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Research paper

The experiences of rural and remote families involved in an inter-hospital transfer to a tertiary ICU: A hermeneutic study

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ABSTRACT

Background: Inter-hospital transfers are necessary for critically ill patients to improve their chance of survival. Rural and remote families experience significant disruption to family life when critically ill patients are required to undergo a transfer to a tertiary hospital. What is not known is how ICU staff can assist these families who are involved in an inter-hospital transfer to a tertiary ICU.
Purpose: To gain an understanding of rural and remote critical care families' experiences during an inter-hospital transfer to a tertiary ICU.
Method: A hermeneutic phenomenological approach was adopted informed by the philosophical world views of Heidegger and Gadamer. Data collection occurred by in-depth conversational interviews from a purposeful sample of seven family members. Interview transcripts, field notes and diary entries formed the text which underwent hermeneutic analysis.
Findings: Being confused, being engaged, being vulnerable and being resilient emerged as significant aspects of the rural and remote family members' experience during a transfer event.
Conclusion: A better understanding of the experiences of rural and remote families during an inter-hospital transfer journey can inform the practice of ICU nurses. This study highlights the specific experiences of rural and remote families during an inter-hospital transfer journey to a tertiary ICU. It also informs nurses of the meaningful ways in which they can support these families with the uncertainty and chaos experienced as part of this journey.

1. Introduction

Inter-hospital transfers (IHT) for medical treatment are necessary to improve the chance of survival of critically ill people.[1] People in rural or remote areas who become critically ill or experience trauma may need to be transported to a tertiary intensive care unit (ICU) for treatment.[2] In 2011, more than 21,000 patients (16% of all Australian ICU admissions) were initially admitted to one of 43 regional ICUs.[3] In 2006, an audit of the three Queensland tertiary ICUs estimated the number of incoming ambulance IHTs of critically ill patients at 450 per annum. It is evident that the number of rural and remote patients involved in an IHT within Australia is significant.[4]

Rural and remote family members (RRFM) experience significant disruption to family life when critically ill relatives move to a tertiary hospital.[5–7] Families make a significant contribution to both the acute and ongoing illness recovery of critically ill patients.[8,9] For critically ill patients, an IHT typically occurs with limited time to fully inform and involve the family. Consequently, the relatives of these patients are likely to have specific care needs that require appropriately targeted nursing and health

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service responses. Limited research has been undertaken to inform ICU staff how to assist families who are involved in an IHT. Hence, the aim of this study was to gain an understanding of rural and remote critical care families' experiences during an inter-hospital transfer.

2. Method

2.1. Study design

A hermeneutic phenomenological approach was chosen as it provided a sensitive mode of inquiry for revealing the everyday practical experience of being a RRFM involved in an IHT. Several underlying assumptions, influenced by the world views of Heidegger[10] and Gadamer,[11] informed the theoretical framework that guided the research process. In Heideggerian terms, family members are human beings with a capacity to reflect upon the nature of their existence in such a way that meaning is revealed.[12] The essence of how families are involved and engaged in the practical activities and relationships experienced during IHT are shaped by their background culture and illuminate significance for them. Family members as temporal beings are capable of attributing meaning to such involvement, as influenced by the past, and their ability to anticipate their future.[13]

2.2. Setting

The setting was the ICU of a large adult metropolitan hospital in Queensland, Australia. The ICU admitted 2345 patients during 2011–2012.[14] During the screening period (March until November 2012), 130 patients were admitted to the ICU via IHT of which 56 were from rural or remote Queensland.[14] The ICU had an open visiting policy for families, operated 25 beds and admitted adult patients for specialist cardiothoracic, spinal, trauma, neurological, medical or general surgical care. The hospital and ICU provide families with information on local accommodation, counselling and financial support.

2.3. Participants and participant recruitment

A purposeful sample of RRFMs were invited to participate in two interviews. Sampling was considered adequate following recruitment of seven family members as no new descriptions were heard and a redundancy in themes was evident.[15] Inclusion criteria comprised: (1) the participant's relative was admitted to the site ICU via IHT from a rural or remote area as per the Australian Standard Geographical Classification-Remote Area system (ASGC-RA)[16]; (2) they were 18 years of age or older; (3) they visited the patient whilst in the tertiary ICU; (4) they had a close and continuing relationship or formed part of the patient's pre-existing support system; (5) their primary place of residence was in rural or remote Queensland. RRFMs were excluded from the study if another family member was already participating, and likewise on compassionate grounds for those whose critically ill relative died within 12 h of being admitted to the ICU.

All patients that were admitted to the ICU via IHT were screened daily by an ICU nurse trained in clinical research procedures. If families met inclusion criteria, this ICU nurse provided them with a brief summary of the study's aims, participant information and consent form. Families gave approval to be contacted by the researcher to clarify any questions and gain written consent.

3. Data collection

Demographic data were collected from each participant. Initial interviews were audio-taped conversations in a private ICU conference room. These interviews typically occurred within the first two weeks of the RRFM's relative being admitted to the ICU and lasted between 45 and 90 min. In line with Drapers' view,[17] the interviews commenced with stem questions, such as: "What circumstances lead up to your relative's accident and the need for transfer to the metropolitan ICU?"; Can you recall one moment during the IHT period that stood out for you?"; "How were you involve in the IHT process?" Informed by Heideggerian philosophy[18] the interviewer (BM), employed probing questions relating to significant incidents, barriers to family involvement, concerns, and anticipated future possibilities.

Follow-up interviews occurred within 2–10 weeks, lasted approximately 20–60 min, and took place in a private room in the hospital ($n = 6$) or via telephone ($n = 1$). Participants reviewed a written summary of their initial interview which enabled validation of key aspects of their experience and clarification and probing of significant issues. The interviewer was a registered nurse with over 10 years of critical care nursing experience.

The interviewer used a diary to reflect on his own experiences of living in rural Australia, being a family member, a registered nurse and caring for families within an ICU and how this could influence the interpretive process. Immediately following an interview, field notes were written to capture descriptive data (gestures, facial expressions, or vocal intonations) that afforded an appreciation of the interview content and context.

4. Data analysis

All interviews were tape recorded and transcribed verbatim. The verbatim transcripts from 14 in-depth narrative interviews, field notes and diary entries all formed the text for analysis. Crist and Tanner's[19] five overlapping phases of hermeneutic textual analysis were followed.

Firstly, transcripts, diary notes and field notes were read and re-read. Secondly informed by Heideggerian assumptions each text was reviewed to elicit background information. A questioning method was adopted that enquired: '*Who are the members of this family?*', '*How are family values and traditions discussed?*', '*What can I glean about social relations within this family?*', and '*How have the family evolved over time?*'. Initial interpretations were then written.

In the third phase, re-reading of transcripts occurred to identify aspects of the IHT experience that were significant across participants. Recognition of both differences and similarities in families' experiences illuminated shared meanings that transcended the particular situation. Fourthly, the four authors met to clarify the emerging interpretations. The fifth and final phase was guided by Heidegger's notion of Dasein, the ontological nature of the IHT experience.[10] By looking within the shared meanings, an appreciation of the background of meaning for each family and the focused experience of the transfer event revealed modes of being a RRFM in the IHT context.

5. Ethics

Ethical approval to conduct this study was granted from both the hospital and university Human Research and Ethics Committees. The research team (BM, MM, UK and AT) had no relationship with the participants or their critically ill relative, were not involved in the direct care of patients in the hospital nor involved in the IHT of patients to the ICU. Pseudonyms were used in data collection, analysis and findings.