Identification of the factors affecting the anxiety and confidence of intensive care patient's relatives and analysis of these factors.

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INTRODUCTION

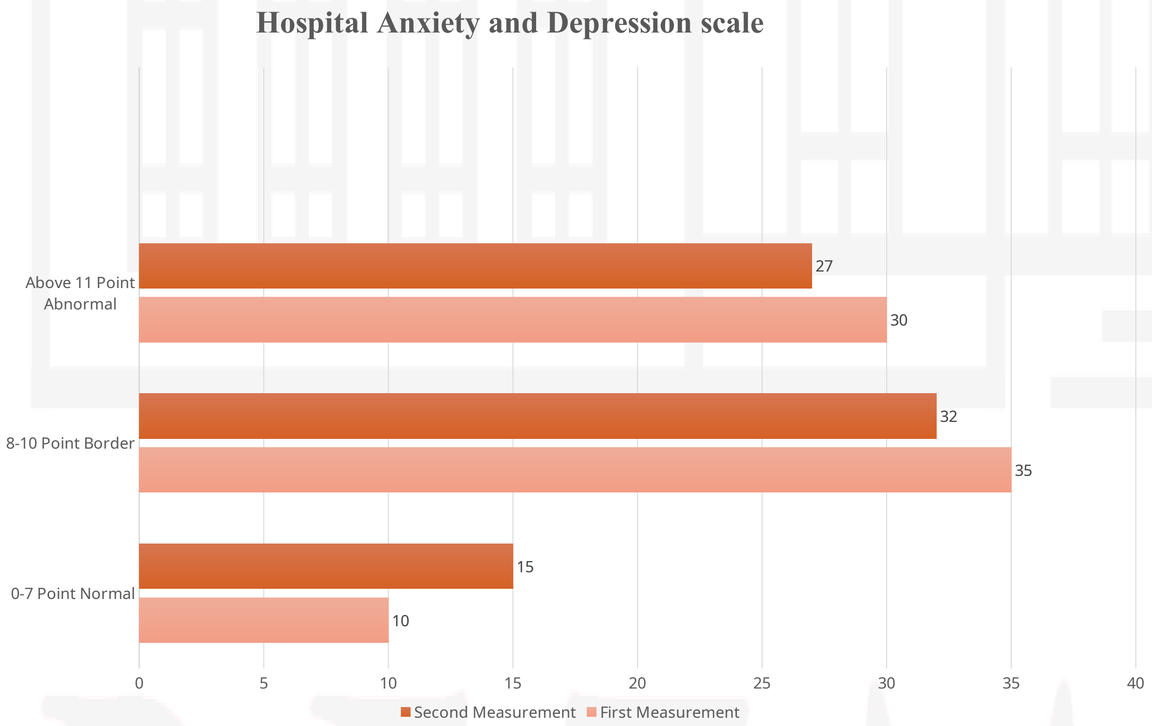
Advancements in healthcare have led to an increased demand for intensive care services, where patients often rely on their families to make critical decisions on their behalf. This responsibility can lead to heightened anxiety and a strong need for trust among the families. Establishing effective communication channels with patient families is crucial, encompassing clear information dissemination, regular visitations, easy access to medical staff, and fostering a sense of trust and active involvement in the patient's care. Evaluating the perceptions of patient families can provide valuable insights for enhancing the quality of intensive care unit services.

METHODS

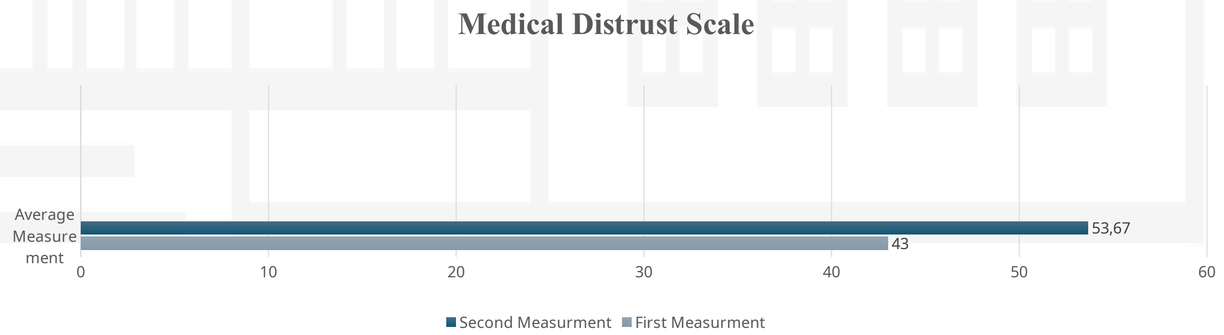
A study group will be formed with family members of patients who initially visited the emergency department, were later transferred to the intensive care unit, and stayed for at least 3 days. Family members must be over 18 years old and have attended regular visits. Those whose patients' conditions changed will be excluded. The study will focus on the first healthcare provider interaction, visit numbers, and visit nature. Data on visit presence and discussions with the doctor will be recorded. The scales will be applied to the same family member at the beginning and end of the ICU stay. Deceased patients' family members will be included. Ongoing hospitalization cases will be excluded. Additionally, family members will complete the Medical Distrust Scale, Doctor Trust Scale, and Hospital Anxiety and Depression Scale.

RESULTS

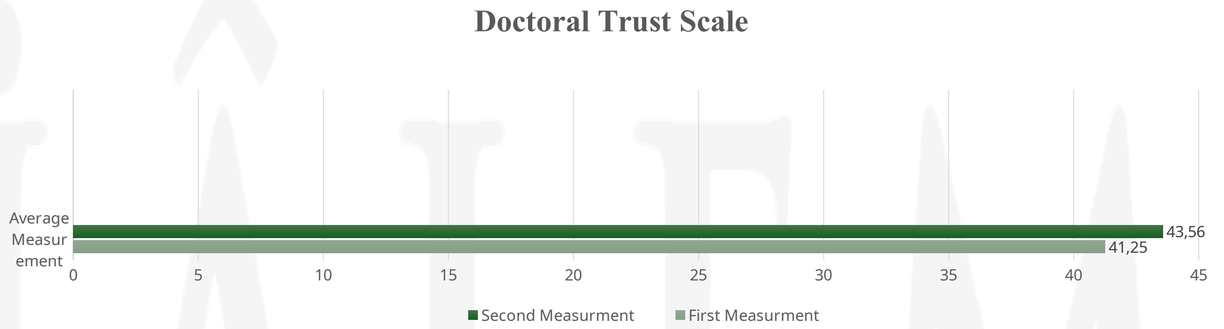
Out of 75 patients with a normal score on our Hospital Anxiety and Depression scale: 10 out of 10 patients remained in the same category. Patients with borderline scores: 6 of 35 patients returned to normal scores. Patients with abnormal scores: 3 out of 30 patients returned to borderline scores. There is a significant relationship between the first and second measurements in the combined chi-square test with a value of 56.43, indicating a statistically significant difference between the two measurements(Graphic 1). In our first administration of the medical trust scale, our group scored an average of 43 points, while in the second administration, they scored an average of 53.67 points. The critical t-value has been calculated to be approximately ±1.976 from the table values, indicating a significant difference(Graphic 2). When we applied the doctoral trust scale for the first time, they scored an average of 41.25 points. In the second application, they scored an average of 43.56 points. When we compare these two values in the t-test, we find a t-value of ± 14.65. This indicates a significant difference between the two groups(Graphic 3).



Graphic 1: Hospital Anxiety and Depression scale



Graphic 2: Medical Distrust Scale



Graphic 3: Doctoral Trust Scale

CONCLUSION

Identifying dissatisfaction risk factors at ICU admission is crucial for healthcare providers to improve care quality for patients and families. The strong link between specific elements during the ICU stay and overall dissatisfaction highlights the need for proactive monitoring and intervention. These insights inform evidence-based strategies to enhance ICU satisfaction by tailoring interventions, improving communication, and enhancing support services. In summary, early identification of risk factors, addressing specific elements during the ICU stay, and implementing evidence-based strategies are essential for improving care quality and satisfaction for families in the ICU.

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