Improving transfer from the intensive care unit: The development, implementation and evaluation of a brochure based on Knowles' Adult Learning Theory

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This paper describes the development, implementation and evaluation of a transfer brochure for family members of patients in an intensive care unit (ICU) to improve patient transfer to a general ward. When family members fail to understand information, they respond in ways that affect patient recovery. The brochure was designed within Knowles' Adult Learning Theory framework and developed using a multidisciplinary team. A mixed design was used to collect data from families and nurses. Results indicate that the brochure helped nurses to address the individual family's issues during transfer from ICU. Furthermore, 95% of nurses (n = 33) recommended its introduction for all future transfers. Family members (n = 82) who received the brochure as part of their transfer were significantly more satisfied with all aspects of transfer than those who experienced ad hoc transfer methods (n = 80). These results provide strong support for Knowles' Adult Learning Theory as an educational foundation for adult learning.

INTRODUCTION

Transfer from the intensive care unit (ICU) is a significant step for patients and families during a critical illness. When family members are either not given, or fail to understand information,1 they respond in ways that affect patient recovery.2 This includes a difficulty in making decisions on the patient's behalf3,4 or through relationship disturbances and psychological distress57 which affect important issues concerning the patient.

Emotional reactions by family members can deter nurses from communicating with families.8 However, inappropriate behaviour might be the result of family members not having their fundamental needs met as they try to grapple with unfamiliar stressful circumstances.9 A primary focus at the time of transfer is family members' emotional adjustment to the changing circumstances in a general ward when families frequently think the patient remains critically ill.

Many studies suggest the use of descriptive brochures1015 to support nurses in their endeavours to provide information to family members as an adjunct to face-to-face communication.1618 The written word provides tangible facts and supports the understanding and recall of information19 at a time when memory might be compromised.20

Education and information-sharing are fundamental and frequently used forms of communication by health-care professionals. Written brochures are one way that this information is provided for a mass audience within the health-care sector. Although well-defined objectives and sound aims underpin the development of brochures, few studies using them base their development on educational principles or ground them

in a learning theory. This results in poorly designed projects that have difficulty optimizing their aims.

This paper presents the theoretical underpinnings and method of development, implementation and evaluation of a brochure used to improve patient transfer to a general ward in an intervention study with family members in an ICU. The study brochure formed the first part of an intervention designed to reduce uncertainty and anxiety; thereby, improving families' satisfaction with transfer. The second component of the intervention comprised face-to-face communication with family members by the ICU nurse who used the brochure to structure and individualize the discussion regarding patient transfer. An overview of humanistic learning theories provides justification for using Knowles' Adult Learning Theory21 to develop the brochure for the intervention.

KNOWLES' ADULT LEARNING THEORIES

Humanistic theories have arisen from the philosophers Maslow and Rogers and are person-centred.22 The underlying principle is a recognition that the adult learner is an autonomous and self-directed learner who aims for learning as '. . . a function of motivation and involves choice and responsibility'.23 Merriam and Caffarella suggest that the humanist approach to learning encompasses more than thought processes and behavioural change because it emphasizes how human emotions can have an effect on learning.23 Humanistic theories also emphasize that the teacher and student work together to develop an effective association.24 Malcolm Knowles is a proponent of a humanistic approach to learning.

Malcolm Knowles was influenced by Carl Rogers who developed an understanding of the needs of the learner. Knowles' Adult Learning Theory expands on the concept of the needs of the learner and focuses on self-directed learning involving the teaching of adults to be in control of their learning.21 Knowles' Adult Learning Theory bases its andragogical model, or the art and science of helping adults learn, on six elements.21 In order for optimal learning to occur, the following are necessary:21

- A need to know
- A responsibility for one's own learning
- The role of experience as a resource in one's learning
- A readiness or applicability of the information to one's life situation
- Motivation to learn
- Problem-centred learning with real-life problems

These elements will not always occur together, particularly in a new area of learning.25 However, adult education can aim to nurture these elements and the teacher (in this case, the bedside nurse) needs to develop an understanding of the learner and initially give considerable direction.21,25 Adults move towards self-

directedness at different rates, depending on life events, and need the information to be meaningful to their life situation.21,26 Educational interventions that incorporate these features are more likely to positively affect learning outcomes.25 Thus, Knowles' Adult Learning Theory was chosen as appropriate to provide the theoretical underpinnings for the current study.

AIM

The aim of the project was to develop a brochure with relevant information about patient transfer for ICU nurses to use in face-to-face communication with family members.

ETHICAL APPROVAL

Ethical approval was received from the ethics committees at the researchers' university and the hospital site. All data are stored in accordance with the National Human Medical Research Council guidelines27 and are computer data password-protected.

STAGES OF DEVELOPMENT

There were four stages in the development of the brochure. The first involved the identification of key stakeholders as the family members of patients recently transferred from ICU, expert critical care nurses and senior hospital personnel. The second stage involved the collection of data from the key stakeholders. The development of the brochure comprised the third stage of the project and the fourth stage involved the implementation and evaluation of the brochure.

Stage one: Identification of key stakeholders

Based upon Knowles' Adult Learning theory, an exploratory descriptive design was used to gather information from the key stakeholders regarding impending patient transfer from ICU. The stakeholders were identified as family members whose relative had been transferred from ICU, ICU nurses, and senior nursing and medical personnel at the study site. As the site's ICU nurses were to participate in other aspects of the study (including brochure evaluation), it was inappropriate to include them in the brochure design. Therefore, the researcher selected a panel of expert critical care nurses, independent to the main study, to contribute data to the development of the educational brochure. Senior hospital personnel were included in the process to ensure the brochure was congruent with the hospital and ICU's principles and practices and to ensure the project gained their support.10

Stage two: Data collection from key stakeholders

Family members

Family members whose relative had recently transferred from ICU were identified as primary sources for information. The sample size for family members was set at 20 participants. This was justified on the basis that data from the sample represented just one aspect of the information to be used for the brochure's development. The convenience sample consisted of those consenting family members who had a relative in ICU for a period >10 h before being transferred to a general ward, their relative was not extremely unstable or dying, the family member could understand, speak and read English, and they had visited the patient in ICU.

A questionnaire was developed by the researcher with reference to the literature in the area of family needs at the time of transfer to gain feedback from the families. Following patient transfer from ICU to a general ward, the questionnaire (Appendix I) asked consenting family members to indicate information important to them around the time of transfer. They were asked to reflect on their own recent experience of the move of the patient from ICU to a general ward. There were 12 questions in the survey: 11 were forced choice with a five-point scale and the final question was open-ended, asking participants if they wanted to comment further. The questionnaire was piloted for clarity and content validity with six family-member participants. All responded that the questionnaire was clear and it was easy to follow the meaning of the questions, which addressed all the important issues. Therefore, no changes were made and their data were included in the analysis.

Following discussion with the ward nurse managers, potential family members who met the selection criteria were approached by the researcher in the general ward. Both oral and written information explaining guaranteed confidentiality and the purpose of the questionnaire occurred. All family members visiting in the general ward were approached and the final sample was determined by the voluntary response of the family members. Only one family member per patient was invited to participate. After giving informed consent, the family member was given a questionnaire that was completed at the bedside.

Findings from family members

Family member questionnaire data are displayed in Appendix II. Those items which were consistently rated as 'not at all important' by participants were deleted from the proposed brochure content. For example, family members did not think it was important to know before transfer how many other patients would be sharing a room with their relative and, thus, this information was not included in the brochure. All other information was considered 'important' or 'very important' and, therefore, was included. The only open-ended responses were comments requesting an 'update and general overall discussion'.

Expert panel of critical care nurses

The professional body, Australia College of Critical Care Nurses (ACCCN) was chosen as an appropriate source of critical care nurses. The Educational Advisory Panel within ACCCN provided the researcher with a finite group of nine nurses innately interested in issues in critical care. In addition, the research study site's ICU educator was included in the expert panel. The educator does not transfer patients and, thus, would not be using the brochure as part of her work. This totalled a sample of 10 expert nurses.

An 11-item questionnaire was developed by the researcher with 10 closed questions and one open-ended question (Appendix III). The questionnaire was piloted with two non-participating critical care nurses for content validity and clarity. No changes were deemed necessary.

The expert panel was contacted, given a brief overview of the project and invited to participate. The written invitation and information letter guaranteed participant confidentiality and outlined the purpose of the study, stating that there were two

components to participation: a questionnaire and a focus group discussion. Return prepaid envelopes were included to facilitate the successful return of completed questionnaires. All surveys were coded to provide the researcher with identifying data should a survey not be returned. One follow-up phone call and/or email was made to act as a reminder. No further phone calls/emails were made.

Findings from expert panel questionnaire

Nine questionnaires were returned (90% return rate). Five of the expert panel members indicated family members were 'sometimes' included in transfer plans and four answered that they were 'hardly ever' included. Five participants thought that their ICU transfer procedure was 'not very good', whereas three considered it to be 'quite good' and one was 'not sure'. All participants considered that family members are 'important' or 'very important' to critically ill patients' recovery (Appendix IV). The open-ended question asked what information they considered important before transfer and results have been summarized in Appendix V.

Expert panel focus group discussion

Focus groups are increasingly being used in health research to flesh out concepts and ideas.28 They are used for the collection of data in an efficient manner from a relatively homogenous group28 on a topic of interest to them.29 The fundamental tenet underpinning the use of focus groups is that group interaction reveals additional data that other methods would not elicit.30 Focus groups also are used in conjunction with other research methods, as in this case, where it was used to build on and further explain and understand quantitative data.29

The focus group meeting involved seven members of the expert panel who came from different states of Australia. Two were unable to attend from the sample of nine. The purpose of the focus group meeting was explained and the moderator31 asked participants to prioritize the information from the open-ended question for possible inclusion in the brochure. Considerable discussion ensued, with some items being deleted following discussion. Other items required clarification, some were grouped together and still others were added. At the completion of each category under discussion, the points were summarized. The five categories subsequently developed were verified by the participants as an accurate representation of discussion. Face validity of the data is important and this was achieved by the moderator outlining the identified issues to the participants for clarification and verification.31

For the two participants not present at the focus group discussion, other arrangements were made to include their comments. A meeting was organized with the ICU educator at the research site for one, while the other, who resided in another state, was emailed and asked to comment. The educator gave site-specific facts about the procedure for transferring patients from ICU. This was important as it was necessary to ensure the brochure was relevant to the site.

Senior hospital personnel

Data gathered from the family members and the expert panel were collated and a draft brochure was developed. This was shown to three Assistant Directors of Nursing and the ICU intensivists at the study site. They suggested minimal changes to the proposed brochure content and gave their support to the project.

Stage three: Production of the brochure

To facilitate broader usage of the information, an eighth grade level of literacy was chosen for the language level of the written brochure.32,33 The draft brochure was sent to three Grade 8 teachers for feedback on the content in relation to sentence construction and word choice. A convenience sample of three teachers who regularly teach eighth grade students provided the sample. They reviewed the brochure content to check that the level of literacy was congruent with that of a beginning eighth grade student. Their comments and suggestions were incorporated into the next draft of the brochure.

A visually appealing document supports the brochure's use.17 A graphic artist was enlisted to assist with the development of a product that is both engaging and professional in appearance. The way material is presented also affects the impact it makes. The print should be of a suitably sized font, with unjustified lines and headings to enhance its readability.17 There is a tendency to overcrowd brochures with information, which can have a negative effect on their efficacy. The brochure was then commercially produced and used as one component of the intervention in the study (Appendix VI).

Stage four: Implementation and evaluation

Adequate preparation for nurses in the discharge process from ICU is recognized as essential.34 The new transfer method using the brochure was introduced into ICU over a two-week period through in-service education and one-on-one sessions with the nurses. Family satisfaction data collection commenced the next day with family members in the intervention group who were transferred from ICU with the support of the brochure. The control group comprised family members and patients transferred from ICU with the previous ad hoc transfer methods. A questionnaire was completed by both groups of family members in the general ward within 24 h of patient transfer.

Findings from evaluation by family members

During the period of eight weeks when the brochure was used, 82 family members were surveyed on their satisfaction with the transfer process. The intervention was successful in significantly improving all aspects of transfer and a more extensive report of the results are reported elsewhere.35 In summary, the intervention group of family members ($n = 82$) experienced significantly higher levels of satisfaction with the information given to them before transfer from ICU ($P = 0.01$) than did the control group ($n = 80$). The intervention group members also recorded significantly higher scores when their level of understanding of the information was evaluated ($P = 0.002$) and they felt significantly 'more prepared for transfer' than those in the control group ($P = 0.001$). They were 'informed as transfer plans were being made' significantly more than those in the control group ($P < 0.0001$) and indicated that they had fewer worries with the information given to them ($P = 0.024$).

Findings from evaluation by intensive care unit nurses

Following the completion of data collection with family members, the ICU nurses who had transferred patients using the brochure were surveyed. These results also are reported elsewhere.36 In summary, the ICU nurses ($n = 33$) found the structured, individualized brochure was helpful in supporting their communication about patient

transfer with family members. Sixty per cent of participants considered that it promoted 'some discussion' or 'a great deal of discussion' about the sick patient. No nurse indicated it promoted 'no discussion'. The nurses indicated that the structured brochure helped by supporting and directing their discussion with family members, who retained the individualized brochure for future reference. Ninety-five per cent of nurses indicated that it provided a useful framework for them to use and recommended its introduction for all patient transfers from ICU.

DISCUSSION

The aim of the study was to produce an educational booklet, grounded in Knowles' Adult Learning Theory, for family members prior to their relative's transfer from ICU. Key stakeholders provided important and relevant information for the brochure, which acted as the foundation for nurse–family member discussion before patient transfer. Family members, critical care nurses and senior hospital personnel contributed to the content. This input ensured that the information was relevant to family members' information needs and, thus, according to Knowles' Adult Learning Theory,21 stimulated their interest and ability to learn.17 The multidisciplinary team used in the brochure's development ensured the product met institutional needs10 and was of a suitable level of literacy.33

It is important that compliance with educational principles relating to effective learning is incorporated into the development of educational material. In particular, the family members' readiness and motivation to learn about the illness and imminent transfer, together with their previous experiences and need for information,21 require the information to be stylized to meet individual information needs. That is, although the use of brochures is a recognized way of providing generic information,10,1214,17 studies report that families would prefer the information to be individualized.37,38 This is congruent with Knowles' Adult Learning Theory,21 which contends that people learn when they realize the information is relevant to them. This was achieved in the current study by the nurses who used the brochure to foster discussion and to individualize the content (including writing specific information on the brochure) for family members.

Although the use of brochures is a recognized way of providing information, evaluation of such interventions in the critical care area is an essential, but frequently forgotten, part of the process.10,1214,17 However, the evaluation of the current study's brochure was an integral component of the project. An extremely positive evaluation by both family members and nurses was recorded. This provides evidence that the brochure addressed the information needs of the key groups for whom it was designed.

LIMITATIONS OF THE STUDY

There are a number of limitations of this study. As it was conducted at one study site, the information that family members thought important cannot be generalized to the broader ICU population. In addition, the small convenience sample used to develop the brochure might not be representative. Participants were excluded if they could not read and write English and it could be argued that these people have even more need for effective communication tools. Although during the intervention phase of the larger study, the majority of family members recorded a mean of 11.2 years of education, there were some with as little as five years of education. This might have

been problematic as the brochure was pitched at a literacy level of eight years of education. However, it needs to be recognized that individuals learn far and beyond their formal education years and eliciting a level of literacy might have proven a more accurate way of evaluating the congruence of the level of language in the brochure and family members' ability to comprehend the information it contained.

CONCLUSIONS

Brochures are frequently used to disseminate facts and information within the health-care sector. They are both time-consuming and expensive to produce, yet few are based on sound educational principles and involve all stakeholders in their development. This paper describes the process of development, implementation and evaluation of a brochure designed within Knowles' Adult Learning Theory framework with the support of a multidisciplinary team.

The brochure successfully supported ICU nurses during patient transfer and helped them to address the individual family's issues. Furthermore, 95% of the nurses (n = 33) recommended its introduction for all future transfers. In addition, when family members (n = 82) who were given the brochure as part of their transfer process were evaluated, they were significantly more satisfied with all aspects of transfer than those who experienced ad hoc transfer methods (n = 80). These results provide strong support for Knowles' Adult Learning Theory as an educational foundation for adult education using individualized brochures. The research site's ICU now uses the brochure for all transfers from the ICU.

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APPENDIX I

Family members questionnaire

Instructions: please indicate your response to the following questions by circling one answer per question.

How important are the following: Not important Slightly Not sure Important Very important

(1) To have an understanding of the ward name and location before your loved one is transferred? 1 2 3 4 5

(2) To know the general ward's phone number before your relative is transferred? 1 2 3 4 5

(3) To know the number of patients each nurse has to care for in the general ward before your relative moves there? 1 2 3 4 5

(4) To know the general ward visiting hours before your relative moves there? 1 2 3 4 5

(5) To know the name of the doctor caring for your relative in the new ward? 1 2 3 4 5

(6) To know the number of patients per room in the general ward before your relative moves there? 1 2 3 4 5

(7) To be included in the transfer process as plans are being made to move your relative out of Intensive Care? 1 2 3 4 5

(8) To be informed, prior to transfer, about the expected outcome of your relative's illness? 1 2 3 4 5

(9) To be informed, prior to transfer, about the proposed treatments for your relative? 1 2 3 4 5

(10) In your experience, are families considered important within this hospital? 1 2 3 4 5

(11) In your experience how often do staff use everyday language when speaking to you? Please circle one response.

5 4 3 2 1

all the time sometimes not sure seldom never

(12) What information do you consider important to have prior to your relative's transfer from the Intensive Care Unit to the ward?

APPENDIX II

Results from family members questionnaire (n = 20)

Item Not important Slightly important Not sure Important Very important Mean (SD)
Ward name and location 4 3 1 3 9 3.5 (1.7)
Ward phone number 2 2 1 6 9 3.9 (1.4)
Nurse/patient ratio 7 1 0 10 2 2.9 (1.6)
Visiting hours 1 2 0 12 5 3.9 (1.1)
Doctor's name 2 0 1 7 10 4.2 (1.2)
Number of patients per room 12 2 0 6 0 2.1 (1.4)
To be included in transfer plans 4 2 0 9 5 3.4 (1.5)
To be informed about outcomes before transfer 1 2 1 4 12 4.2 (1.2)
To be informed about treatments before transfer 2 3 0 5 10 3.9 (1.4)
Are families considered important? 1 0 4 6 9 4.1 (1.1)
Never Seldom Not sure Sometimes All the time
Use of everyday language 0 0 2 5 13 4.5 (0.7)

APPENDIX III
Expert panel questionnaire

Instructions:

Please circle your responses by choosing one answer per question.

After you have completed the questionnaire, please place it in the envelope supplied and return it to the researcher.

(1) From your experience, are relatives included in transfer plans of their family member moving from ICU to the general ward as plans are being made?
5 4 3 2 1
always sometimes not sure seldom never
(2) How would you rate your unit's current transfer procedure for critical care patients' relatives?
5 4 3 2 1
excellent quite good not sure not very good poor
(3) How would you rate your hospital's attitude to family members?
5 4 3 2 1
excellent quite good not sure not very good poor
(4) How important are family members to critically ill patient's recovery?
1 2 3 4 5
not important slightly important not sure important very important
(5) In your experience, do close relatives accompany their family member upon transfer to general wards?
5 4 3 2 1
always sometimes not sure seldom never
(6) How important is it for relatives to know the number of patients per room in the general ward?
1 2 3 4 5
not important slightly important not sure important very important

(7) How important is it for relatives to have access to phones in the general ward?
1 2 3 4 5
not important slightly important not sure important very important
(8) How important is it for relatives to know the nurse:patient ratios in the general ward?
1 2 3 4 5
not important slightly important not sure important very important
(9) How important is it for relatives to understand patient expectation by the nurses in the general ward?
1 2 3 4 5
not important slightly important not sure important very important
(10) In your experience, do close relatives know that a different health care team (nurses and doctors, etc.) will be caring for their family member in the general ward?
5 4 3 2 1
always sometimes not sure seldom never
(11) What information do you consider is important for family before their relative is transferred from the ICU to a general ward? Please list.

Focus group arrangements:

I am willing to attend the focus group during the 8th World Congress in Sydney in October.

Yes

No

The researcher will contact you closer to the time to provide details of the time and place for the focus group meeting during the 8th World Congress of Intensive Care Medicine.

Please complete your contact details: phone ..... and/or

E-mail address .....

APPENDIX IV

Expert panel results (n = 9)

Item Not important Slightly important Not sure Important Very important Mean (SD)
Families important to recovery 0 0 0 3 6 4.7 (0.5)
Number of patients per room 0 2 1 3 3 3.8 (1.2)
Phone access in general ward 0 0 0 5 4 4.4 (0.5)
Nurse/patient ratio in ward 0 0 1 6 2 4.1 (0.6)
Nurses' expectation of patient in ward 0 0 2 3 4 4.2 (0.8)
Never Seldom Not sure Sometimes Always
Families included in transfer plans 0 4 0 5 0 3.1 (1.0)
Families accompany patient upon transfer 0 1 0 7 1 3.9 (0.8)
Know there is different health team in ward 0 3 0 3 3 3.7 (1.3)

Poor Not very good Not sure Quite good Excellent
Rate unit's current transfer 0 5 1 3 0 2.8 (0.9)
Hospital's attitude to families 0 0 0 9 0 4.0 (0.0)

APPENDIX V

Expert panel comments

Transfer plans Ward orientation Staff orientation Ward expectations Reassurance and support
Why they are leaving ICU and expected length of stay in ward Reason for chosen ward for transfer Staff in ICU do not look after patient Expectation of patient regaining more independence Facilities and support structures for relatives
Progression of health state Location and layout of ward Will there be any follow-up by the ICU team? Any changes to care If any problems, ICU is still close at hand
Cessation of pharmacological therapy Visiting hours and any limitation on ward (e.g. no flowers) Names of doctors taking over care Treatment plan and the expected outcomes Who family should turn to for help if they are unsure?
Patient might be transferred earlier than expected Overview of differences in equipment between ICU and general ward Name of clinical nurse consultant in general ward Patient's current health/illness status A period of readjustment is often necessary
Reasons why delays might occur Ward telephone number Skills of the nurses in general ward What education will be provided to the patient? If the patient has a communication disability, it might increase anxiety

APPENDIX VI

Pretransfer brochure

Transfer from ICU

....for relatives

Relatives provide vital support to critically ill patients. We see your role in their recovery as important. Your relative's illness will extend beyond this time in Intensive Care. The next move you and your relative will make is to a general ward. This brochure will help you understand the transfer from Intensive Care to the general ward.

A nurse will speak with you about this move to the general ward. This will provide an opportunity for you to discuss any issues you have.

Patient s Name:

1 Transfer Plans:

- Your relative's condition now allows for transfer to a general ward. Do you know the plan of care for your relative?
- We anticipate your relative will be discharged to the ward around ……..am/pm on …….. However, this may change unexpectedly.
- Some treatments for your relative in the general ward may change.
- Everyone is an individual. Your relative's length of stay in hospital is also individual. Ask the nurse or doctor in the ward when your relative can expect to be discharged.

2 Ward Information:

- Your relative will be transferred to Ward..... This ward specialises in caring for patients with conditions similar to your relative's condition.
- For A and B wards, use the BLUE lifts but for C, D and E wards use the ORANGE lifts to get to your ward.
- To contact your relative or the ward, please ring 3240 2111
- The general visiting hours are:
  Weekdays: 12md - 2pm ; 4pm - 8pm.
  Weekends & public holidays: 12md - 8pm.

3 Staff Information:

The staff in the general ward may be new to you. The following information will be of use to you.

- The doctor's name is Dr.……
- The name of the nurse in charge of the ward is ……
- In the general ward, one nurse will be caring for a number of patients. This tells you that your relative's needs are changing.
- If your relative continues to require a physiotherapist, occupational therapist or speech pathologist, there is one for your ward.

4 Expectations in the general ward:

- There are a range of issues relating to the care of your relative in the general ward. The nurse will speak with you about these.
- Daily ward rounds occur in the general ward - ask your registered nurse in the general ward when this occurs. You may wish to speak with the team caring for your relative.
- Different equipment may be used in the ward, for example - continuous monitoring equipment may no longer be needed.

5 Support for Relatives:

- If you are worried about something, contact the nurse caring for your relative first. They will help you.
- The ward's social worker can be contacted for you by the nurse caring for your relative.
- The chaplain can be contacted the same way.