How to reduce the negative psychological impact of MRSA isolation on patients

Patient isolation is necessary to prevent MRSA cross infection but steps must be taken to minimise the psychological impact of this infection control measure.

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MRSA is contagious and difficult to treat, and the isolation of infected patients is recommended by the Department of Health. However, isolation can have a negative psychological impact on patients and is controversial. This literature review explores the effects of isolation based on three themes: isolation environment and psychological impact; stigma of MRSA; and nursing care.

INTRODUCTION

The problem of treating Staphylococcus aureus was solved, for a time, with the discovery of penicillin in the first half of the 20th century. However, by 1959, 90-95% of all strains were penicillin resistant (Department of Health, 2007). Meticillin became the common treatment but resistance became a problem again, resulting in meticillin resistant Staphylococcus aureus (MRSA) (DH, 2007).

Although MRSA can live harmlessly on the skin and in the nose, it can cause infections ranging from boils to bacteraemia (DH, 2007). It is usually transmitted by contact from skin to skin or from skin to a contaminated surface (DH, 2008; DH, 2007).

The DH (2009) recommended source isolation to prevent cross infection. However, isolation can have a negative psychological effect on patients (Morgan et al, 2009; Madeo, 2003; Ward, 2000) and its use is controversial.

LITERATURE SEARCH

Three recurring themes were identified in the literature:

- Isolation environment and psychological impact;
- Stigma of MRSA;
- Nursing care.

ISOLATION ENVIRONMENT AND PSYCHOLOGICAL IMPACT

Isolation and sensory deprivation have been identified as a cause of stress and have been used as part of interrogation techniques (Denton, 1986). In clinical practice, a minority of patients valued the isolation environment but the majority viewed it as a negative experience (Oldman, 1998; Knowles, 1993). Sarafino (2008) suggested this is due to individual personality type. People with type A personalities have a strong sense of control and deal more effectively with stress (Sarafino, 2008) whereas those with type B personalities possess a weak sense of control which, in times of stress, can make them feel helpless, trapped and depressed (Sarafino, 2008).

Madeo (2003) suggested patients’ preference for isolation depended on their normal social environment.

Feeling separated

Separation from others is identified as one of the negative effects of isolation. A small qualitative study found that patients were frustrated at the loss of companionship and the inability to watch ward activities or attract staff attention (Knowles, 1993). Cava et al (2005) and Hawryluck et al (2004) studied the experience of quarantined patients affected by severe acute respiratory syndrome (SARS) in Canada and described how they felt isolated and found the lack of social and family member contact difficult.

Isolation has been described as traumatic; patients can become discontented with being confined while others can walk around (Madeo, 2001). Oldman (1998) identified that isolated patients felt excluded and lonely, although in this study two participants with a view on to the ward, allowing them to see nursing staff, were unaffected by isolation.

Monotony and boredom

Participants from three studies described lack of visual contact and meaningless activities during isolation (Cava et al, 2005; Oldman, 1998; Knowles, 1993). Some described this by keeping themselves busy, cleaning their rooms and watching television (Knowles, 1993) while others became attention seeking and anxious (Oldman, 1998).

Some described an increased focus on room fixtures, such as a clock and paintings (Gaskill et al, 1997) and patients confined to bed may be frustrated when these objects are out of their line of sight.

Psychological problems

Isolation can cause sensory deprivation, resulting in disorganised behaviour and symptoms such as boredom, lack of coherent thinking, anxiety, fear and depression (Moore, 1991; Denton, 1986). Isolated patients have a statistically significant increase in anxiety and depression levels (Laliotis, 2003; Tarzi et al, 2001) and the susceptibility and severity of altered mood states increases with length of isolation (Laliotis, 2003; Madeo, 2001; Oldman, 1998).

Hawryluck et al (2004) found statistically significant increased rates of depression and post traumatic stress disorder (PTSD) in people quarantined at home with SARS who were on a low wage or had been isolated for longer than 10 days. However, these people were facing a traumatic national crisis due to the widespread quarantine experience, impact and disruption to normal daily life and were prevented from going to work, which may have caused financial stress. These findings are not necessarily applicable to isolation for MRSA but it has been reported that patients can develop PTSD following hospitalisation in intensive or coronary care (Taggart, 2004).

Interestingly, Kennedy and Hamilton (1997) found increased anger was the only psychological effect of isolation. However, their research focused on MRSA isolated patients with spinal cord injury and the findings are difficult to generalise. Further research is needed in this area to assess whether this relationship is significant.
Impact on recovery

Patients have suggested that isolation hinders rehabilitation/recovery because physical space in isolation rooms is limited and they are not able to leave for physiotherapy (Kennedy and Hamilton, 1997; Knowles, 1993).

Kennedy and Hamilton (1997) found isolation was detrimental to participants’ adjustment to spinal cord injury. This could be attributed to the traumatic and disabling nature of their injury and limited ability to use strategies, such as tidying their room, to counteract the effects of isolation.

Privacy, solitude and personal control

Some patients enjoyed the control isolation gave over activities such as watching television and listening to the radio, telephone and clock and paintings, provide comfort, entertainment and stimulation. These should be positioned so they are accessible and visible to those confined to bed. Use of cohort wards for patients who are colonised or infected with MRSA can prevent spread of infection and address the negative psychological impact of isolation (Curran et al, 2006).

STIGMA OF MRSA

Many patients do not understand their MRSA infection and its mode of transmission and it is suggested that this can lead to feelings of stigmatisation (Gasin et al, 2008; Hawryluck et al, 2004; Oldman, 1998). Stigma has been defined as a perception that discredits and damages the identity of those affected (Goffman, 1968).

Patients focused on measures taken to prevent contagion, such as a dislike of gloves and aprons (Cava et al, 2005; Hawryluck et al, 2004), which made them feel dirty and unclean (Madeo, 2001; Oldman, 1998). Madeo (2001) and Knowles (1993) suggested that patients attributed the reluctance of nursing staff to enter rooms as a fear of infection and this can be interpreted as a form of prejudice (Jaramillo, 1999).

M adeo (2001) described patients’ contempt for source isolation signs on the doors as they feared it deterred staff from entering the room. There is evidence that some nurses fear infection and its impact on earning capacity (Knowles, 1993).

Perceptions

Cava et al (2005) and Hawryluck et al (2004) found patients were scrutinised by others after SARS quarantine.

The SARS outbreak was a national problem in Canada with major media coverage, limiting confidentiality and provoking public fear and negative attitudes (Hamour et al, 2003). MRSA also encounters considerable and often sensationalist media coverage, and evidence suggests that patients and the public have limited and often inaccurate knowledge about the nature and transmission of healthcare associated infection (Gould et al, 2009). Therefore, patient confidentiality is vitally important to protect them from the harmful scrutiny of others (Hamour et al, 2003).

Self regard

MRSA infection itself does not appear to have a direct negative impact on an individual’s psychological state. Although some patients were fearful about infecting their friends and family (Hawryluck et al, 2004; Oldman, 1998), and others were angry towards the hospital (Newton et al, 2001), there was no mention in any of the studies that MRSA directly affected their psychological state. In fact, participants in Newton et al’s (2001) study commented on the asymptomatic nature of MRSA and “not feeling any different”.

It is evident that MRSA itself does not result in stigmatisation, but the attitudes of other people and the way in which it is managed do.

NURSING CARE

Information giving

Participants in Newton et al’s (2001) research described MRSA as a “bug” and a “virus” or did not know what it was. The majority also had no idea how long the infection would last, with one believing it would end when he left hospital.

BOX 1. RECOMMENDATIONS FOR PRACTICE

Isolation environment

● Plans for new wards should consider the positioning and size of isolation rooms so patients have contact with staff and are able to continue rehabilitation. Windows should provide a view of ward activities.

● Room furnishings, such as a telephone, television, radio, clock and paintings, provide comfort, entertainment and stimulation. These should be positioned so they are accessible and visible to those confined to bed.

● Use of cohort wards for patients who are colonised or infected with MRSA can prevent spread of infection and address the negative psychological impact of isolation (Curran et al, 2006).

Staffing

● Higher nursing ratios in general hospitals correlate with more rapid discharge, fewer nosocomial infections and potentially lower mortality (Needleman et al, 2002).

● Nursing ratios should be sufficient to allow dedicated time to be spent with patients who are isolated to enable effective care.

Managing negative effects

● Nurses should encourage visiting to reduce feelings of loneliness and boredom, and improve patient experience (Madeo, 2001; Ward, 2000).

● They should prepare patients for isolation and explain the rationale to minimise distress and difficulty adjusting, reduce anxiety and increase satisfaction.

● Particular attention should be given to those expected to have a long period of isolation, which makes them more vulnerable to negative effects (Madeo, 2001; Oldman, 1998).

● Involving members of the multiprofessional team should be considered (Needleman et al, 2002).

Assessment

● The regular psychological screening of patients who are isolated will help identify problems, and give an opportunity to implement individualised interventions and evaluate care provided.

Education and training

● Educating nurses about MRSA infection, aetiology and transmission is important to allay nurse prejudice, enable effective information sharing with patients and relatives, alleviate fears, explain interventions and protect patients from stigmatisation (Jaramillo, 1999).

● Nurses need to be aware of the potential psychological harm of isolation and how to deal with it.

Communication

● Nurses should be aware of the stigma associated with infection precautions.

● Strict confidentiality of MRSA status can help to protect patients against the harmful scrutiny of others, although this can be difficult with the overt use of infection control precautions and should be discussed with patients (Gould et al, 2009).

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Lack of information can lead to anger, frustration and anxiety (Hawryluck et al, 2004) and patients complain they are given mixed messages about their management and protocols to follow (Cava et al, 2005). The haste with which isolation may be started can lead to difficulty coming to terms with changes in care and patients need careful preparation (Cava et al, 2005; Oldman, 1998).

**Patient satisfaction**

Lack of attention from nursing staff is identified as a problem in the literature (Newton et al, 2001; Oldman, 1998). Healthcare staff contact with source-isolated patients was approximately half that of non-isolated patients, and the length of time spent with isolated patients (in room contact time) was 22% less (Morgan et al, 2009).

Lack of visual contact between patient and nurse was seen as a barrier for care as the only method of attracting attention then became the call bell (Knowles, 1993). Waiting too long for the call bell to be answered resulted in patients feeling neglected, angry and anxious, and had implications for their physical health with reported episodes of avoidable incontinence (Knowles, 1993).

Oldman (1998) found nurses were concerned and felt guilty about not spending enough time with patients in isolation although, when they did, they also felt guilty for not being available on the ward. Nurses appeared to understand how patients felt about isolation. However, there is evidence that, when the latter showed signs of depression, nurses tended to reduce contact because they lacked skills in dealing with psychological needs (Madeo, 2001; Knowles, 1993).

**REFERENCES**


**CONCLUSIONS AND RECOMMENDATIONS**

It is clear that isolation has potential negative psychological consequences. See Box 1 for recommendations for practice on how to reduce its impact.

While isolation of patients infected with MRSA is recommended to control the spread of multiple drug resistant organisms (Morgan et al, 2009), a key lesson must be learnt: isolate the organism, not the patient. Isolating patients reduces opportunities to interact with patients and staff. It is vital that patients are empowered to remain in control and receive high quality personalised care.

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