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# **Challenges to constructing a cyborg ontology in critical care; crafting person-centred practice.**

BACCN Conference  
Glasgow 2016

# Content

- Context of research
- Sampling & data collection
- Coding within Atlas Ti
- Constructed codes and vignettes
- Crafting a cyborg ontology
- Implications for practice

## Study aim & research question

Results presented form part of a larger study;

*“Constructing a grounded theory of the critical illness trajectory”*

### Aim

- To discern, understand and explain the relationship between patient, Registered Nurse (RN) and family member (FM) in the context of Adult Critical Care

### Research question

- How do RNs respond to the needs of patients and family members in Adult Critical Care?

# Methodology & ethical approval

- **Constructivist Grounded Theory** (Symbolic Interactionist perspective)
- A spiral of concurrent data collection, analysis and theory construction
- Coding and memo writing starts with first interview
- Purposive sampling with theoretical sensitivity
- Theoretical sampling - searching for patterns and variations
- Theoretical saturation – no further data required
- Substantive or formal theory that accounts for data and context variations
- The final report is considered to be an analytical & explanatory product rather than a descriptive account
- IRAS approval gained via proportionate review (13/LO/0798)



## Critical Care Registered Nurse demographics

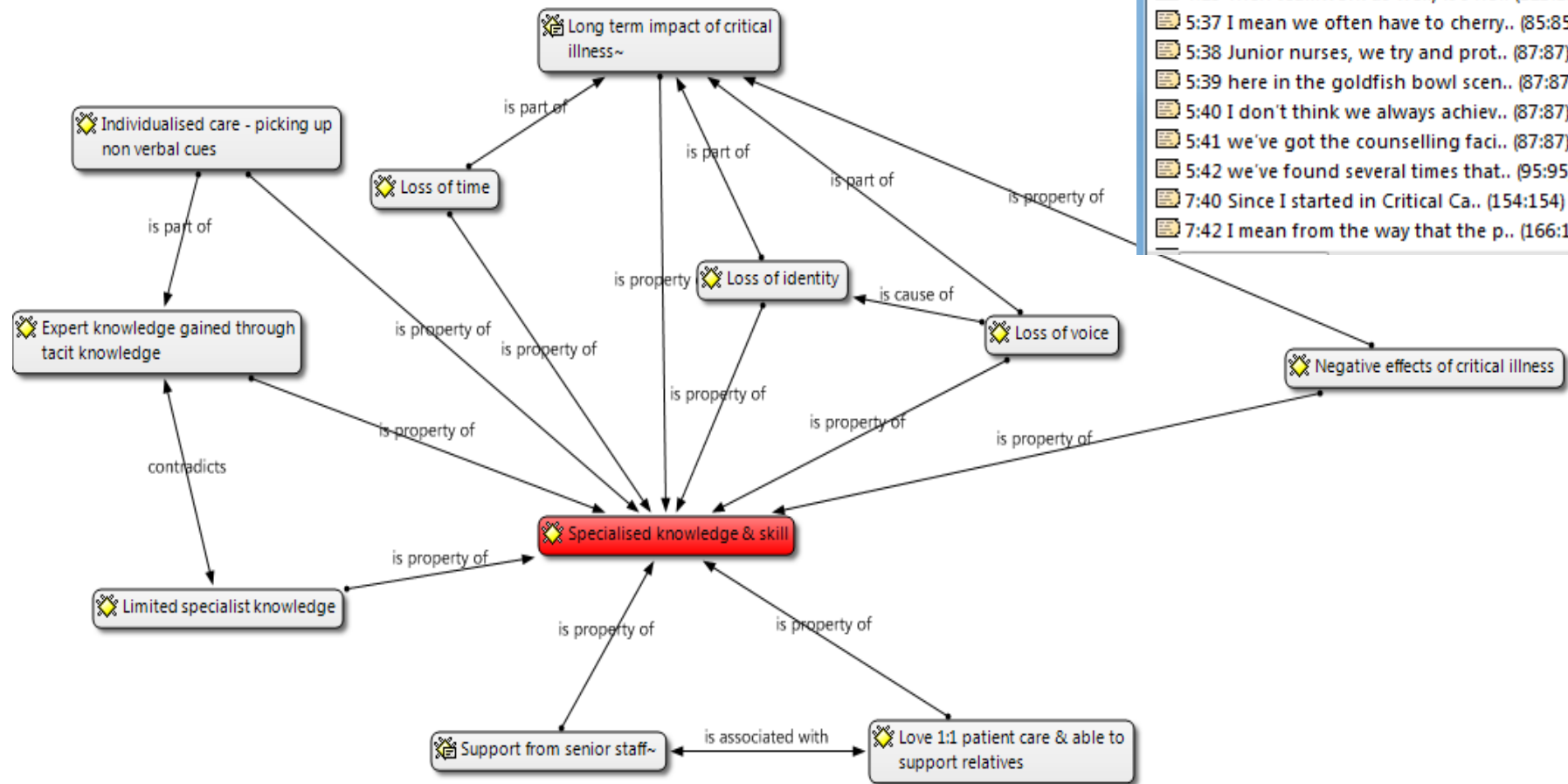
Research code	Gender	Pseudonym	Years of AGCCU experience	Post registration education in AGCC	Band
S01	F	Gail	11	Yes	6
S02	F	Amanda	18	Yes	7
S03	F	Aricha	1.5	No	5
S04	M	Paco	4	Yes	5
S05	F	Kay	24	Yes	7
S06	F	Karen	27	Yes	6
S07	F	Clarín	3	No	5
S08	F	Mary	25	Yes	5
S09	F	Jane	11	Yes	6
S10	F	Cathy	11	Yes	6
S11	M	Velta	1.5	No	5



# Data Management Atlas ti™

24 Quotations for Code Support from seni..

- 1:4 there's a lot of support, a lo.. (15:15)
- 2:11 I have to ask them if they're .. (65:67)
- 3:11 If for some reason I can't, no.. (35:35)
- 3:35 . I think we are quite, like a.. (121:121)
- 3:37 we are quite good supporting e.. (123:123)
- 3:38 I have a couple of friends, no.. (125:125)
- 3:41 Every time I actually had real.. (143:143)
- 4:3 I need to find out how relativ.. (17:17)
- 4:22 First of all your assurance, I.. (97:97)
- 4:29 Then teamwork as well, it's no.. (123:123)
- 5:37 I mean we often have to chery.. (85:85)
- 5:38 Junior nurses, we try and prot.. (87:87)
- 5:39 here in the goldfish bowl scen.. (87:87)
- 5:40 I don't think we always achiev.. (87:87)
- 5:41 we've got the counselling faci.. (87:87)
- 5:42 we've found several times that.. (95:95)
- 7:40 Since I started in Critical Ca.. (154:154)
- 7:42 I mean from the way that the p.. (166:166)





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## Focus codes

- *Personal & professional challenges*
- *Delirium assessment & management*
- *Family presence*
- *Crafting specialist knowledge and skill*
- *Challenges in care transition*



## Personal and Professional Challenges

**Gail:** *‘what I find difficult is when I’ve looked after patients with bowel cancer, my dad had bowel cancer, so you can relate to things, and when relatives have got small children, I’ve got small children, and seeing what they’re going through, that’s quite challenging and hard emotionally...’.* (S01)

**Mary:** *‘...we are emotional people and we are professionals ...one relative the other day, when her loved one died, she fell to the ground, and so I sat on the ground with her, ...sometimes we cannot want to... it’s hard to go to that place, but it’s vital for the families that we do’* (S01).





## Personal & professional challenges

Amanda after working in critical care for 18 years appeared to be struggling with the emotional challenges of working in an environment where proximity to death is ever present:

- **Amanda:** *I'm sick of death, I am sick of death, I went through a phase, about six months ago I thought, I am just so sick of death, not necessarily that we had a big patch of people dying, but I thought, oh, you know, we're either stopping somebody dying, they're dying, ...perpetual death, isn't it? Perpetual death, and I have had enough now, I have had enough. I've got another year and I'll be happy to go. (S02).*

Amanda seriously questioned the appropriate use of technology that may prolong life, which in her view, was of very poor quality: *'I think medical science is absolutely fantastic, but it needs to be used properly and I don't think necessarily these days it is, and that's why we've got the problems that we've got.'* (S02)



## Personal and professional challenges

**Aricha:** *'...it can be stressful because of workload, it can be stressful because of your emotions, you sometimes just have horrible, horrible days that you run all day and you don't get anywhere with a patient, you don't see the patient getting any better, actually sometimes just see the person going backwards and you just feel frustrated.'* (S03).

Aricha went on to explain the personal cost of working in AGCCU in contrast to the ward environment:

*'When I used to work on the wards and now, I see the difference, I can't actually, I can't actually go home and switch off.'* (S03)



## Personal and professional challenges

In contrast Mary who had 25 years of bedside critical care nursing experience spoke of her ability to ‘*switch off*’ having done all that she could to care for both patient and family member in critical care, in the fullest sense of the word. There was one caveat:

**Mary:** *“I think I’m able to switch off at the end of the day, I do my best while the patient is here, I do anything, I’ve taken a patient to a wedding, I’ve done all sorts, I take them out for walks and really tried to do my best while the patient’s here. But once they’ve gone [died].... then that’s it...I don’t go to patient’s funerals...”* (SO8)



## Personal & Professional challenges

- **Kay:** *“... the emotional challenges are the pressures, we cancelled an elective yesterday, you’ve got the consultant having a go at you because you’re cancelling someone who’s got cancer... they’ve got three consultants coming in for a cancer surgery and that patient’s obviously geared up... so you can only imagine, you gear yourself up for such a surgery and then it doesn’t go ahead, like it’s your fault. How is that my fault, we had 12 patients yesterday, and they don’t want to hear it, and I totally get they’re the ones that have got to go and face the patient at the end of the day, so I understand that, but that is awful, it makes you feel bad, ...you don’t just have them [beds], then you’ve got the anaesthetist ringing, and that’s how it is most mornings, it’s like ring, ring, ring when you’re like this, there’s no beds. And that is the emotion, because you feel you should be delivering, that is when you feel that you’re not doing your job properly because you should be able to do it and you can’t...” (S05).*

Kay demonstrated personal identification with such challenges; *“... and then you think, what if that was me, what if that was my op and it was cancelled? We’ve all got relatives, you know...”*



## Delirium assessment & management

- **Karen:** *“I’m mentoring at the moment A and B on the course, and I’ve learnt a lot [about delirium] because they’re doing a different course to the one I did, and I think it is something we need to work on quite a lot. I didn’t know all the sorts of delirium there are and I thought I did, but I didn’t know anything.”* (S06)

Kay described the risk and consequence of caring for patients who are experiencing hypo-alert delirium.

- **Kay:** *“...it’s I think a failing probably from us and nursing, when people are withdrawn they’re less demanding of our nursing time in terms of when you’ve got a very busy unit, and sometimes I think our focus can be shifted.”* (S05).

## Visiting hours –contention!

**Paco:** *“Right, from my point of view unfortunately it’s good as we’ve got the restriction visiting simply because you won’t be able to do all stuff that we have to do, personal care, physiotherapy, ward rounds, medication, investigation, kind of tests, etc, etc, it’s impossible”*  
(S04)

Karen, however, objected quite strongly to the visiting regime in place at the time of interviews:

**Karen:** *“I don’t like it... if this was my family member in here, I would find the hours very restricted...”*

## Family presence

Cathy also expressed concern over the restricted visiting hours:

- **Cathy:** *“Currently our visiting hours are limited to two hours in the early afternoon and then four hours later on in the day. I think they should be a bit more flexible to the patients’ needs actually... especially if they have delirium, because often it’s their loved ones that bring them back to where they need to be” (S10).*

Clarín struggled with working in a “goldfish bowl” environment.

- **Clarín:** *“...but the people [family members], they’re just constantly like observing you or they’re telling you, oh, you haven’t done nothing, ...I don’t know, it does intimidate me, or you’re just going to do something and they just make a joke like, but it’s not a nice joke, I don’t like that, and I try to back off a little bit because that will make me fail as a nurse, because it will stress me out.” (S07).*

## Transitional Care

- **Gail:** *“...it’s a big jump when you’ve had that one to one and then going to the wards where you might not see anyone for ages, or you see a lot of agency staff, you don’t get that continuity”. (S01)*

She went on to refer to the pressure on critical care beds that could lead to a “*busy discharge*” but how she would endeavour to prepare patients for the transfer to a different level of care:

- **Gail:** *“...sometimes it is quite a busy discharge I must admit, if we’ve got pressure on us to get patients out, but if I know I’ve got a patient going [to the ward], I talk to the patient about how things are on the ward and obviously you’re not going to have this one to one care,...(S01)*





## Limited preparation for transition

- **Kay:** “...do we prepare patients for discharge? We talk to them just generally....”

Cathy described, in technical detail, how a discharge can be enacted.

- **Cathy:** “suddenly they’ve been half asleep using their PCA, pain control’s better, inotropes are off, they’ve still got a chest drain in, they’re coming round, they’re waking up, we’ve said everything’s alright, we’re going to try and get you a bed, they don’t really know what that means, and then a bed comes up, this is in an ideal situation obviously, a bed comes up, quick as a flash, arterial line out, off we go. You know, we’re sending more patients out with central lines now,” (S10).

## “*Crafting*”

Within the social science literature, *crafting* refers to encompassing of technical skill and manual dexterity with insightful judgement and interpretation (Melia 1987, Carmel 2013).

Experienced nurses show the ability to *craft a cyborg ontology* or hybrid of human and machine but the journey to such proficiency can be tortuous.

Time to move away from thinking of technology and humanistic care as parallel dualisms or binary concepts rather that they are part of our social reality (Lapum et al 2012, Oakley 2007).



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machine  
& human  
combined

nature of reality

## Crafting a cyborg ontology

- Emotional work or labour (Stayt 2008, Siffleet et al 2015, Kelly and Smith 2016) clearly forms a central role for critical care nurses; the daily confrontation with death is abundantly evident in this study.
- Emotional toll is exacerbated further by the increased bed pressures aggravated by current austerity measures.
- Nurses appear to be bounded by the walls of the critical care unit, and experience personal and professional conflicts in their role.
- Experienced critical care nurses can transcend the obtrusive nature of technology.
- Journey to such proficiency is demanding and the data presented reveals the challenges that nurses experience along the way.



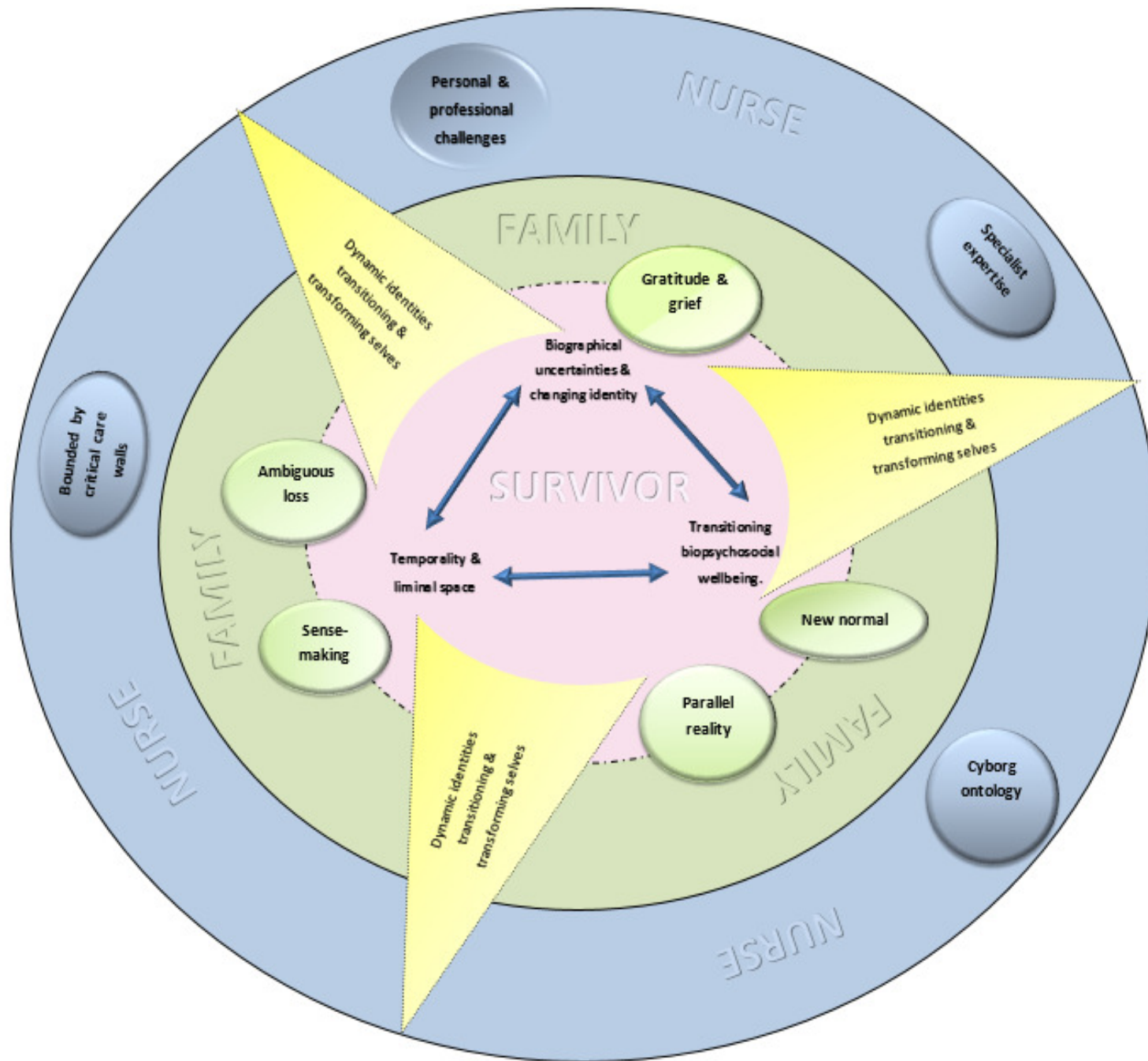
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## Moral distress

Nurses are further challenged since the boundary between life and death has been changed by modern scientific developments.

Technological advances can place people in an acute liminal space between life and death. This can create moral distress for nurses:

***Amanda:*** “...just because you can, it doesn’t mean you should, and that frustrates me.... the expectation of the public is to live forever, but it’s not based on a reality.”(S02)



## Implications for practice

- Nurses thrive in a practice environment and culture that allows them to be seen, heard and understood.
- Transformational leaders who demonstrate empathy and engage with staff evoke the human emotion of feeling cared for in the workplace (Baggett et al 2016).
- Help build resilience against compassion fatigue (van Mol 2015) and ultimately prevent the development of PTSD in staff (Mealer 2012).

## Specific strategies for all of us

- Strive to understand the values of others
- Provide a forum for discussion/debriefing
- **Collaboratively** establish goals of care
- Use, as appropriate, decision making frameworks
- Being alert to the development of compassion fatigue and act pre-emptively to diminish its development

What organisational changes are needed to preserve moral integrity?



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Critical Care nurses in this study experienced and demonstrated:

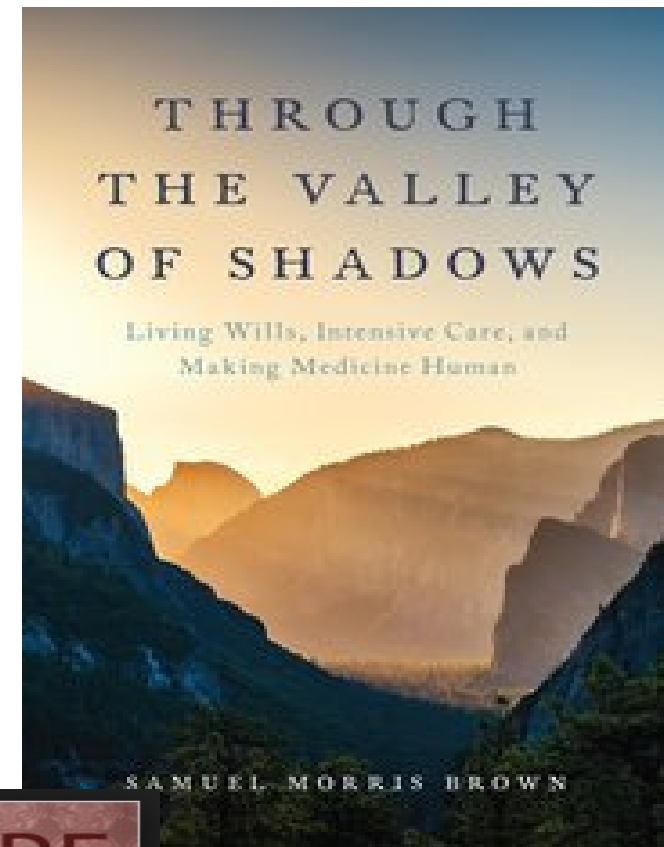
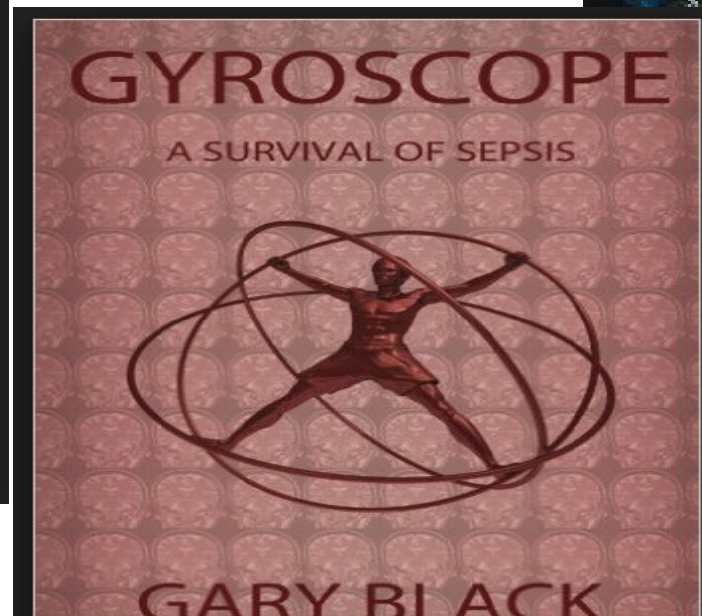
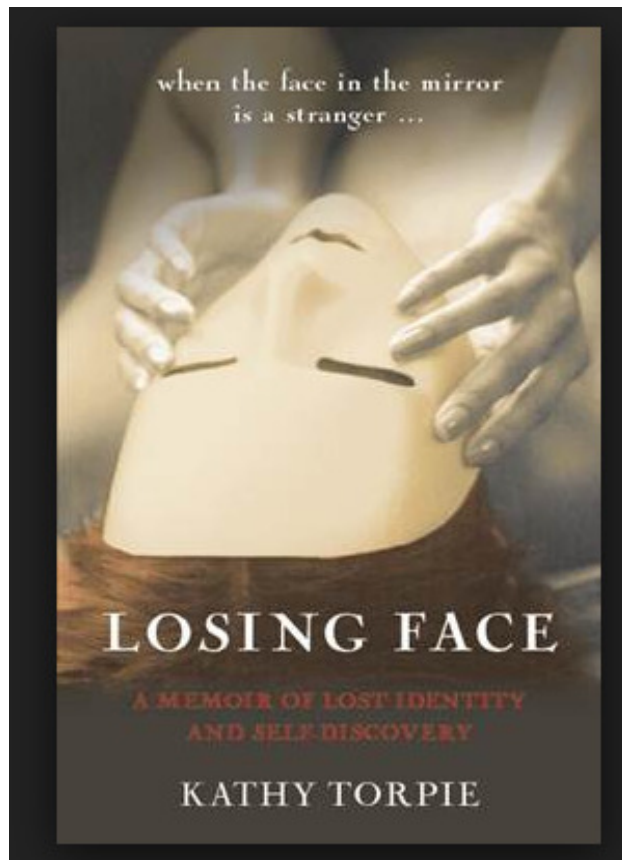






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## Reading material....





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