Critical care nurses’ lived experiences of interhospital intensive care unit-to-unit transfers: a phenomenological hermeneutical study.
Abstract

Objective

To explore critical care nurses’ lived experiences of transferring intensive care patients between hospitals.

Methods

A phenomenological hermeneutic approach using data generated through individual interviews with 11 critical care registered nurses.

Setting

Two general intensive care units in Sweden.

Findings

Five themes were identified: it depends on me; your care makes a difference; being exposed; depending on interprofessional relationships; and sensing professional growth. These themes were synthesised into a comprehensive understanding showing how transferring intensive care patients between hospitals meant being on an ambivalent journey together with the patient but also on a journey within yourself in your own development and growth, where you, as a nurse, constantly are torn between contradictory feelings and experiences.

Conclusion

Interhospital intensive care unit-to-unit transfers can be a challenging task for critical care nurses but also an important opportunity for professional growth. During the transfer, nurses become responsible for the patient, their colleagues and the entire transfer process. In a time of an increasing number of interhospital intensive care unit-to-unit transfers, this study illuminates the risk for missed nursing care, showing that the critical care nurse has an important role in protecting the patient from harm and safeguarding dignified care.
Keywords: Critical care; Critical care nursing; Transfer; Patient transfer; Caring; Phenomenological research; Hermeneutics; Qualitative research, Qualitative studies
Implications for clinical practice

- In a global context where there is an increasing number of interhospital transfers, intensive care nurses’ responsibilities and efforts to maintain the dignity of vulnerable and exposed patients during transfers should be acknowledged and honoured.

- From being mostly considered as a patient safety problem, it is time to regard interhospital transfers as a phenomenon that comes with the risks of missed nursing care.

- Interprofessional simulation training could be beneficial for promoting nurses’ professional growth and preparing them for the challenging task to transfer intensive care patients safely and carefully between hospitals.
Introduction

Over the past decades, interhospital intensive care unit-to-unit transfers of critically ill patients have been increasing, both internationally and in Sweden (Blakeman and Branson, 2013; Droogh et al., 2015; Intensive Care Society, 2019b; Swedish Intensive Care Registry, 2015). Furthermore, the growing centralisation of specialised intensive care services to university hospitals has evoked the need for more transfers to and from local acute hospitals. Transfers become necessary when care needs can only be met in a particular hospital or when a lack of staff or intensive care unit (ICU) capacity arises (Barratt et al., 2012; Swedish Intensive Care Registry, 2015). A transfer is as a multiphase process consisting of preparations; internal and external transfers; the ambulance transport; and the handover procedure (Adam and Cebollero, 2011). Organisation and competence requirements within transfers vary (Droogh et al., 2015; Kiss et al., 2017). However, dedicated transfer teams and vehicles with permanently integrated intensive care equipment have become more common (Droogh et al., 2015). The Swedish Association for Anaesthesia and Intensive Care (SFAI) stated that for safe transfers, medical equipment and accompanying healthcare personnel must be adapted to patient needs (Swedish Association for Anesthesia and Intensive Care and the Swedish Intensive Care Society - SFAI, 2015). Similar guidelines can also be found internationally (Intensive Care Society, 2019b). In the Swedish context, a critical care registered nurse (CCRN) or a certified registered nurse anaesthetist (CRNA), both of whom hold a one-year postgraduate qualification education, is responsible for the patient’s care during the transfer, and in special circumstances, a physician may accompany the patient as well. CCRNs provide competent and holistic care and are important members in the multidisciplinary team in caring for patients and their families (EfCCNa, 2004; Lakanmaa et al., 2015; Williams et al., 2006). The ambulance is usually staffed with two healthcare personnel, of which at least one should be a registered nurse. The attending physician at the
Transferring hospital is medically responsible for the patient during the transfer until the patient is registered at the receiving unit (National Board of Health and Welfare, SOSFS 2009:10).

Transfers take place in a high-tech mobile environment, making it challenging for the CCRN who is involved (Gustafsson et al., 2010; Valentin et al., 2011). Gustafsson et al. (2010) found that during interhospital transfers, nurses experience worries and concerns regarding safety issues when involved in infrequent work tasks and when handling unfamiliar or malfunctioning equipment. Being constrained by the environment and feeling afraid are other experiences that may be present in health personnel when transferring critically ill patients (Eiding et al., 2019; Senften and Engstrom, 2015). Additionally, the risk for adverse events during transfers varies (Droogh et al., 2015; Kiss et al., 2017) but should be expected (Lyphout et al., 2018; Swickard et al., 2018). Technical and medical problems can arise, and the accompanying CCRNs depend on their own ability to solve problems (Droogh et al., 2012). Previous studies – which often include different nursing contexts and specialisations, such as anaesthetic, paediatric and prehospital care – have primarily focused on the transport phase itself (Gustafsson et al., 2010; O’Leary et al., 2018; Senften and Engstrom, 2015). Therefore, the CCRNs’ experiences with the interhospital intensive care unit-to-unit transfer process as a whole is sparsely studied. In a context where there is increasing transfers and dedicated transfer teams are unusual, caregiving during transfers may become an increasingly important part of the CCRN’s responsibilities. Studying transfers from the CCRNs’ perspective can generate increased knowledge of these unique experiences, which can eventually lead to quality improvements in the care of a fragile group of patients who are often overlooked in intensive care research.
**Objective**

The aim of the current study was to explore critical care nurses’ lived experiences of transferring intensive care patients between hospitals.

**Methods**

The present study utilises a phenomenological hermeneutical approach, which was first inspired by Ricoeur’s (1976) philosophical ideas and developed by Lindseth and Norberg (2004) into a research method; the current approach is built on individual interviews with CCRNs, allowing us to explain the meanings people ascribe to their lived experiences and thereby gaining knowledge and understanding of the phenomenon of interest. The authors’ preunderstanding consisted of clinical experiences from intensive care practices and transfer processes, as well as teaching intensive care nursing.

**Setting and participants**

The current study was conducted in two general level 3 (Intensive Care Society, 2019a; Marshall et al., 2017) ICUs in Sweden that contained six and seven beds, respectively, and that served a population of almost 325,000 people; both hospitals treated adult medical and surgical patients. The CCRN-to-patient ratio varied between 1:1 and 1:2, and assistant nurses (AN) assisted the CCRNs. During data collection – which occurred between December 2016 and September 2018 – combined, the units had 2,069 intensive care admissions, and 257 became subject to interhospital intensive care unit-to-unit transfers (Swedish Intensive Care Registry, 2019b). No dedicated transfer team existed; instead, CCRNs, CRNAs and physicians with a specialisation in anaesthesiology were responsible for different parts of the transfer process. A CCRN or CRNA was responsible for the patient’s care, and an ambulance
staffed with two healthcare personnel not involved in the specific intensive care of the patient was used.

The criteria for participation were being a CCRN who had experiences with caring in the interhospital intensive care unit-to-unit transfer process and a willingness to talk about these experiences. Based on patient transfers from a larger research project (Blinded Reference) in which they agreed to participate as secondary participants in an observation study, six participants were recruited. Simultaneously, they were asked about participation in the current study. Another five participants were recruited through a personal verbal dialogue with the manager. Recruitment was conducted in accordance with the principles of purposeful sampling, here with an emphasis on variation regarding gender, age and years of ICU experience. All of the invited participants consented to take part in the study. Based on Malterud et al.’s (2016) ideas regarding sample size, the sample finally resulted in 11 CCRNs: nine women and two men between the ages of 34 and 57 and who had between 1 and 27 years of intensive care experience.

Data collection

Data collection was conducted by the first author between December 2016 and September 2018. All authors possessed competence regarding intensive care research, interviewing and qualitative methodologies. The interviews took place in an undisturbed room in the ICUs before or immediately following the participants’ working hours. All interviews were conducted in Swedish and began with the following open question: ‘Can you please tell me about your experiences of transferring intensive care patients between hospitals?’ The interviews were performed with a reflective and open attitude. In one of the ICUs, the first author was previously known as a nurse to some of the participants. During the interviews,
follow-up questions such as ‘Tell me more about this’ or ‘How did you experience that?’ were asked. The intentions behind these questions were to stimulate reflection, return to the story and make the experiences easier to remember. The interviews lasted between 42 and 57 minutes, totalling 9 hours and 6 minutes of data material, all of which were audio taped and saved on an encrypted external disc. All interviews were transcribed verbatim by the first author. Quotes from the interviews used in the presentation of the findings were translated into English. To preserve the equivalence of the meanings, the translation process included in-depth reflections among the authors, close consultation with a professional reviewer in the English language and a translation and back translation process.

Data analysis

According to Lindseth and Norberg (2004), the analysis consists of three reciprocally related phases: naïve understanding, structural analysis and comprehensive understanding. The main analysis was conducted by the first author, but all the authors took part in various discussions throughout the analysis process.

Naïve understanding

First, the interviews were read multiple times with an open-minded attitude to gain an initial and broad understanding of the meaning of transferring intensive care patients between hospitals as a whole, as detailed by the participants. The naïve understanding was written down as text to guide the continued analysis process.

Structural analysis

After an in-depth reading, each interview was divided into meaning units relevant to the participants’ experiences of the phenomenon. The meaning units were condensed to formulate
expressions of meaning, and using critical reflection, they were merged based on their similarities and differences to create subthemes and themes. This process was characterised by objectivity and proximity and contained an interpretation of what the text says to what the text talks about, from explanation to understanding. The identified themes were compared with the naïve understanding, meaning units and the text as a whole through critical reflection that occurred back and forth among all the authors. This process challenged and confirmed our interpretation and understanding. During this phase, MAXQDA 18 software (VERBI-Software, 2018) was used to structure and keep track of our analysis. This facilitated the movement back and forth between the parts and the whole, which is consistent with the phenomenological hermeneutical interpretation theory (Ricoeur, 1976).

Comprehensive understanding
To reach a comprehensive understanding, the interviews were read once again and interpreted through a critical movement back and forth between the whole; the authors’ preunderstandings; naïve understanding; the structural analysis; the aim of the study; and the relevant literature. In this way, the dialectical movement between explanation and understanding continued towards an in-depth interpretation and comprehensive understanding (Ricoeur, 1976). We used an open and critical reflective approach to temper our preunderstanding. Hence, we had to proceed more slowly regarding the analysis, leading to an eventual agreement among the authors that the findings represented the most trustworthy understanding of the data. This final phase enabled a new and deeper understanding of the experiences of transferring intensive care patients between hospitals.

Ethical approval
The current study was conducted according to the Declaration of Helsinki (World Medical Association, 2013) and approved by the Regional Ethical Review Board in Sweden (Dnr 507-16). Written permission to conduct the study was obtained from the heads of the involved ICUs. The current study was preceded by multiple sessions of information both verbally and in writing at the involved ICUs. All participants received verbal and written information about the study, stating that participation was on a voluntary basis and detailing their right to withdraw at any time and without explanation. All of the participants signed an informed consent paper to participate.

**Findings**

*Naïve understanding*

Transferring intensive care patients evokes a feeling of being the person who is responsible for the transfer and that the transfer ends well, a feeling which is directed towards patients, colleagues and yourself. To be responsible can be stimulating because it contributes to one’s professional growth, but it can also evoke feelings of loneliness, even when other health personnel are present. Feeling lonely can arise from doubting the competence of others, while the presence of known colleagues or colleagues who possess the skills you lack contributes to feelings of being supported and secure. Unfamiliar environments can be experienced as challenging when the feeling of being ‘at home’ is lost and you face the need to give up control. Being aware of the patient’s vulnerable and exposed situation during transfers can be emotionally troublesome, bringing forth feelings of one’s own inadequacy.

*Structural analysis*

Five themes were identified, as follows: (1) it depends on me; (2) your care makes a difference; (3) being exposed; (4) depending on interprofessional relationships; and (5)
sensing professional growth (Table 1). The themes are presented under separate headings with the integrated subthemes italicised and with quotations from the interviews – with the participant numbers in parentheses – presented with pauses, faltering and repetitions removed.

Table 1. Overview of the themes and subthemes.

<table>
<thead>
<tr>
<th>Themes</th>
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<td>Your care makes a difference</td>
<td>Providing good care</td>
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<td>Being there for the family</td>
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<td>Being exposed</td>
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<td>Being unprotected away from ‘home’</td>
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<td>Being aware of the risks</td>
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<td>Depending on interprofessional</td>
<td>Solicitude for colleagues in the situation</td>
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<td>relationships</td>
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**It depends on me**

Transferring patients involves experiences of being lonely, even if surrounded by others. Being lonely becomes evident outside of the ICU, where you become aware of being the only person competent in intensive care practice. Being in an unknown environment can mean missing well-known colleagues whose skills are known and a simultaneous experience of doubts regarding the ambulance personnel’s competence. Being lonely becomes a tangible experience that means experiencing a feeling that the transfer depends on you. This was narrated as follows:
If I go with an ambulance nurse, then I do not feel safe in the same way as if I were going with a colleague from the ICU. (2)

Finding confidence in yourself is a need experienced during transfers. Seeing your own role as central becomes a source of confidence because you realise that only you can contribute to a secure transfer where the patient’s well-being is the focus. Having to find confidence in yourself means having an experience that the transfer depends on you:

I think that it is up to me to make sure that the patient feels well during the transport and that it will be safe and that the patient is feeling well. (4)

Transferring patients is also characterised by facing responsibility, such as responsibility for the patient’s care and the patient’s family. It is experienced as a responsibility that is necessary to take, but also a responsibility you take out of free will; it is something that you value, protect and reluctantly give away. Facing responsibility means having an experience that the transfer depends on you. For example, this was described as follows:

I don’t sit flat and let someone else take over the responsibility. No I don’t do that, it’s my responsibility to make sure the patient is transferred. (5)

Your care makes a difference

Experiencing that you are providing good care is essential and means experiencing that your care makes a difference. Providing good care means merging a safe transfer with dignified care that is appropriate for the situation, where the patient is given the opportunity to feel safe.
Being present and viewing caring during transfers as a part of a patient’s care process contributes to the experience of providing good care. One nurse stated the following:

*The patient was sedated and not really with us cognitively, but you still have to inform the patient and be with the patient so that it becomes worthy and good.* (3)

*Being there for the family* in a difficult time feels important. Through being there, one wants to give the family assurance that the transfer will go well, making the family feel safe; hence, this means having the experience that your care makes a difference.

*But of course I have to get the family to understand that this will go well; I have to give them the security before we go.* (4)

During transfers, you experience *being part of the patient’s journey*, one that you make together with the patient and are privileged to be a part of. The journey is experienced as an opportunity for survival or one that brings patients closer to their families, which means being a part of something where your care makes a difference for others:

*It is something beautiful, I think; I take care of you and make sure you come home properly.* (1)

*Being in an involuntary noncaring situation* means becoming aware of missed caring that could have been provided in other circumstances. The practicality of preparing the transfer takes over, the patient’s vulnerability becomes visible, and it becomes difficult to be close and
create a peaceful atmosphere around the patient. Other patients you are responsible for receive less attention, and you are forced to hand over their care to colleagues:

*When we are out of beds, I feel inadequate because all of the focus needs to be on the patient who is to be transferred to make the transfer as good as possible, and then, the other patients become neglected.* (8)

**Being exposed**

Not being involved in transfers often enough or having nursing activities that must be performed simultaneously while other health personnel continually claim your attention is experienced as being in a state of *feeling stressed*, which means being exposed during the transfer. Suddenly, a decision that a patient has to be transferred may arise, leaving you with little time for mental preparation or planning, and you become stressed. As expressed by one nurse:

*I think I was surprised when I came to my work and the patient was so ill, and it dawned on me that the patient needed to be transferred.* (1)

Being exposed as a consequence of the reluctance to *give up control* appears when the sense of control that you experience and value in the ICU tends to disappear as the care moves outside the ICU. The experience of giving up control becomes a reality when you need to rely on the assessment of others and have to get to know the patient in a short amount of time:

*When I transfer a patient back home (to the original home ICU), I have usually not met the patient before but must completely rely on a verbal report which is often quite short.* (10)
The feeling of being unprotected away from ‘home’ appears when leaving your known ICU and entering an unfamiliar environment. Being in an environment where accessibility to the patient is limited and where equipment is hard to find gives rise to the feeling of being unprotected away from home. Suddenly, there is uncertainty about the prerequisites to provide good care, which means experiencing a feeling of being exposed:

*In the back (of the ambulance) where you care for the patient, I do not know the area since before, I do not know where the things I might need are.* (9)

During transfers, there is a constant feeling that problems can occur at any time, which means being aware of the risks. Transfers performed because of a lack of ICU resources are experienced as the quality of care being impaired because the transfer is hindering you from reaching out with important caring activities, such as ventilator weaning, comfort sedation or mobilisation. Even when postponed, you experience that the transfer remains in the centre, making it hard to shift focus and return to previously planned care or to initiate new caring activities:

*I think the quality of the care suffers. That the patient does not get it as good as it should because now, we cannot perform this nursing activity, for he will soon leave, and so it may not be that he goes anyway.* (2)

**Depending on interprofessional relationships**

Being in a transfer situation evokes feelings of solicitude for colleagues in the situation because nurses raise awareness together about the expectations and concerns they may
struggle with in relation to the upcoming transfer. Strong collegial bonds and genuine feelings of concern arise because colleagues should not be exposed to unsecure situations, and a need to protect each other arises. This was described as follows:

*These events mean that you care for your colleagues. I do not want any of my colleagues to do anything that they do not feel comfortable with.*

You feel it is important to have someone to problematise the situation with, hence *valuing support from others*, which means having a feeling of secureness and that the situation is manageable. Being seen by colleagues is valued because this raises a sense of collegial control that someone is watching over you. The need to find security in other nurses who have experience in that particular environment can suddenly occur, as follows:

*I feel safe to have an ambulance nurse with me in the back of the ambulance. I think that person has local knowledge, finds everything if I need something from their equipment; they find everything and know where everything is placed.*

Sometimes, discussions between other health personnel take over, intrude and drain the energy you need to accomplish your duties. Suddenly, you experience *frustration over poor teamwork* and feel like a middleperson instead of a member of the team, and the feeling of depending on interprofessional relationships becomes tangible. When more people than needed become involved in the transfer, you may experience frustration because your overview of the situation is likely to be lost:
But if it gets to be too many people, it can get messy I think, and then, I don't know who made what in the end. (10)

**Sensing professional growth**

Transferring intensive care patients evokes experiences of *growing with the task*. The feeling of the complexity of the task and its challenges will constantly imprint themselves on you, but gradually, you also have the feeling that you can handle this. The feeling of joy and satisfaction as you cope with a challenge becomes clear. When you overcome the challenge, your newly acquired experience becomes a source from which you experience growth from the task, which means finding professional growth. For example, the following was expressed by a nurse:

*Being on a transfer by yourself is not just a negative experience; there is always some nervousness and uncertainty there, but the experience also means professional development.* (7)

For the nurse, transferring intensive care patients also contains experiences of *valuing acquired competence* that you come to possess. With time, you see the connection between the acquired competence and your handling of the task’s complexity:

*I now feel that I am more prepared and that I could handle the situation if the patient becomes more unstable in another way.* (8)
Although you still regard the task as complex and as one that can end up in an exposed situation, the task becomes valuable and something you would like to be a part of. Valuing acquired competence means having a sense of professional growth.

**Comprehensive understanding and reflections**

The interpreted comprehensive understanding is formulated through the metaphor that transferring intensive care patients between hospitals means being on an ambivalent journey together with the patient but also being on a journey within yourself in your own development and growth, where you – as a nurse – constantly are torn between contradictory feelings and experiences. While being lonely, you need to face the responsibility that arises and find confidence in yourself while at the same time valuing interprofessional collaboration. You experience yourself being exposed while stressed and unprotected because of being away from the well-known ICU environment; hence, your awareness of risks becomes a heavy burden. Despite this feeling of being exposed, you experience professional growth when growing with the task and becoming more competent as a nurse. Being in noncaring situations while you do your utmost to provide good care for the patient and the family elicits a feeling that your care makes a difference.

Feeling solely responsible and a need to handle that responsibility during transfers has previously been shown by Hall (2001). Responsibility can be understood as the responsibility that comes during the encounter with the other and which, in a human way, one cannot refuse to accept. In this responsibility, everyone is connected to one other, but at the same time, one cannot expect reciprocity (Lévinas et al., 1993). Unlike other studies (Eiding et al., 2019; Gustafsson et al., 2010), experiences of loneliness can be understood as something more than just being the only one with intensive care competence and being away from close colleagues.
We understand the nurses’ tangible experience of loneliness as follows: in the perceived responsibility lies a loneliness that originates from the responsibility itself and extends to the other without reciprocity, thus offering a broader perspective and a deeper understanding of the nurse’s experience. From a caring science perspective, the nurses’ professionalism means that they wholeheartedly take responsibility and dare to make choices for good and dignified care (Eriksson, 2018; Ostman et al., 2019). In the transfer process, as in all caring, the nurse possesses responsibility for the patient and must hence respond to the patient’s needs based on the life world approach (Dahlberg et al., 2009). Having limited access to the patient’s voice and lived experiences must be considered challenging and may open up vulnerability in the nurse (Todres et al., 2014). The patient’s situation has also been shown to consist of different elements of being exposed (Blinded Reference). Therefore, being exposed can be understood as a shared phenomenon. This is consistent with Senften and Engstrom (2015) who found that nurses and patients shared the phenomenon of fear during transfers.

As in other studies (Eiding et al., 2019; Gustafsson et al., 2010; Senften and Engstrom, 2015), the nurses experienced transfers as being part of a risky event. Interestingly – and in contrast to these previous studies – our findings reveal that the nurses showed an awareness that missed caring activities, such as weaning from mechanical ventilation and mobilisation, could pose a risk to the patient in the long term. For example, Barratt et al. (2012) have shown increased length of intensive care stay because of transfers and the Swedish Intensive Care Registry (2019a) reported higher mortality among patients transferred because of a lack of ICU resources compared with transfers that occur on medical indication. Thus, the nurses in our study demonstrated an awareness of the risks associated with transfers from a wider perspective than previously known (Eiding et al., 2019; Gustafsson et al., 2010). One reason for this may be that the participants consisted of CCRNs who, compared with other specialties
involved in transfers that have been included in previous studies, have knowledge and understanding of the patient’s entire intensive care process.

Doing their utmost but still experiencing involuntary noncaring situations has previously been presented by Ringdal et al. (2016) during intrahospital transfers and Sandstrom et al. (2016) during trauma team events. Moral distress, which is frequently experienced among CCRNs, can occur when the caring activity preferred from an ethical or moral perspective is not possible (McAndrew et al., 2018). Although primarily associated with treatment decisions and end-of-life care (Fridh, 2014; McAndrew et al., 2018; Wiegand and Funk, 2012), our findings show that transfers can include noncaring situations that contribute to moral distress (McAndrew et al., 2018). Few effective interventions to reduce moral distress exist and research is limited. However, cultivating mentoring relationships and promoting interprofessional critical reflective practice and communication are considered important (Colville et al., 2019; McAndrew et al., 2018). Besides negative outcomes for nurses, moral distress can lead to compromised patient and family care (Henrich et al., 2017). These noncaring situations and moral distress can mean the absence of care, which, in turn, can result in suffering related to caring (Eriksson, 2018). Being torn between a genuine desire to provide good care and being forced to be in noncaring situations can be understood from the perspective that good care becomes visible in its absence (Arman et al., 2015).

Seeing value in transfers as an avenue for professional growth has previously been described by Eiding et al. (2019). Indeed, Meleis (2010) noted that acquiring new knowledge and skills can be seen as part of a transition, a process from one state to another that moves one’s own development forward. At the same time, our findings also show that nurses experience dependency and are aware of and value interprofessional collaboration. Previous studies
(Kvande et al., 2017; Paradis et al., 2013; Paradis et al., 2014; Reeves et al., 2015) have shown that interprofessional collaboration in intensive care can be adversely affected by hierarchical structures and a disagreement in the epistemological approaches between medicine and caring science. Despite this, health personnel within intensive care have proven to be able to perform highly collaborative care when efficiency is required (Reeves et al., 2015). A transfer is a complex phenomenon that requires clinical skill and efficiency, as well as well-functioning interprofessional collaboration (Droogh et al., 2015; Kiss et al., 2017). Interprofessional simulation can have the potential to promote all these aspects, and in particular, great opportunities for improved interprofessional collaboration are emphasised (Buljac-Samardzic et al., 2020; George and Quatrara, 2018; O'Leary et al., 2018). In the future, it may be important to implement interprofessional simulation in education and clinical training. Because transfers can pose a risk to dehumanised patient care (Blinded Reference), we argue that the nurse should be seen as central to protecting the patient’s perspective during the transfer process. The nurse’s professional growth may facilitate their position in the interprofessional collaboration in a context where the medical perspective is dominant, where caring science risks being devalued (Paradis et al., 2013) and where their voices and advocacy for the patient risk being silenced (Kvande et al., 2017). From a caring science perspective, it becomes even more important to strengthen the nurse’s position and, thus, equalise the relations in interprofessional collaboration.

**Methodological considerations and limitations**

In a phenomenological hermeneutical study, several interpretations are possible (Ricoeur, 1976). The authors’ research competence and collaborative and critical reflective approach encouraged a critical stance on our interpretations and preunderstanding. This is considered to have contributed to a deeper understanding of the phenomenon being studied (Lindseth and
Norberg, 2004). The analysis was facilitated by the use of software for research and contributed to the rigour of the study. The first author’s experience as a CCRN contributed to valuable knowledge and the ability to orient the participants towards the phenomenon. Hence, we argue that the findings present a probable and trustworthy interpretation of the meanings of CCRNs’ lived experiences. All participants considered that they had enough time to talk about their experiences. However, the fact that the first author was known to some of the participants may have influenced the interviews and can be seen as a limitation. The number of participants and the fact that the study was conducted in two smaller ICUs can affect the transferability of the results. Finally, variation among the participants contributed to a richer illumination of the phenomenon, and quotes from the interviews are used, which strengthens the findings and contributes to transparency.

**Conclusion**

The current study revealed that interhospital intensive care unit-to-unit transfers can be a challenging task for the CCRN, but it is also an important opportunity for professional growth. Therefore, future intensive care should stimulate continuing education and competence development in this area. During the transfer process, nurses experience a major responsibility for the patient, their colleagues and the entire transfer process. As the number of interhospital intensive care unit-to-unit transfers continues to increase, the current study illuminates the risk for missed nursing care and the fact that the CCRN has an important role in protecting the patient from harm and in safeguarding dignified care.
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