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Work relationships and Intensive Care Decision Challenges among Critical care nurses: a Phenomenological study

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Abstract
The objective of critical care is to reach consensus on desired outcomes and attain realistic goals of care; yet, many of these decisions are complex with several elements that care professionals must take into account, some of which are contentious and can hinder inter-professional cooperation. The aim of this study are to explore how critical care nurses relate and participate with other health care professionals in deciding patient care in intensive care unit in Ahmadu Bello University Teaching Hospital in Zaria, Nigeria. The research design utilized for the study was a qualitative hermeneutic phenomenological design, where eleven (11) intensive care nurses were involved in an in depth interview. Results indicate that participants operate fair trust relationship, unnecessary arguments leading to unwarranted time wasting before giving the desired care were identified as factors hindering collaborative decision making among other factors. Intensive care nurses faced some challenges which include poor supplies, communication gap and leadership issues. The study concluded that intensive care nurses face conflicts during decision making and strategy such as avoidance behavior is used to resolve it. It was recommended that team members should promote collaboration with one another in order to create a less stressful environment with mutual respect unconditionally.

Keywords; *Intensive care unit, Phenomenology, Nurses, inter-professional collaboration Ahmadu Bello University Teaching Hospital, Nigeria*
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Introduction

Collaboration among critical care team members is not always a straightforward affair particularly when team members fail to talk about how to organize activities and communicate intended goals in patient management or fail to appraise their performance (Leduc, 2017).. Despite the paradigm shift towards inter-professional collaboration when it comes to patient care, nurses in the intensive care unit (ICU) considered themselves to be a passive player during a clinical conversation in terms of patient management (Verd-Aulí, Maqueda-Palau, & Miró-Bonet, 2020).

However, literature reveals the importance of information sharing and decision-making processes and identifies potential barriers to successful team performance in patient management such as lack of effective conflict management and the presence of multiple and sometimes conflicting roles (Humphrey et al., 2017).

Weart, (2008), posited that, patient care tasks are predominantly carried out by teams: nurses work together in the ward on different shifts, and their contributions to care are complemented by physicians, and other professionals, such as pharmacists, radiologists, or physical therapists that

contribute their expertise during a patient's hospital stay. Inter-professional collaboration is particularly important in settings where patients' conditions are critical and the environment is less predictable, such as ICU (Rochon et al., 2015).

A collaborative approach is central to the provision of the best possible intensive care that is coordinated by a team member (such as ICU nurse) with aim of facilitating effective coordination and communication (Puthucheary, 2015). Fundamentally, with proper collaboration from team members in intensive care unit , the nursing workforce shall offer their best to the patient with life-threatening conditions, in the absence of which, the patient receives less quality care and thus nursing care objectives become less fulfilled.

Uchendu, Windle, and Blake (2020)posited that nurses constitute the biggest group of healthcare professionals in hospital settings (intensive care unit inclusive), and are the only professionals that provide 24-hours care with prolonged direct physical contact and engagement with patients, an immersive encounter which other health care professionals are not privileged to experience by nature of their professional role. Nurses are in a better position to narrate their encounters and experience of what decision making is and its associated challenges (Terzioğlu, and Uslu Şahan, (2017).

Furthermore, one of the areas identified by Aletras and Kallianidou (2014) where nurses are facing greater difficulties in their everyday work is ICUs and an area that needs to be improve upon in staff collaboration. From the foregoing, the real situation of nurses' experience of collaborative practices in critical care settings in Nigeria is not well explored and documented qualitatively which may pose a risk of poor workforce performance.

Objectives:

The objectives of this study are to explore the experiences of critical care nurses on inter-professional collaboration with other health care professionals in intensive care unit and to identify the challenges critical care nurses experience while working in intensive care unit.

Materials and Method

Study Design

This qualitative study used hermeneutic phenomenology. Phenomenology aims to uncover the meaning and common features of an experience and reveal taken for-granted assumptions Neubauer, Witkop, and Varpio (2019), thus leading to a deeper understanding of an experience.

This approach was used to obtain subjective descriptions of nurses working in intensive care unit in the workplace, explicate their meaning and essence; and articulate the context of these inter-professional experiences

Study populations and Sample;

The study population were nurses working in the Critical care unit of Ahmadu Bello University, Teaching Hospital, Nigeria. A purposive sampling technique was used to recruit the required number of nurses expected to reach data saturation. They were eleven (11) in number as at the time of data collection who have spent more than six (6) months of practice in intensive care unit and were willing to participate in the study. Scholars in qualitative research (Van Manen, 1996; Van Manen. 1997) recommend the use of purposive sampling to recruit participants.

Tool and method of data Collection

In-depth interview (IDI) in form of a semi-structured interview (***SSI***) using guiding questions (semi-structure schedule) and a tape-recorder to ensure the reliability of recorded answers. The audio was then fully transcribed. Interviews used a narrative approach. In-depth interview of participants thoroughly clarified information from

participants each lasting 45-60 minutes. Thereafter, two follow-up focus group sessions (comprising three participants each), were conducted checking for member and further analysis and interpretation of the data.

Participants narrated in their own words their work related experiences, setting. Perceived challenges and concerns, the behavior of the people they work with and their reflection of the experiences/challenges. For the most part, participants were allowed to introduce issues they considered important and essential to their story. Follow-up questions clarified or elicited additional information. There was verbatim transcription of narratives which were analyzed to extract significant statements, formulate meanings and form theme clusters.

When the researcher reached data saturation, the researcher stopped collecting data.
Qualitative researchers employ the principle of data saturation, which occurs when themes and categories in the data become repetitive and redundant to the point where further data gathering yields no new information (Denise & Polit, 2012).

Scientific Rigor of the tool
Confirmability: participants were given back interview transcripts and findings.

Credibility: researcher captures and expresses the reality of how things are from the perspective of others (informants and fellow researchers).

Dependability-adequate facts concerning inter-professional collaboration in the setting of the critical care unit were provided, as well as the capacity for readers to independently validate their interpretive inferences.

Transferability-The researcher provides rich, detailed descriptions of the Inter-professional collaboration ("thick description"), as well as a thorough description of the structures, assumptions, and processes revealed by the data, allowing readers to independently assess whether and to what extent the reported findings are transferable to other settings.

Ethical Consideration.
Before recruiting respondents, the Ethical Review Board (ERB) of Ahmadu Bello University, Zaria, approved the study with reference number ABUCUHSR/2021/008.

End of Data Collection
In this study, data saturation was achieved with interviews obtained from nurses who worked day, afternoon and night shifts to mark the end of data collection. Data saturation is reached when there is enough information to replicate the study (O'Reilly & Parker, 2012; Walker, 2012), when the ability to obtain additional new information has been attained (Guest et al., 2006).

Data Analysis
ATLAS.ti, was used to ease the laborious task of analyzing text-based data through rapid and sophisticated searches and line-by-line coding.

This started with reading of participants' transcripts as wholes individual to gain understanding of inter-professional collaboration and circumstances. Data analysis using hermeneutic cycle that involves reading, reflective ting and interpretation of data in a rigorous manner. In keeping with these principles, after reading each transcript, there was writing of interpretive and reflective summaries of the data alongside coding for possible themes. Further of transcripts continued to identify themes and patterns. Earlier researchers (Laverty, 2003; Lopez and Willis, 2004;Kakkori, 2009) acknowledge the need for active involvement of study participants in data interpretation process by engaging them in an ongoing conversation, this was observed during data analysis. The eleven (11) participants' follow-up was used to re-examine and interpreted the texts leading the combined analysis of key themes that captured experiences of inter-professional collaboration and challenges.

Results

Inter-professional collaboration (IPC) of intensive care unit Nurses

Inter-professional collaboration (IPC) is becoming widespread in intensive care unit because of increasing complex needs of patients. Successful Inter-professional collaboration among intensive care unit nurses is influence by various factors. These factors are trust and respect, communication, professional culture, administrative support, law and regulation. IPC is a situation in which participants experience physical presence of different professionals as the need arises in the care of critically ill. Majority of participants (8/11) in this study adjudged inter-collaboration as not working in isolation in ICU but inadequately experience in the study setting.

Themes

Identifying work relationships

Typical responses from participants include;

As an ICU nurse, we witness patient condition getting worse or better, one will still have to discuss with ICU Physician (*anesthetic physician), the team physician and if there is need for another team doctors apart from the parent team to come and see the patient is the nurses task because we are the one that are closer to the patient.It is our responsibility to inform the appropriate physician as the case may be and to suggest to them but it is not really working here actually even if you make your suggestion the most of the time they just feel like we are saying what you like, is not every time they listen to what you say, inter-professional what is it call is not really there, let me be frank (PV, indepth Interview, IDI)*

PVI, a sectional head/administrator of the unit with about fifteen years of experience in the care of critically ill while also discharging administrative responsibilities, such as liaising with the various leaders of the different professionals that serve/work in intensive care unit, she explained as follows:

''The inter-professional collaboration in the area like ours, especially in this our own ICU, that is, the general Intensive care. It is a type of collaboration that you do to all areas of principle [all professionals]. When other professionals in special areas comes in, you joined hands together. Example, when the neurophysician comes in, when neurosurgeons comes in, at times it could be frustrating here (PVI, indepth Interview, IDI)''.

The participants described collaboration as something that was expected at a time that there is a patient on admission though usually through anesthetist as that is the physician resident in ICU.

Well working with other…healthcare,…professionals ,… we had a good working relationship ,…and with the anesthetic physician being the main ICU medical doctor(PI, indepth Interview, IDI).

The participants also read meaning to collaboration as invitation of a specialist by anesthetic physician for contribution of specialist care for a given patient as the patient condition dictates. Participant IV described inter-professional collaboration as she echoed:

Inter-professional collaboration in the sense that you as the nurse don't just work in isolation, we are like under anesthesia, we don't just say because is the airway that is our concern. We just take care of the airway and neglect other presenting symptom that patient has, as the primary team doctors are also taking care of the patient. There are other conditions that might arise and you might need other departments to intervene, just for instance, like a patient we have, who came for a surgical procedure, but along the line had cardiac arrest who has been in the unit for a while and along the line, he developed other condition so, we have to also invite nutritionists to come. So that the patient will have the adequate diet he needs. And then apart from that, the physiotherapist has to come in because patient is unconscious, and who needs the exercises to be able to prevent all these rigidity and all that. And also even within the doctors, because you are the one

that did the surgery, that doesn't mean that if the patient has another co morbidity you definitely have to invite, like the medical team, the neurology to come and analyzes neurological status so I feel all the other professionals too have to come to play, a times responses of the team (s) to the call is/are delay that usually negatively affect the patient (PIV, indepth Interview, IDI).

Fair and Trusting relationship

A sound and healthy relationship is expected to exist among health care professionals in intensive care unit, however, an above average of healthy inter-professional relationship is what was reported to exists as at the time of collection of data. The participants have the followings excerpts:

PII: You have to bear everything, you know some people, however you work with them, they will not appreciate. So you have to be patient in working with others, it is important to have good relationship with other professions like the anesthetic physicians, but you know, sometimes they use to downgrade some staff, sometimes the nurses (PII, IDI).

PVI: On relationship, I do tell them to save life first in ICU, which is more than what we may be arguing about, within 4 – 5 minutes we may lose life, so we have to work, though is difficult, is only when you learned how to work that everybody is a specialist in his own area, before we work perfectly. Am not telling you that we have 100% oh…! If I tell you is a lie. (PVI, IDI).

Identifying work challenge in ICU

This section present the findings derived from research question which reveals the challenges being face by participants in the ICU that include major themes of; *inadequate supplies, communication gap and leadership issues*. Analysis of the data identified three themes on the current challenges being faced by the participants. The findings of this research question are summarized as follows:

1. Inadequate supplies" and "shortage of trained team members'

A. Man power shortage

the challenges we have is a shortage of manpower because in ICU one patient can keep you standing aaa.. that is the challenge but some time when we informed them[management]. They will say it is only one patient we are having, but that patient can keep you standing because you have to give the patient intensive care ,, like that ,..that is the challenges that we are having(PI, indepth Interview, IDI)

PII: Our challenges sometimes are; A times shortage of gas in the pipe for oxygen administration, which can easily lead to deterioration of patient condition (PII, IDI).

B. Unstable ICU team members.

P9: From time to time, resident clinicians are posted to ICU without prior experience which usually affect the work flow, some of them will come in, they'll have to pipe low first and learn how to cope, then the older they get in the unit, the more they blend with everybody. (P9, IDI)

P9: You know, sometime we used to have changes [that is, unit rotation]. My problem with that, is nurses who are untrained as nurse intensivist use to be posted to our ICU, they actually support workforce but it takes time to adapt to the unit (P9, IDI).

2. Communication gap

a. lack of clearly written patient management protocol

PIV: No written manual in this ICU that guides our activities, but…especially like ICU admissions protocol. We are not supposed to bring in any kind of patient to the ICU (PIV, IDI)

P10: Our challenges include; Admitting patient into ICU by physician anesthetist (as the recognized ICU Physician) without

following admission criteria e.g political patient, not discharging patient even after stability and claiming to be waiting for a senior colleague's directive. When wrong patients are brought to ICU by anesthetist we feel demoralized, not happy. Sometimes, we are not informed when they [anesthetist] are being invited to review a patient in another unit/ward, so that we can be better prepared. And, again in few instances, Patient are admitted without diagnosis clearly written (P10, IDI).

3. Leadership issues

a. superiority complex

PVIII: As part of the challenge Ngmnnn ,… ,….first, is …. no man is an island. Everyone is bound to make mistakes and everyone wants to at the same time give meaningful inputs,…if you want to correct someone's mistakes, then you have to be humble,.. bring yourself down and do it….. That I have to say because some people they just feel like okay, they are the head so they wouldn't want to listen to nurses or nurses what do they have to say,… You understand? and with that is affecting some patients in terms of decisions and so, no team is better than any …we are all important. So, we have to humble ourselves and listen to ourselves and try to always make the patients center of our topic like since the patient is still the one that will be at the receiving end,(PVII, IDI).

Discussion

Experience of the critical care nurses relationship with other health professionals in an intensive care unit (ICU) environment

The relationship is reported to be conditional mutual and reciprocal, with in some instances with the negative impact on the care process, below are previous findings on the position of participants in this study; Lemmers and van der Voort (2021), states that One of the challenging things in ICU is building a workplace trust relationship because of decision-making, time sensitivity and the dependency of critically ill patients on team members, the trusting relationship according to be participants is fair. To buttress this further Okello and Gilson (2015) documented that, the type of relationship, whether trust or distrust workplace relationship with colleagues directly or indirectly influence performance, a trust workplace relationship promotes social interaction and cooperation among team members, it has an impact on workers performance and quality of care.

It is only through unconditional relationships that collaboration can be promoted (Manthous, Nembhard, & Hollingshead 2011). With adequate understanding of each other's expected skills and expertise among ICU team members which can only occur in their teammates' expertise unconditionally. Team members must perceive that the outcomes of their interventions are dependent on the knowledge of other team members, and those others' outcomes are dependent on their knowledge.

Professionals working in ICU must work together because each has separate and important skills, knowledge and perspectives in the interest of the entire organization (Alameddine, Dainty, Deber, & Sibbald, 2009). This is important especially if the contributions of others are respected.

Nurses could not provide nursing care to critically ill patients on their own. They needed a multi-disciplinary team effort. They were aware of this fact, but they received little support from management and medical doctors. This created a more stressful work environment(Scholtz, Nel, Poggenpoel, & Myburgh, 2016)

Challenges critical care nurses experience while working in intensive care unit (ICU) environment.

Inadequate supplies" and "shortage of trained team by most participants, absence of ICU protocol/guidelines in patient care, and unstable team members, all of these and their consequences have been well established in previous studies via the below empirical studies;

There may be availability of intensive care unit but access to services of the unit may be a challenge which can contribute to hospital morbidity and mortality because of lack of material and trained human resources (Malelelo-Ndou, Ramathuba,& Netshisaulu, 2019). This does not rule out the possibility that a lack of resources is related with an increase in demand for health-care resources.

Chatterjee and Pandit, (2017), on manpower planning, recommended improvement in the system of manpower planning and the need for an upgrade in the quality of staff. Only in this way can different types of care providers be able to appropriately serve Africa's teeming Population. Furthermore, communication barriers and lack of admission guidelines have been identified as elements that negatively affect referral and admission practices to intensive care in a qualitative study among doctors(Mtango, Lugazia, Baker, & Johansson, 2019)

In the ICU, usually, a mix of staff profile always exist, some may be newly posted have little critical care experience, some have practical abilities but are still unprepared to execute complex nursing procedures, because of these varied differences, nurse leaders are expected to adapt their leadership style to listen and carry along every subordinate to ensure that the delivered health care meets the ICU goals (Flynn, 2016).

Conclusion and Recommendation

On the issue of relationship with other health professionals in intensive care unit (ICU) environment, the study revealed that: participants operate fair trust relationship, and they even use avoidance as a strategy to avoid conflicting relationship.

The study revealed various challenges facing CCN while working in intensive care unit (ICU), ranging from human and material resources shortage, unstable workforce and lack of regards for nursing workforce. To encourage inter-professional collaboration, team members should be friendlier to one another in order to create a less stressful environment with mutual respect that is not conditional in the interest of the patient, knowing full well that no professional is a highland in the care of the critically ill.

In order to avoid role conflict in ICU environment, there is need for provision of ICU guide manual/protocol which should be evidence based. This could be done if team members are well informed on their expected roles as a complement to institution policies and educational/professional background.

To overcome the challenges, adequate provision of resources, stable workforce through adequate remuneration and more cordial and friendlier relationship among team members.

Conflict of Interest

No conflict of interest among authors.

Submission Declaration

This work has not been published previously and it is not under consideration for publication elsewhere.

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