ORIGINAL ARTICLE

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ADVANCED AIRWAY: FEELINGS EXPERIENCED BY PATIENTS IN PRE AND POST ENDOTRACHEAL EXTUBATION

VÍA AÉREA AVANZADA: SENTIMIENTOS EXPERIMENTADOS POR PACIENTES EN PRE Y POST EXTUBACIÓN ENDOTRAQUEAL

VIA AÉREA AVANÇADA: SENTIMENTOS VIVENCIADOS POR PACIENTES NA PRÉ E PÓS EXTUBAÇÃO ENDOTRAQUEAL

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ABSTRACT
Objective: to exhibit the feelings lived by patient hospitalized in an emergency room during the pre and post endotracheal extubation period. **Method:** qualitative research conducted with patients at a university hospital in the state of Paraná, during the first semester of 2017. Data collection took place through seven semi structured interviews, submitted to thematic content analysis. **Results:** there were identified four thematic categories that exhibited feelings of a traumatic experience by pain, lack of dialogue, unknowledge of the professional that was taking care, difficulty in communication, and anguish. **Final Considerations:** it becomes important to humanize the assistance in a way to realize that the patient is not an ill body anymore, but rather, a holistic human being that must be taken care of beyond merely technical procedures.
Key-words: Intubation, Intratracheal; Artificial Respiration; Emotions; Emergency Medical Services; Qualitative Research.

RESUMEN
Objetivo: revelar los sentimientos vividos por pacientes hospitalizados en un servicio de urgencias durante el período pre y post extubación endotraqueal. **Método:** investigación cualitativa realizada con pacientes de un hospital universitario en el estado de Paraná, durante el primer semestre de 2017. La recolección de datos ocurrió a través de siete entrevistas semiestructuradas, sometidas a análisis de contenido temático. **Resultados:** fueron identificadas cuatro categorías temáticas que revelaron sentimientos de una experiencia traumática por dolor, falta de diálogo, desconocimiento del profesional que atendía, dificultad en la comunicación y angustia. **Consideraciones Finales:** se vuelve importante humanizar la asistencia de forma que se perciba que el paciente ya no es un cuerpo enfermo, sino un ser humano holístico que debe ser cuidado más allá de procedimientos meramente técnicos.
Palavras-Claves: Intubación Intratraqueal; Respiración Artificial; Emociones; Servicios Médicos de Urgencia; Investigación Cualitativa.

RESUMO
Objetivo: desvelar os sentimentos vivenciados por pacientes internados em um pronto socorro no período pré e pós extubação endotraqueal. **Métodos:** pesquisa qualitativa desenvolvida com pacientes de um Hospital Universitário do Estado do Paraná, no primeiro semestre de 2017. A coleta de dados se deu por meio de sete entrevistas semiestruturadas, que foram submetidas a análise de conteúdo temática. **Resultados**: identificaram-se quatro categorias temáticas que desvelaram sentimentos de uma experiência traumática pela dor, falta de diálogo, desconhecimento do profissional que estava prestando os cuidados, dificuldade de comunicação e angústia. **Considerações finais**: torna-se importante humanizar a assistência de maneira a perceber que o paciente não é mais um corpo doente e, sim, um ser humano holístico que deve ser atendido para além dos procedimentos meramente técnicos.
Palavras-chave: Intubação Intratraqueal; Respiração Artificial; Emoções; Serviços Médicos de Emergência; Pesquisa Qualitativa.

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INTRODUCTION

Endotracheal intubation consists in the insertion of a tube in the trachea either orally or nasally, a procedure indicated in cases of emergency, in which there is a need to sustain the airways permeability. [1]

The difficulties in communication forces that, in most of the times, patients submitted to the procedure of endotracheal intubation see their expressions of opinion annulled, added to the existence of decisions regarding their own treatment being made without their knowledge, leading to feelings of uselessness and stress. Therefore, the difficulty in communication felt by mechanically ventilated patients is a current issue, and this can be softened through support programs of verbal and non-verbal communication developed by multiprofessional teams. [2]

To highlight a clinical picture is essential, although the perceptions and feelings of patients should not be lost sight. To do so, communication is held as an important tool to be used by health professionals. [3]

The raise in awareness from all health professionals that directly take care of patients is of a fundamental importance, so that care provision becomes more individualized and well-adjusted every time, which guarantees the value and inclusion of the hospitalized individual in their own caring process, observing the patient fully, aiming to not overload technical procedures. [4]

Patients under endotracheal intubation need the weaning from mechanical ventilation (MV), that is, the patient's liberation from a mechanical ventilatory support. Hence, the weaning is not the same as extubation, which can be seen as the weaning's result. During the weaning process it is needed to prioritize strategies and criteria, including the evaluation of ventilatory, clinical, and biochemical parameters.[5]

In the face of the considerations above and the scarcity of studies under the theme related to patient's feelings in the pre and post extubation period, we believe that this study is relevant, once it will contribute to nursing teams and other health professionals reflect towards the importance of communication with patients, as well as make them see the patient fully, which means, beyond technical procedures.

Therefore, there is the following inquiry: What are the feelings of patients who experimented the process of endotracheal extubation? In order to answer this questioning, we traced as objective exhibit the feelings experienced by patients hospitalized in an Emergency Room (ER) during the pre and post endotracheal extubation period.

METHOD

A qualitative study took place with patients submitted to endotracheal intubation with a following procedure of extubation in an Emergency Room of a university hospital. It consists of a teaching hospital, the third largest of Brazil's south region, composed by 306 beds, all designated to the Unified Health System (SUS in

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Portuguese), that assists all medical specialties from children to adults.

The criteria for inclusion were the following: ER patients extubated, at least, 6 hours before that reported memories from any moment during the intubation process, over 18 years old, with a Mini-Mental State Examination (MMSE) score between 17 and 27. We collected the data between May and July 2017, identifying 33 patients who were submitted to an extubation procedure. From these, 15 (45.5%) did not show enough conscious level to be interviewed, 8 (24.3%) did not hold memories related to the intubation procedure, 3 (9%) had received hospital discharge before the evaluation to become possible interviewees. Thus, 7 (21.2%) fitted within the criteria for inclusion in this study and were selected as research participants.

We collected sociodemographic data from patients' promptuaries (age, cause of hospitalization, cause and duration of intubation, and emergence time) and undertook individual interviews using the following guiding research question: Tell me the feelings you have experienced when you were intubated and after the extubation. The interviews were 35 minutes length in average and were audio taped as well as fully transcribed.

We analyzed and interpretated data according to the Content Analysis[6] technique and the following steps: pre-analysis, material exploration, and interpretation of results. During the pre-analysis we organized the material, that is, we carried a floating reading of the interviews aiming to identify the particularities of each interviewee that contributed to the elaboration of first impressions. After this, we moved on to the exploration of material phase, in other words, we proceeded with the codification of interviews, in letters and numbers, in a way that the samples concerning the study were clustered in units of analysis with analogous meanings that originated the categories. Lastly, we interpretated the results, to do so we analyzed the unrefined results in a valuable and meaningful way, by analyzing and discussing such discourses from the interviews.

This study was submitted to the Human Research Ethics Committee from the State University of Londrina, obtaining favorable decision for the research to be carried out (CAAE nº 66237717.0.0000.5231). To preserve participants' anonymity, their speeches were identified by the letter E followed by their interview number.

RESULTS

As mentioned before, seven patients took part in the study, out of them, six were male, and the average age was 41.5 years old. The intubation took, in average, 125.1 hours, the emergence time (time elapsed between the removal of sedation and the extubation moment) was of 44.4 hours in average. Below, table 1 shows data related to age, cause of hospitalization, cause and duration of intubation, and emergence time of interviewed patients.

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Table 1 - Characterization of research participants. Brazil, 2017.

	Age	Cause of Hospitalization	Cause of intubation	Duration	Emergence
E1	59	Acute Myocardial Infarction	Lower consciousness level after cardiac arrest	192 hours	72 hours
E2	50	Burn	Respiratory failure	13 hours	13 hours
E3	17	Diabetic Ketoacidosis	Lower consciousness level after	12 hours	12 hours
E4	18	Suspected H1N1	Respiratory failure	192 hours	36 hours
E5	27	Exogenous poisoning with psychoactive drug	Lower consciousness level after convulsive seizure	144 hours	72 hours
E6	62	Acute pulmonary edema	Respiratory failure	11 hours	10 hours
E7	60	Cardiac arrest	Lower consciousness level after cardiac arrest	312 hours	96 hours

Source: The authors

From the interviews, four categories emerged and are presented further:

1. Feelings of anguish experienced with endotracheal intubation

In this category patients revealed feelings experienced as soon as they retook their consciousness, as shown in the excerpts:

God forbids me! I don't wish even for a dog what I've suffered. It's of an anguish by itself. I can't even tell the size of such anguish, impotence in the face of such situation, [I] couldn't do anything. (E1)

Feeling under the weather, a despair, nasty thing, an anguish all the time. It's like a car you're driving and suddenly you hide your head and let this car get all the way there and hit. [I] felt desperation, total incapacity. (E2)

[I] felt flustered. As if tons of wires were indeed inside me, as if a person pulled [them] and all my organs had been pulled out together, as if it was fishing. A non-measurable anguish. (E4)

An awkward feeling of deep anguish. I thought I was choking with something and [it] didn't get out. [E6]

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2. Feelings of time disorientation due to sedation

Patients verbalized that more than negative sensations, the sedation process and the intubation procedure also caused temporospatial disorientation:

I slept again, not sure if I've slept or fainted, but I guess I've fainted, because when I woke up, I realized that [I] was with several doctors around me, but I didn't know if it was day or night or even where I was. (E3)

I lost track of day and night and where I was. But after [they] told me I was at the hospital, that's when it hit me. (E6)

3. Frustration in the attempts of verbal and non-verbal communication due to intubation

The deponents affirmed that it was highly rare having someone to talk, explain something both by voice and signals. They also reported having huge difficulties to communicate. That is what the following excerpts reveal:

> *I tried, but no one could understand me. [They] told that I shouldn't chat. Moreover, no one understood me through gestures. I asked for a tiny cup of water showing [it] through signals once my voice wouldn't come out, but no one understood. Then someone came and asked if I wanted 'cachaça' and laughed. But God is good and a lady came and I told her to come very close, [I] made a signal and she understood. There are angels that take care of us.* (E1)

> *I even tried to talk, but couldn't say a word, [I] didn't have any voice and making signals was not possible, I was tied.* (E3)

> *Couldn't talk because I tried talking but it felt that the tube got even deeper inside, [it] hurt more from within, the throat ache, the lungs felt as if [they] were being pulled outside. You know, people talked very little to us and not even gestures I could make once [I] was tied.* (E4)

> *Due to the hose [endotracheal tube] I didn't talk, I gave signals when they released me to take that hose off me. The throat got stuck. The doctors and nurses didn't talk with us, [they] just said: calm down.* (E6)

> *They didn't understand anything! Then I asked for a tiny cup of water, once the voice wouldn't come out, no one understood! Another person came, then I made a signal that [I] wanted to reach a cup with water, but this person lacked in respect with me, asking to me: Is it 'cachaça' that you want? Another person came again and I told her to get very close, [I] made a signal because I couldn't talk, then she understood.* (E7)

4. The experiences in the endotracheal extubation process

The patients reported how the process was intense, painful, and without much explanation, indeed they could not differentiate the professional who took care of them. The excerpts show this reality:

> *I woke up with a bunch of doctors (I think they were) around me. Then they just said: cough! Then I coughed and they desintubated* [extubated] *me. [It]*

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> *was painful, horrible pain, [I] got very scared.* (E3)

> *There were a bunch of people that I didn't know who they were. [They] just took the tube out, no one said what was happening, didn't even get to a point of talking, [it] was horrible and intense.* (E4)

> *[It] hurt, the blood was stuck on that hose. [It] was something awful, weird, horrible. Even nowadays I expectorate a little blood, maybe it got hurt right? The hose was pretty dirt in blood when [they] took it out.* (E6)

DISCUSSION

The Coronary Artery Disease (CAD), as an example the acute myocardial infarction, represents the main cause of worldwide death and the largest clinical and financial impact within hospital institutes. The CAD when caused by the obstruction of the blood flow becomes inefficient to the given myocardium region, unleashing an unbalance between the supply and consumption of oxygen, being needed, in some cases, the use of ventilatory support to prevent death. [7]

For the traumatized by burns the possibility of endotracheal intubation must be admitted, once the conditions are tough due to facial edema, the laceration of soft parts, tumescent upper respiratory tract by inhalation of either steam, or carbon monoxide. It is also worth mentioning the decrease of the coronary flow and, consequently, the decrease in the cardiac contractility in the after-burn period, events which, most of times, lead to endotracheal intubation. [8]

In relation to diabetic ketoacidosis, this is considered a type of complication that might have acute severe effects, with chronical debilitating complications.[9]. From these complications, one of the procedures needed to patients is the endotracheal intubation. [10] For H1N1, many treatments are available, from which ventilatory support and extracorporeal membrane oxygenation are included. [11]

Regarding the acute pulmonary edema, this is a severe clinical syndrome caused from the alveolar filling by liquids, which complicate the hematosis.[13]. It is a very common issue in contexts of urgency and emergency due to the deterioration of gas exchange, being needed, sometimes, the use of invasive ventilation. [14]

On what concerns cardiac arrest (CA), despite advances related to prevention and treatment, the death evolution is still significant. From this, the procedure of endotracheal intubation under these situations is essential to save lives and diminish sequels. [15]

During the weaning due to mechanical ventilation the basic patient's need was the continuous assistance that unfolds in a non-stop, stable, wide, and dynamic monitoring, with immediate responses to physiological and psychological changes. [16]

The insecurity felt when the patient wakes up and faces mechanical ventilation was identified in this study, indicating feelings as incapacity, lost of control over themselves, raising the hospital as a place in which preserving one identity and individuality is not possible. [17]

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A study conducted in Denmark with the goal of exploring the patients' experiences of being awake during mechanical ventilation entailed new opportunities and challenges for critically ill patients. Patients found themselves at the interface between agency and powerlessness, as they were able to interact, yet were bound by contextual factors such as bodily weakness, technology, spatial position, and relational aspects. [18]

Experiences of intubated patients reveal that they lived ambiguous feelings of sickness, exhaustion, confusion, breathing difficulty, and others such as struggle with breathing recovery, body, life, family, and everything considered meaningful to them. Images and good dreams represent strong support while recovering from such experiences. [19]

It is worth highlighting that the family must be nearby when the sedation is off and consciousness is retaken, so the patient might feel sheltered and safe knowing that a close relative is with them, diminishing possible psychological issues. [20]

In Switzerland, the participants of a research with an objective of describing experiences of patients undergoing mechanical ventilation reported that not being understood led to feelings of panic and frustration. Also, when awaking, they described distress by having the tube in the throat and thirst, feeling that their bodies were weak, paralyzed, what resulted in a feeling of dependency on others, as well as the sense of time disorientation. [21]

Another study indicated that when awaking while being intubated and ventilated, patients described such situation as frightening, beyond the fact that not being able to communicate lead them to sensations of being trapped in an dysfunctional body, once, according to them, they could understand everything said, but did not have any accessible support to communication in order to be able to respond efficiently, and they judge that there was a lack of humanization in this relationship. [22]

We emphasize that such relationship between the patient and the team is fundamentally important, mainly in situations in which the mechanical ventilator blocks verbal communication. The facts of not being able to speak and realizing that one is in a different environment, specially a hospital, make the patient becomes insecure and anguished. It is necessary that the interaction and the perception, mostly from the health professional, are deeper in order to make the comprehension as complete as possible. Even though the communication cannot be verbalized by the patient, it is believed that a therapeutic relationship built on trust and mutual respect can be developed. [23]

The communication, either verbal or not, becomes a tool to promote a humanized care. Thus, it helps to promote emotional care, considering an ability to understand the invisible, that is, what many times cannot be noted or perceived, once it demands sensibility related to verbal and non-verbal manifestation by the patient. This process can indicate to the health professional, mainly the nurse, each human being

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individual needs, in other words, see the patient in a holistic way. [24]

A study pointed out that non-verbal communication is essential to the patient, despite being a strategy to reduce fear, anguish, and grant security to them. In this same study, it was shown that although patients were sedated and deprived of verbal communication, they made use of facial expressions in an attempt to establish a type of non-verbal communication. [25]

In a specific part of this study, we could identify the lack of ability from the professional when gesticulating to the patient to know if they wanted alcoholic beverage, when the patient made signals asking for water. The professionals need to reflect, become aware and notice the way they treat and relate with patients. It is needed to be aware and alert to the patients' communication needs, posit and take care of them respectfully, always communicating, regardless their level of consciousness. [26]

Related to physical restraint, with the humanization of care practices and legislations aimed to the patient's safeness, the restraint is used in a therapeutic way and not as repression, therefore, it should take place when the patient offers risk to themself and the health team. [27] Highlighting the importance it should be explained to the patient the reason why they are being taken care this way, even if the professional evaluates that the patient is not understanding the situation.

To make the extubation procedure humanized even deeper it is needed the creation of a protocol containing the professionals in charge of the patient's extubation process, as well as the systematization of this process. [28] The pain was also verbalized by the interviewees in this study. The pain is one of the key complains by patient hospitalized in intensive care unit beds. A research indicated pain as the main distress caused by extubation. [21]

FINAL CONSIDERATIONS

For all the interviewees, distress was unanimous, even with several professionals present during the pre and post extubation process, the feelings were of a traumatic experience, whether it came by pain, lack of dialogue, lack of knowledge of the professional that was taking care, difficulties in communication, anguish and even fear of death. It is from a unique importance to humanize the assistance in a way to realize that the patient is not an ill body anymore, but rather, a holistic human being that must be taken care of beyond technical procedures.

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