

Original Article

The lived experiences of intensive care patients on transfer to a general ward

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ABSTRACT

Background & Aim: This study aimed to discover the lived experiences of patients transferred from the intensive care unit (ICU) to a general ward, to reach a deeper understanding of this phenomenon.

Methods & Materials: This is a qualitative study with an interpretative phenomenological approach, which is conducted at hospitals affiliated to universities, and private hospitals of Tehran in 2013. Eighteen participants were purposefully selected for face-to-face and semi-structured interviews.

Results: The findings revealed that the ICU patients experienced various feelings during the process of transition to a general ward. In this regard, three main themes were identified: “happiness of return” (consisted of three subthemes: “return to living,” “return to family,” and “return to a general ward”); “separation anxiety” (consisted of two subthemes: “anxiety of separation from the equipment” and “anxiety of separation from ICU staff”); and “spiritual development” (consisted of two subthemes: “being thankful to God” and “well-wishing toward others”).

Conclusion: The findings of the present study showed that recognizing and focusing on each patient’s individual needs, emotions, and expectations is essential to provide more holistic and patient-centered care during the process of transition from ICU to a general ward. Accordingly, there is a potential need to develop structured and formal discharge planning in the clinical settings like Iran where this topic has not been touched yet.

Introduction

Advances in the nursing care of patients in intensive care units (ICUs) and development in rehabilitation programs have led to faster improvement and shorter stays in ICUs (1). However, the technical facilities and human resources of ICUs are finite. There are high demands for ICU beds and a reduction in patients’ length of stay in ICU leading to an acceleration of patients’ transfer to the general wards (2, 3). Admission to ICU is potentially a scary and stressful experience. Patients experience such

fear and stress both during admission, discharge or transfer from ICU. The findings of related studies indicate that transfer from ICU can have as many destructive effects as those on admission to ICU (4-6). Patients may show emotional withdrawal symptoms as well as experience anxiety, panic attacks, depression, changes in time and place orientation, varying degrees of sleep disorders, changes in memory and concentration levels or even hallucinations and nightmares (4-9). Even though, some healthcare professionals believe that transfer of patients from ICUs to wards is a relatively simple and routine hospital procedure, Odell’s study shows that transfer to a general ward is not an easy experience, and most patients are not sufficiently prepared to face transfer and its associated consequences (10). Many patients consider discharge from ICU as a

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marker on their road to recovery and improvement in their physical well-being; yet, due to changes in the level of care and loss of ICU equipment, most of them begin to worry about the transfer to a general ward (2, 9).

The nursing diagnosis of "relocation stress" was introduced in 1987 and confirmed by NANDA in 1992 (4) as being a state of loneliness, depression, anger, and concern. Anxiety, changes in eating and sleeping habits, dependency and insecurity, as well as an increased need for a sense of security are phenomena associated with relocation stress. In other words, relocation stress can be defined as an experience of physical or mental distress due to transfer from one environment to another (11). In this definition, changes in physical habitat have been emphasized, while the concept of transfer, in addition to changes in physical habitat, could also be defined as the transition of time, state, or stage. The transfer is a multidimensional concept, which is described as a process as well as a period. One of the main elements of transfer is how the concerned person experiences, often perceiving it as a threat, and associating it with mental images and ambiguities of the new role and status (12). In line with nurses' responsibility in helping patients to achieve physical and mental health after discharge from ICU, is the necessity to consider patients' experiences and needs as this plays a significant role in enhancing their quality of life after discharge from ICU (13). With a deeper understanding of these experiences, nurses can plan the required changes for the process of transfer to the ward, and prepare the grounds for providing holistic nursing care (10). Chick and Meleis (12) believe that helping patients in the process of transfer from one stage of illness to another is one of the most fundamental nursing missions; this is where it can be seen that nursing is both science and art, associated with processes and experiences of transition in achieving health and welfare. Thus, for planning and effective implementation of nursing procedures, it is essential to consider the personal perceptions and interpretations of the people concerned and the process of transfer. Discovering the experiences and perceptions of ICU patients in transfer to a general ward can lead to en-

hanced nursing knowledge in relation to patients' physical and mental problems, create a good perspective, and consequently reduce a gap in nursing knowledge (8). There is no qualitative study regarding the lived experiences of patients during transfer from ICU to a general ward in the Iranian context, where religious beliefs are dominant in all aspects of people's life. As well, family intimacy and emotional closeness at an interpersonal relationship are of great importance in this context. So, this study aimed to discover the nature of this phenomenon in the Iranian context.

Methods

This qualitative study conducted from February to October 2013, using interpretive phenomenology.

The study settings included general wards of four hospitals affiliated with universities and private hospitals in Tehran. The inclusion criteria were determined based on clinical experiences and the literature:

- Participants had to be over 18 years of age
- Participants should be able to communicate, understand, and speak the Persian language
- Participants were to be oriented in time and place
- Participants had to have been in ICU for a period of more than 24 hours
- Participants whose length of stay in a general ward after transfer from ICU was at least 48 hours.

The exclusion criteria included:

- Individuals who were too ill, weak or confused to take an active part in the interview process.

Prior to beginning each interview session, the interviewer visited the general wards of the hospitals, described the purpose of the study to the head nurse of the department and asked about patients who fitted the research inclusion criteria. The potential participants were provided with information about the research purpose, and if they have a tendency to participate in the study, appointments were made. The interviewer (forth author), who was well acquainted with qualitative interviews, began the data collection

of comprehensive interviews. The digitally recorded interviews were conducted individually at the patient's bedside without the presence of hospital personnel and behind closed doors to observe patient's privacy. Effective communication of the interviewer with the participants helped to provide trustful relationships, which let them express their feelings and experiences. As well, the staffs were asked not to disturb during the interview to observe patient's privacy. In total three patients declined to participate in the study because of their worsened physical or psychological conditions. While recording interviews, the interviewer took notes of patients' nonverbal messages (body language). The interview began with open-ended questions about current problems and reason for admission to ICU, and ended with the main question about the experiences and feelings during transfer to a general ward. Some of the questions used in the interviews included: "How did you feel when you heard about your transfer to a general ward?" "What made you perceive it in this way? Please give an example." "How did you feel during the last few days, after discharge from ICU?" "What do you think the main reason for these feelings may be?" These questions formed an interview guide that was shaped by the literature review, the proposed concerns of the patients and also the researchers' clinical experiences. Issues raised by participants were then taken to subsequent interviews with other participants to explore the extent of the concerns among all the participants. Also the interviewer asked probing questions such as, "What do you mean by this?" "Why do you think in this way?" to uncover deep understanding of their concerns and the meaning of the experience to the participants.

The content was analyzed immediately after each interview. In total, 18 interviews were conducted, each taking 20-40 minutes. There were 12 female participants and 6 male, with an age range of 19-70 years (47.00 ± 15.45). The duration of hospitalization in ICU varied from 1 to 10 days, and in the general ward between 2 and 4 days. Diekelmann et al. (14) method was used for data analysis, which is a seven-step process based on Heideggerian hermeneutic phenomenology. As this study conducted based on an

interpretive phenomenology approach, the interpretation carries assumptions based on researcher's own experience that govern the extent of what can be disclosed. In this respect, the researchers approached each interview text with openness and went beyond the gathered data by including their own assumptions to discover the wisdom and develop a deeper understanding of the researched phenomenon. The researchers shifted back and forth by focusing on personal assumptions backed by looking at the participants' experiences and interpreted them based on their personal assumptions and professional experiences (15, 16). The analysis is typically performed by an interpretive team and involves seven steps: (a) reading the interviews to obtain an overall understanding; (b) writing interpretive summaries and coding for emerging themes; (c) analyzing selected transcripts as a group to identify themes; (d) returning to the text or to the participants to clarify disagreements in interpretation and writing a composite analysis for each text; (e) comparing and contrasting texts to identify and describe shared practices and common themes; (f) identifying patterns that link the themes; and (g) eliciting responses and suggestions on a final draft from the interpretive team and from others who are familiar with the content or the methods of this study. This method provides the opportunity to attain the highest interpretation level; indeed, as the analysis process is reflexive and circular, it enables a dialogue between participants' narratives and researchers' pre-understandings, leading to a comprehensive interpretation (17). To achieve this, after conducting the interviews, the transcribed texts were reviewed several times to gain a general understanding. Then, an interpretive summary was written by each team member for each interview, and attempts were made to extract hidden meanings. The extracted meaning units from each interview were compared with the other interviews, grouped and abstracted to related subthemes and main themes. In this way, the hermeneutic cycle and continuity of the movement from parts to whole and from whole to parts were observed. During the analysis process, meetings were held with the research team members, including two professors and one

nursing Ph.D. candidate, well acquainted with qualitative analysis methods. During the analysis process, the interpretive summaries and the emerging themes were discussed so that a general consensus on emerging themes could be reached. To clarify any ambiguity in relation to team members' perceptions and to ensure the accuracy of data, the interview transcripts were returned to participants. The interpretations reflected the participants' experiences, where more clarification was needed in three cases. Data collection was continued when no new sub-themes and themes could be identified. This was reached by the 18th interview. Guba and Lincoln's (18) four criteria of credibility, dependability, confirmability, and transferability were applied to achieve the rigor of the findings (19, 20). The credibility of the findings was established by prolonged contact with participants, deep involvement and immersion in the data, as well as having team sessions to reach comprehensive and deep interpretations. The research illustrated dependability by how decisions were taken about data collection and analysis. By recording the activities and steps taken in data analysis and by illustrating the processes that led to conclusions, and by presenting evidence and examples, readers are able to confirm the findings. Choosing participants from both sexes and various age ranges, length of stay in ICU, length of stay in a general ward, and participants with different medical problems from hospitals affiliated to universities and private settings helped to satisfy the data transferability.

This article is the result of a project conducted and supported by the Nursing and Midwifery Care Research Center and approved by Tehran University of Medical Sciences Ethics Committee (Research Number: 90-03-99-14561). Written and verbal information about the purpose of the study was given to all participants, and written consent was obtained. All the participants were provided with information about the voluntary nature of their participation in the study. They were also informed that they are allowed to refuse to participate or decide to stop their participation at any time. The participants were assured that their identities would be concealed in the analysis and reporting of the data to protect their privacy.

Results

While observing the hermeneutic cycle and repeated comparison of interpretation summaries, we extracted three main themes from interviews: "happiness of return" consisted of three subthemes, which are "return to living," "return to family," and "return to a general ward;" "separation anxiety" included the subthemes of "anxiety of separation from the equipment" and "anxiety of separation from ICU staff;" and "spiritual development" consisted of two subthemes, which are "being thankful to God" and "well-wishing toward others."

Happiness of return

The main theme of "happiness of return" consisted of three subthemes: "return to living," "return to family," and "return to a general ward."

Return to living

In their statements, all participants spoke of experiencing feelings of happiness and relief about the transfer to a general ward. One of the main reasons for this was their sense of returning to a more normal life because of the improvement in their physical condition and reversal of their life-threatening condition. A 44-year-old woman, hospitalized for 7 days in ICU for the transient cerebral ischemic attack, stated:

"I was so happy... It was as if I was born again, and that is what happened to me, a re-birth."

Return to family

As there should be no disruption in providing necessary care for patients and to avoid transmission of infections, restrictions were imposed on visitors in ICU, hence most patients were unhappy about not receiving visits from their families due to restrictions. Most patients were, therefore, happy about the transfer as this meant they were able to see their families more regularly again. A man diagnosed with a bladder tumor stressed that the presence of one of the family members comforted him:

"During transfer to the ward I felt comfortable and said to myself in the ward I will have someone to look after me."

Return to a general ward

Seeing poor physical conditions in other people in the ICU, dressing of wounds and performing invasive procedures, and particularly seeing other patients' deaths, was a distressing experience for the participants. This was given as one of the reasons for feelings of comfort and peace, and relief from unpleasant and disturbing events when transferred to a general ward. For example, a 70-year-old woman hospitalized in ICU for 4 days due to a stroke expressed her feelings as:

"One of them died in ICU. He was an old man, it upset me, it reminded me of myself, I said to myself, this will happen to us 1-day too. But it saddened me, you know, dying is a bit gloomy. I asked when they were going to send me to the ward."

Patients stated that it was possible to connect with patients in the ward, as they were alert and were in better physical condition. This was effective in experiencing feelings of happiness and comfort in most participants. A 53-year-old woman who had been transferred to a general ward 4 days before stated:

"I was happy, as I knew at least everybody would be together in the ward and some patients talk to each other."

According to some participants' experience, the ICU was a disturbing and crowded environment, and one of the reasons of their peacefulness after getting transferred to the ward was getting rid of all disturbing noises and being in a calm and relaxed atmosphere. A 57-year-old woman, after 3 days in ICU, expressed her negative feelings during her stay at ICU:

"Your brain bursts in ICU, your nerves are wrecked, they walk about and talk too much, they are under your skin and it's more peaceful in the ward."

Separation anxiety

The main theme of "separation anxiety" consisted of two subthemes: "anxiety of separation from the equipment" and "anxiety of separation from ICU staff."

Anxiety of separation from the equipment

Although discharge from ICU means removal of life-threatening factors and leads to positive

feelings in the patient, according to the findings of this study, patients' experiences are not only confined to happy feelings, but experiences of a wide range of positive and negative feelings, originating from their joys and concerns. In other words, while being happy about their improved physical conditions, participants felt dependent on monitoring equipment and did not feel safe or secure in a general ward. A 23-year-old woman said about her uncertain feelings:

"Transfer out of the ICU made me feel happy and meanwhile concerned; as the monitors and special equipment help me feel secure in ICU."

Anxiety of separation from ICU staff

Some of the patients stated that they had kind and friendly relationships with ICU staff, hence separation anxiety and facing new personnel in the ward were their main concern, especially because they believed that the nurse/patient ratio was low in the ward and that they would not receive the care they needed. After 1-week in ICU, a 39-year-old woman expressed her concern about separating from the staff as follows:

"When moving from one place to another, you are worried how your new place will be like, and how one is received there."

Spiritual development

The main theme of "spiritual development" consisted of two subthemes: "being thankful to God" and "well-wishing toward others."

Being thankful to God

The findings of this study manifested various interpretations of spirituality in the statements by participants. Some of them considered their improvement and returned to health as divine intervention and described their gratitude and praise to God and other spiritual feelings when being transferred to a general ward. They also expressed that experiencing such feelings gave them a sense of safety and security. A 44-year-old woman described her feelings after 7 days in ICU as:

"I asked myself how could I thank God? God made a miracle for me because I had such a deep faith, which gave me the power to heal."

A 32-year-old man, after 10 days in ICU, talked about his closeness to God during the

transfer period:

“When you are so ill, alone and frightened and you feel that there is very little hope to return to life, you believe that only God can help you in that situation...when they told me that I would go back to the general ward, I had a deep feeling about God that I had never experienced before... I felt that a strong power supported me... all my dreams about a new chance for life came true...”

Well-wishing toward others

Also being transferred out of the ICU promoted a sense of fellow-humanity and well-wishing towards other patients. A 65-year-old woman with a brain tumor expressed her altruistic feelings about fellow patients:

“There was a young girl beside me who had a terrible accident the day before her wedding day... when I was leaving the ICU, I sincerely asked God to help her... I hope that God listens to my prayers... it was so difficult for me to see a young girl in that situation...”

Discussion

This study which aimed to discover the lived experiences of patients transferred from the ICU to a general ward; revealed that the patients had a wide range of feelings and experienced various emotions during the transfer time from ICU to a general ward. The feelings experienced were extracted under the three main themes of “happiness of return,” “separation anxiety,” and “spiritual development.” Such a wide range of experiences based on positive and negative feelings are in line with other studies in this field (8, 10, 21). Based on the results of the current study, all participants had positive experiences on transfer to the ward, primarily due to improvement in their physical conditions and spending more time with family. The researchers believe that this issue might be related to different factors required to be investigated more specifically in different contexts. Given the current study participants’ main complaint about restrictions on family members visiting and consequently being deprived of their emotional support might be the significant factor that led to this experience. Many studies emphasized the

important role of ICU patients’ family members in their emotional support; they recommended that facilities for family members to interact with the patient for support and better therapeutic outcomes should be in place (2, 3, 8). It should also be considered that patients’ family members have a pivotal role in ICU transitions, and their active participation in decision-making could lead to more comprehensive and patient-centered care plans which consequently impact on quality of care. Because of the patients’ physical and psychological morbidity, relatives may be unable to have complete involvement in the planning and caring process of the transition stage (22, 23), yet the presence and frequent visits of family members of ICU patients has been considered as a significant aspect of nursing care in many studies. The extent of these positive outcomes may vary in different contexts with different cultural backgrounds. In a quantitative study in Sweden, the results showed that there were no significant differences between the ICU patients’ loved-ones visiting frequencies and positive outcomes (24).

The results of the present study also revealed that anxiety about separating from ICU personnel and ICU equipment was the main reason for having uncertain feelings and only partial happiness on transfer to the ward. Clinical experience and evidence suggests that patients regard ICU as a safe and secure environment, and when they are told they are being transferred to another ward, they feel a sense of insecurity (3, 23, 25). A quick transfer, without prior knowledge of the patient (26), and lack of the patient’s readiness to accept a change of conditions (8), plays a significant role in the feelings of fear and anxiety mentioned. Various studies have proposed strategies for effective adjustment of patients, including a gradual reduction in the level of patients’ dependency, continuity of care in the ward (27), emotional support for patients, and using counseling (28). In this regard, informing the patients about the different structure of ward-based care, different nurse-to-patient ratios, demonstrating the patients’ health condition stability and their independence of high-level staff support or specific equipment, are crucial to prevent adverse psychological effects during the transition pro-

cess (29, 30). Physical and psychological adjustment constraints including pain, fatigue, sensory problems, anxiety, post-traumatic stress disorders, depression, and communication problems might potentially lead to reduced personal ability to cope with relocation stress (3, 31, 32).

Saarmann (26) discussed stress and coping theory in relation to reasons for experiencing or not experiencing feelings of stress and anxiety in patients in transition. He states that the concept of stress is multidimensional and is influenced by the person's mutual relationship with the environment that is created by his or her evaluation of existing conditions. The most important factors affecting patients' stress are personal factors (e.g. knowledge, beliefs, faith, and goals), and factors associated with existing conditions (events, supports, physical environment, etc.). In this respect, Chick and Meleis (12) mentioned different response patterns to the process of transfer, including confusion, anxiety, depression, stress, irritability, changes in mental image, changes in functional roles and in self-confidence. They emphasized that even in similar situations; people experience conditions and emotions according to their personal interpretations and perceptions.

One of the emerging themes of the present study was spiritual development, in which the participants were feeling close to God and thankful to God, meanwhile wishing the same blessings for other patients, too. Indeed, the patients gained a different attitude to life and felt closer to fellow sufferers. While confiding in God and begging God, most patients thanked God for a second chance to benefit from the divine gift of life. It seems somehow, with the aid of their religious beliefs, they tried to cope with the stress of transfer to the ward. In line with this study, Papathanassoglou and Patiraki (33) reported that ICU patients experience some degrees of the transformation of self, spiritual arousal and personal growth as a consequence of suffering from a critical illness. This is also evident in other studies, as disability and critical illness provide contexts for spiritual growth and contribute to positive outcomes, such as effective adjustment and adaptation (34). In a study regarding Muslim women's experiences of suf-

fering in Jordanian ICUs, the findings revealed that religious beliefs helped them to make sense of their current situation by considering it as a test from God and an opportunity to be close to God (35). The main focus of the present study's participants on the experience of spiritual development might have arisen from the dominance of spirituality and religious beliefs in all aspects of Iranian patients' lives (36-38). However, it should be noted that resorting to spirituality or religious rituals such as prayer and recourse to God, is an inseparable part of human life, especially in life-threatening crisis situations, such as an illness, which can provide a rich psychological support and shelter for people (39, 40). A comprehensive ICU discharge plan should, therefore, take account of spiritual care aspects, in response to patients' spiritual and religious needs, based on their value system. Having regard to this significant aspect of critical care nursing seems crucial in other clinical settings too, especially in contexts similar to Iran, where religious beliefs are of great importance in all aspects of people's lives.

Galvin proposed an idea with regard to critical care that requires the integration of "hand" (technical skills), "head" (protocols and evidence), and "heart" (ethical and human dimensions) (41). To generalize this to an ICU transition stage means that integration of the spiritual domain into the ICU discharge planning, along with physical and psychological aspects of care, would provide a holistic and integrated discharge plan, incorporating the patients' physical, emotional and spiritual needs, in which the patient is considered as a whole person within an individual, cultural and religious context.

All the previously mentioned considerations require a formal structured plan for patients' discharge to general wards, and related standardized guidelines; consequently, the lack of structured ICU discharge plans in Iranian clinical settings should be reconsidered. Ultimately, to reach this goal, other clinical guidelines regarding ICU discharge planning could be considered; the most emphasized issues in such guidelines include daytime discharge, early discharge planning, and early weaning from equipment and one-to-one nursing care, patients' family in-

involvement in the discharge process and maintaining continuity of care by direct handover from critical care staff to ward staff with adequate written documentation about patients' physical and emotional needs (3, 22, 32).

Conclusion

The present study's findings showed that the positive feelings expressed by ICU patients, such as happiness of return, were based on care associated with some negative experiences such as separation anxiety that meanwhile might have led to spiritual development. The findings of this study could form a suitable framework for identifying the mentioned patients' needs and perceptions, and could be used for planning nursing interventions in response to their physical and mental needs during recovery and transfer out from ICU; that could provide the possible holistic and professional care for them. Indeed, the present study's findings highlighted the need to raise awareness of critical care nurses regarding the necessity of having in place structured planning and adequate preparation of the patients for their transfer to general wards, especially in countries like Iran where such issues have been neglected and have not even been considered. As noted before, Iranian people's religious values, including believe in one God who is life-giver and guides humanity to what is best for them in this life, is evident in any aspects of their life including health related problems. Accordingly, the findings of this study, especially spiritually domain may be applicable for developing structured guidelines to assist health care professionals in providing holistic and appropriate care in ICUs concerning transition and transfer, in the Iranian context and also in other countries with similar contexts. As this study provides a deeper understanding of Iranian patients' needs, feelings, expectations and concerns in ICU transition processes, based on their lived experiences, the findings could be adapted worldwide and even in diverse clinical settings, especially in contexts with a strong religious belief. We recommend developing a systemic ICU discharge program for Iranian patients based on their authentic needs explored in this

study, in similar studies, and also by benefitting international guidelines, which have to be adjusted, based on the Iranian context.

As this study's findings are based on participants' subjective views in a specific context, therefore it seems that diverse methodological studies in different settings and contexts are needed to address the gap of knowledge in this regard. There is a lack of literature about the spiritual domain of nursing care in ICU transition stages, and especially in religious contexts like Iran. Meanwhile, with no structured discharge plans available for the ICU transition processes, it is recommended that future research focuses more on evaluation of spiritual, religious and also cultural aspects of critical care nursing to identify the impact of the mentioned factors to smooth patients' discharge from ICU and make the transition process effective.

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Conflict of interest

The authors declare no conflict of interest.

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