



## Research paper

## Relocating an intensive care unit: An exploratory qualitative study



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At the conclusion of this article a Continuing Professional Development activity is attached

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## ABSTRACT

**Background:** As new hospitals are built to replace old and ageing facilities, intensive care units are being constructed with single patient rooms rather than open plan environments. While single rooms may limit hospital infections and promote patient privacy, their effect on patient safety and work processes in the intensive care unit requires greater understanding. Strategies to manage changes to a different physical environment are also unknown.

**Objectives:** This study aimed to identify challenges and issues as perceived by staff related to relocating to a geographically and structurally new intensive care unit.

**Methods:** This exploratory ethnographic study, underpinned by Donabedian's structure, process and outcome framework, was conducted in an Australian tertiary hospital intensive care unit. A total of 55 participants including nurses, doctors, allied health professionals, and support staff participated in the study. We conducted 12 semi-structured focus group and eight individual interviews, and reviewed the hospital's documents specific to the relocation. After sorting the data deductively into structure, process and outcome domains, the data were then analysed inductively to identify themes.

**Findings:** Three themes emerged: understanding of the relocation plan, preparing for the uncertainties and vulnerabilities of a new work environment, and acknowledging the need for change and engaging in the relocation process.

**Discussion and conclusions:** A systematic change management strategy, dedicated change leadership and expertise, and an effective communication strategy are important factors to be considered in managing ICU relocation. Uncertainty and staff anxiety related to the relocation must be considered and supports put in place for a smooth transition. Work processes and model of care that are suited to the new single room environment should be developed, and patient safety issues in the single room setting should be considered and monitored. Future studies on managing multidisciplinary work processes during intensive care unit relocation will add to the learnings we report here.

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## 1. Introduction

Worldwide, ageing healthcare facilities are being replaced or refurbished to accommodate the changing needs of healthcare services including modifications to model of care, increased number

of beds, technology advancements, and patient privacy needs.<sup>1,2</sup> Hospitals and clinical areas such as the Intensive Care Unit (ICU) are adopting the single patient room design instead of the traditional open environment with multiple patients in one room.<sup>3</sup> This shift in ICU architecture is likely because research suggests that the single room model reduces hospital acquired infection rates.<sup>4,5</sup> Environmental change to an ICU can include differences in the location of the hospital, the physical structure of the ICU, the model of care and work processes that are suited to the new environment.

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To understand the change management issues related to changes to the ICU environment the concepts of both *change* and *transition* may both be important. Change is considered to be about the outcome and is situational, which consists visible events that can happen quickly, for example, the move of the hospital will happen on the day. Transition is a process of how people prepare to go through the process and adapt to the environment, which is a longer process that extends from before to after the actual change.<sup>6–8</sup> Within the process of hospital relocation it is important to consider the transitional process of staff members trying to cope with the change from the old to the new environment.<sup>8</sup>

A strategic transition management plan is required to support staff to ensure a successful transition,<sup>9</sup> and to facilitate the continuity of quality care. Workplace culture, leadership, and organisational structure have significant impact on the process and success of relocation and staff transition.<sup>10</sup> In addition, relocation may cause stress and emotional strain to existing staff, and lack of necessary and timely education, support and communication regarding the relocation may create uncertainty and have the potential to impact teamwork and staff turnover.<sup>10</sup>

Due to the unique challenges of relocating an ICU, acuity of patients and array of therapies used in ICUs, it is reasonable to assume that the relocation of an ICU and subsequent transition of staff to a new work environment and model of care may be more complex than other departments of the hospital. However there is limited literature available that address issues related to the relocation of ICUs.

## 2. Aims of the study

The aim of this study was to identify challenges and issues of relocating to a geographically and structurally new ICU, from the perception of staff working in this clinical area. This paper reports Phase 1 of a three-phased project which was aimed to implement strategies to support the nursing service delivery during the ICU relocation process.

## 3. Study design

This was an exploratory ethnographic study underpinned by Donabedian's structure, process and outcome (SPO) framework.<sup>11</sup> Donabedian recommended that healthcare organisations' performances could be assessed in the domains of structures (facilities, equipment, personnel, and organisational structure), processes (what is done in providing care to patients) and outcomes (effects of care on patients and populations).

### 3.1. Setting

This study was conducted in a 15-bed, level 3 ICU (a tertiary referral unit which is capable of providing comprehensive critical care services)<sup>12</sup> of a 580 bed Australian tertiary teaching hospital. The study commenced 6 months prior to the relocation of existing health services to a new 750-bed hospital located 5 km away and built on a greenfield site. Changes to the ICU included a different configuration to the work environment where complete separate single parallel patient rooms in a pod of 10 were used as opposed to the previous predominantly open shared room model, where only 4 beds were single rooms. Critical care services were also expanded with the potential for 50 ICU beds, and new services including cardiothoracic surgery and children's critical care were added which requires the recruitment of suitably trained new staff, training of existing staff, development of new protocols, and variations to normal routines in order to provide safe patient care. Hospital relocation occurred over two days (27–28 Sep, 2013) with the ICU being

the last clinical unit to exit the old hospital. A relocation project team was established and planning for the hospital relocation commenced 2 years before the anticipated hospital move with specific planning for the ICU move commencing 12 months prior.

### 3.2. Participants

All staff working in the ICU including nurses, doctors, administration and support staff, allied health staff, and hospital relocation transition management committee members were invited to participate. In order to gain insight on what issues concern the nursing service delivery during the ICU relocation transitional period, a total of eight senior ICU nurses formed members of a reference group for this project where their role was to collaborate with the research team and identify key areas of inquiry to guide group and individual interviews. We invited non-nursing staff to participate the study because nurses work closely with other disciplines in ICU. These non-nursing staff will provide important insight on teamwork related nursing issues that needs to be considered during the ICU relocation.

### 3.3. Data collection

We used ethnographic data collection techniques including focus group and individual interviews as well as document review. A total of 55 participants, which included about 50% of the ICU nursing staff and representatives from other professional groups, consented to participate in the study. Table 1 shows the demographic information of the participants. Staff participants represented all age groups and role classifications of various professional groups. Among the participants, small number of staff had experience in paediatric ICU (7%), in ICU relocation (11%), and hospital relocation (18%). Twenty-two staff members (40%) had

**Table 1**  
Participant demographic information (N=55).

Characteristic	N	%
Gender		
Female	45	82
Male	10	18
Age (years)		
20–29	9	16
30–39	19	34
40–49	13	24
50–59	13	24
≥60	1	2
Employment classification <sup>a</sup>		
Grade 5 RN	29	53
Grade 6 RN	9	16
Grade 7 RN	5	9
Consultant	4	7
Other	8	15
Prior work experience <sup>b</sup>		
Paediatric ICU	4	7
Cardiothoracic ICU	22	40
Single room ICU	22	40
Relocation of hospital including ICU	6	11
Relocation of hospital but not relocation of ICU	10	18

<sup>a</sup> Grade 5 RN: bedside registered nurses; Grade 6 RN: registered nurses who are often in charge of the shift; Grade 7 RN: Registered nurses in management roles including Nurse Unit Managers, Clinical Nurse Consultants, or Educators; Consultant: intensive care medical specialists; Other: staff working in support roles such as ICU secretaries, and staff working in allied health roles including dietitians, physiotherapists, are included in this category. We did not list the sub categories in the table because some of the professional groups only had 1 participant which could potentially be identifiable.

<sup>b</sup> Staff prior experiences: some staff had answered "yes" to more than 1 categories, thus the total of this section is more than 100%.

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