to evaluate interventions that can improve communication between health care providers in the ICU (Kryworuchko et al., 2013).

Un paziente con emorragia cerebrale intrattabile in ventilazione artificiale: le questioni etiche.

Terapia Intensiva Generale e Neurologica ed Anestesia Generale

Corso Pratico A.A. 2014-15 (12 marzo 2015)

Federico Nicoli
Dottorando di Ricerca in
Medicina e Scienze Umane
Università degli Studi dell'Insubria (Varese)

Questioni presenti:

Legate al paziente e alla famiglia: - **I desideri della famiglia** - **La storia del paziente**	**Legate agli interventi:** - **Proporzionato/Non Proporzionato** **- Rischio/beneficio**
Legate all'équipe sanitaria: - **Le decisioni prese sono state condivise?** - **La paura dell'eutanasia?** - **Quali le motivazioni per un non-intervento?**	**Legate alla relazione équipe-famiglia:** - **la relazione come "luogo decisionale": ne va anche di chi si prende cura, non solo di chi è curato** - **Quale il processo decisionale per arrivare alla scelta di 'non iniziare'?**

Non mettere in ventilazione meccanica il paziente:
potrebbe non essere atto eutanasico.

In una condizione di terminalità (criterio prognostico), un trattamento può configurarsi (clinicamente ed eticamente) come sproporzionato e quindi vi è la possibilità (non doverosità) di rinunciarvi sia non iniziandolo che sospendendolo, in quanto la causa della morte è fortemente legata alla malattia e non alla sospensione o non inizio dei trattamenti.

Se null'altro è fattibile, cos'altro si può fare?

La prognosi terminale sembra avere una diretta influenza sulla questione morale inerente alla decisione di sospendere o non-iniziare una terapia di sostegno vitale:

tali scelte si orientano a valorizzare quanto più possibile la vita negli ultimi istanti (dignità del morente) evitando l'accanimento, ma al tempo stesso sembrano accelerare l'inevitabile processo del morire.

Arrendersi al limite?

In una logica di resistenza – resa (non solo al dolore) può essere considerato eticamente lecito:

A) In una condizione di terminalità, arrendersi alla malattia, ciò sembra non delinearsi né come disprezzo della vita, né come atto eutanasico

B) Sospendere o non iniziare un trattamento quando mi rendo conto di aver dato tutto quello che potevo offrire (sia come medico, sia come paziente).

<u>In conclusione</u>: nessuna scelta è eticamente neutra e tutte le scelte vanno condivise e motivate, dentro una relazione, nella quale tutti i protagonisti hanno una parola da dire e non un veto da porre.