

IDENTIFYING CONSISTENT TRANSITIONAL CARE BARRIERS AMONG ICU NURSES

Meghan E. Squire and L. Lee Glenn¹

College of Nursing, East Tennessee State University, Johnson City, TN 37614

Abstract

Häggsström, Asplund, and Kristiansen (2012) published a number of noteworthy strengths in their recent study of transitional care from ICU to general medical-surgical wards. These strengths include a clear explanation of the immediate danger and timeliness of the purpose, good sample size, prolonged engagement with the participants, member checking after the interviews, excellent auditability, excellent coding methodology, and many others. However, due to the possibility of bias and the lack of evidence, the conclusions that nonspecific hospital organization features and individualized care plans deliver quality transitions is not supported.

The recent study by Häggsström, et al. (2012) that was published in the *Intensive and Critical Care Nursing* concluded, “The study reveals the importance of a healthcare organization that provides the possibility for delivering coordinated, strengthening, and person-centered transitional care.” However, that conclusion is not supported because no evidence was presented comparing different health care organizations with regard to how they delivered transitional care. In fact, the findings listed were all known before the study had taken place and the methods used suggest a possible bias, as explained below.

First, as far as importance of the healthcare organization is concerned, the only way one can show this is to compare different types of health care organizations (defined as the transition from

ICU to medical-surgical units for patients) and look at their effects on the quality of transitional care, including patient experiences. It would also be necessary to rule out the possibility that any differences found were due to organization rather than other critical factors such as staff training, skill mix of the hospital staff, nurse-to-patient ratio, hospital finance, or dozens of other factors. Nothing like this was done in the study, even though two different hospitals were studied, so the main conclusion is really just an opinion that is not based on study findings. A secondary conclusion is also drawn that individual care plans facilitate the transition, in addition to various unspecified strategies used by the nurses. The secondary conclusion, which states individual care plans are the key element, contradicts the main conclusion that the critical factor is at the organizational level. With absence of quotes from nurses who did and did not use individual care plans or various

¹Corresponding Author: Meghan E. Squire, College of Nursing, East Tennessee State University, Johnson City, TN 37614-0658. Email: squirem@goldmail.etsu.edu.

strategies, the contradictory secondary conclusion has no support from the study findings.

Second, the study did not present any new ideas or new findings to this research topic. All of the listed findings were known before the study took place, as easily seen by reading the literature review in the introduction section of the above study. In fact, some of the quotes from the nurse participants supported previous studies cited but again contradicted the conclusions of the study. For example, a ward nurse said that when transitioned, patients feel as if their life threatening ailments were behind them, and felt happiness about their progress. This quote indicates that transitioning details might be minor compared to the relief of being transitioned. Therefore, despite all of the analysis of conversations with the nurse participants, no consistent picture emerges other than the general idea that doing everything better in every way will improve the transitioning experience.

Last, biases are difficult to remove from any qualitative study, but the methodology in the above study makes it especially prone to the opinions of the interviewers. The ICU nurse is depicted as wonderful individual that always attempts to do the right thing but is limited by stress and lack of empowerment. The possibility that some ICU nurses make mistakes or do not carry out the job in the manner they should is not even remotely considered. Consequently, the study has the tone of propaganda to promote ICU nurses, with statements such as: “The nurse’s role in ICU transitional care is important,” and “It is also essential that the nurse’s role both pre- and post-transfer is recognised ... (Häggröm et al. 2012)” Rigorous methodology that can reduce the innate tendency of researchers to be biased was not used, such as (1) the use of more than one independent interviewer where the additional interviewer(s) are not ICU nurses, (2) peer debriefing using both ICU and non ICU health care workers, and (3) negative case analysis to deeply explore findings that were not inconsistent with the main themes derived. Two of the authors did partially view the coding used by the interviewer for the specific purpose of reducing potential bias by the interviewer, which was apparently an ICU nurse, however it appears that this attempt may not have been successful, and that the findings may have colored by a pro-ICU nurse bias. The conclusion statement about the importance of health care organization in providing

for good transitions from ICU could be interpreted as blaming the entire health care organization, with the exception of the ICU nurse, for problematic transitions from the ICU.

The study has much strength, including a clear explanation of the immediate danger and timeliness of the purpose, good sample size, prolonged engagement with the participants, member checking after the interviews, excellent auditability, excellent coding methodology, and many other strengths. Despite these strengths, due to the possibility of bias and due to the shortcomings of the evidence described above, the conclusion that unspecified hospital organization features or individual care planning are important for delivering quality transitions from intensive care units is not sufficiently supported to be implementable in intensive care units of hospitals at this time.

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CONFLICT OF INTEREST STATEMENT

The authors have no financial or other form of conflict of interest that would bias their information and opinions.

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