‘Targeting’ sedation

ABSTRACT:

Aims and objective: This paper presents and discusses the findings from a phenomenological study which provides insights into the intensive care nurses' 'world' following changes in the sedation management of patients in an intensive care unit.

Background: Intensive care sedation practices have undergone significant changes. Patients, where possible, are now managed on lighter levels of sedation, often achieved through the performance of sedation holds. The performance of sedation holds is normally carried out by the bedside nurse but compliance is reported to be poor. There has been little exploration of the nurses' experiences of these changes and the implications of sedation holds and subsequent wakefulness on their delivery of care.

Design: Following ethical approval, 16 intensive care nurses, experienced and inexperienced, from within a general intensive care unit.

Methods: A Heideggerian phenomenological approach was used. Data collection consisted of interviews guided by an aide memoir and a framework adapted from Van Manen informed the analysis.

Results: The findings reveal new insights into the world of the intensive care nurse in light of the changes to sedation management. They demonstrate that there have been unforeseen outcomes from well-intentioned initiatives to improve the quality of patients' care. There were implications from the changes introduced for the nurses care delivery. The main themes that emerged where 'working priorities' and 'unintended consequences', in turn revealing embedded tensions between evidence based targets and holistic care.

Conclusions: Intensive care nurses find the current approach to changes in sedation management can threaten their professional obligation and personal desire to provide holistic

care. The ‘targeted’ approach by healthcare organisations is perceived to militate against the patient-centred care they want to deliver.

Relevance to clinical practice: Sedation management is complex and needs further consideration particularly the potential constraints ‘target-led’ care has on nursing practice.

Keywords (max. 10): intensive care, nurses, Heideggerian phenomenology, sedation, healthcare targets, patient safety

(Words 295 excluding keywords)

INTRODUCTION:

Driven by research evidence and national targets, sedation practices in ICUs are undergoing change (Kress *et al*. 2000, Girard *et al*. 2008, Jackson *et al*. 2009, NHS Quality Improvement Scotland (QIS) 2009, Strøm, Martinussen & Toft 2010). Traditionally, ventilated patients in ICU were kept deeply sedated and only gradually weaned off sedation. However current evidence supports a more wakeful patient with the introduction of ‘sedation holds’ (SH) encouraging them to regain consciousness (Girard *et al.* 2008, Kress *et al*. 2000). There is little research exploring ICU nurses assessment or management of sedation or the implications that such changes have for their practice. This study, employing a Heideggerian hermeneutic phenomenological approach to enquiry, sought to provide insights into the world of the ICU nurse and explore particularly, how a healthcare ‘target’ influences their clinical decisions for the care of their ventilated patients.

BACKGROUND:

Currently, healthcare staff perceive themselves to be under constant pressure to achieve national targets and to defend their position robustly if targets are not met (British Medical

Association 2007, World Health Organisation (WHO) 2007). There is evidence that some national targets have failed to consider the full implications of these well-intentioned initiatives. An example of this is demonstrated in the recent withdrawal of the four hour waiting targets in Accident and Emergency departments (Royal College of Nursing 2010) when it was revealed that instead of encouraging improvements in care, the pursuit of such 'goals' in fact created pressure on healthcare staff, who risked hurried and less than ideal decisions (Topping & Campbell 2010). More recently, a Scottish health board was found to have 'manipulated' waiting time figures in order to meet statutory waiting time targets, once again illustrating the pressures felt by staff to meet today's 'target culture' (British Broadcasting Corporation 2012). However, target driven care is arguably still being sustained and encouraged across healthcare practices.

The National Patient Safety Programme is one such programme that has adopted and promotes such target driven-approaches for the improvement in patient care. As part of a national initiative, the Scottish Patient Safety Programme (SPSP) has been rolled out nationally across Scottish healthcare organisations (NHS QIS 2009) and has been designed to standardise evidence based approaches to care delivery, which is said to improve patient safety. As part of the SPSP, awork stream within intensive care has been developed to address specific areas of clinical practice, particularly the reduction of infection rates. Of concern was the issue of ventilator associated pneumonia (VAP) associated with an increased length of stay in ICU and an increased morbidity and mortality. In order to address this, the SPSP has developed 'bundles' of care. A bundle is described by the Institute of Healthcare Improvement (IHI) as "….a structured way of improving the processes of care and patient outcomes: a small, straightforward set of practices…when performed collectively and reliably, have been proven to improve patient outcomes." (IHI 2012). The 'ventilator care bundle', adapted by SPSP from its original IHI form, combines a number of interventions or elements to achieve this (Box 1).

The successful achievement of all these elements is reported by SPSP to prevent the development of VAP.

The purpose of sedation is to keep the critically ill patient comfortable and to facilitate care and therapeutic interventions, such as mechanical ventilation (MV), that may be required during this time. However, sedation practices in ICUs are undergoing significant changes. Traditionally it was deemed best practice for patients to receive significant volumes of sedation as it was considered that any degree of patient awareness would result in detrimental outcomes (Rowe & Fletcher 2008, Wunsch & Kress 2009). However, in more recent years a more 'wakeful' ICU population is being encouraged as increasingly robust evidence suggests that there are positive physical and psychological outcomes for patients who are managed with smaller doses of sedation (Kress *et al*. 2000, Jones *et al.* 2007, Girard *et al*. 2008, Dun & Baker 2008). It is research evidence such as this that underpins the SH element of the VAP bundle, specifically that a SH as part of a patient's daily care can assist in lowering the total volumes of sedation medication administered, reduce the need for MV and thereby reduce the rates of VAP and both the patients' length of stay in ICU and overall time in hospital (Kress *et al*. 2000, Girard *et al.* 2008).

Despite the research based evidence surrounding the benefits of SHs as part of the SPSP national drive, they have not been implemented as readily as anticipated (Mehta *et al*. 2006, Patel *et al.* 2009, Tanios *et al*. 2009, Dotson 2010). ICU nursing staff spend more time with patients than any other health care professional, and are well placed to implement the change. However, little evidence is currently available as to their decisions surrounding sedation assessment and management, and even less about their thoughts and feelings regarding SHs. Ultimately it must be assumed that a more wakeful ICU must have significant implications for the nurses' daily practice and their 'world' of care. A survey undertaken by Tanios et al (2009)

revealed that there is a lack of nursing acceptance in its implementation due to the patient agitation generated and the subsequent risk, and occurrence, of adverse events associated with more wakeful patients. Dunn and Baker (2011) speculate whether it is the latter fear that is hindering the implementation of SHs. There seems to be difficulty striking the balance between delivering holistic *and* research based care (Thompson *et al*. 2004). Furthermore, the 'unknown' long term psychological sequelae were revealed as a significant concern for some healthcare clinicians (Tanios *et al*. 2009, Shehabi & Weisbrodt 2011,). The evidence supporting the adoption of SHs has been questioned too, particularly the improvements in mortality reported in some studies, and the design of such studies in terms of sample size and the heterogeneity of the populations studied (O'Connor, Bucknall & Manias 2009, Augustes & Ho 2011, Shehabi and Weisbrodt 2011). There is a call for more rigorous trials and international collaboration to improve and validate the current SH evidence base and an uneasiness that perhaps sedation practices have been changed "prematurely" (Shehabi & Weisbrodt 2011 p339). Indeed, as Tanios et al (2009) reported, adverse events such as potentially unplanned line, tube or drain removal as a result of patient agitation after a SH impair the desired quality of care. The avoidance of adverse events is an integral part of healthcare practice, quality improvement and the professional duty held by both doctors and nurses: to do no harm.

AIM:

Within current healthcare organisation this study aimed to explore ICU nurses' experiences of sedation management, specifically the implementation of SHs as a means of achieving a more wakeful patient. For the purposes of this paper, the researcher has chosen to focus upon the influence of a specific healthcare 'target' and the implications it had for the nurses providing care.

METHODS:

Sample and setting*:* The researcher used a purposeful sampling method. Sixteen practising ICU nurses were interviewed between March and August 2010. The setting for this study was an eighteen-bedded, medical and surgical ICU. Facilitated by her existing research coordinator role within the ICU setting, the participants were approached informally by the researcher in the first instance and then given a study information sheet from which to consider their participation. All nurses approached agreed to participate; none was excluded. Of interest, there were equal numbers of male and female nurses recruited and the ICU nursing experience of those interviewed ranged from three months to eighteen years (Table 1). To be eligible for the study, ICU nurses had to be a registered nurse, employed by the health board, work within the general ICU and have given written consent to participate in a digital, audio-recorded interview.

Methodology: Theoretically the research design is based on interpretivism, and a phenomenological approach to inquiry underpinned this study. If a research question is related to human experience, a phenomenological approach is invaluable and effective in gathering data (Vivilaki & Johnson 2008). It seeks to illustrate the different human experiences as they are lived by different individuals (Van der Zalm & Bergum 2000). The researcher adopted a Heideggerian, hermeneutic, phenomenological approach, a 'science of interpretation'. Heidegger espoused the idea that human beings always come to a situation with a story or 'pre-understanding' and that it is these that assist the researcher in the interpretation and understanding of other's 'lived experiences'. The process of interpretative hermeneutics offers the readers a different perspective and understanding, in such a way as Koch (1999) neatly says "the researcher hopes will illuminate a phenomenon, uncover an interest, or sensitize a health care practitioner to respond in a different or more appropriate way" (p28). It is a way of

bringing forth interpretations of others' 'worlds' to unveil aspects of these worlds which may otherwise go unnoticed, and encourage reflection upon the way in which their 'world', and the 'world' of others with whom they interact, is seen. In keeping with Heideggerian phenomenology the researcher has acknowledged her presuppositions and their potential bearing on interpretation (Table 2). The use of reflexivity is central to qualitative research and ensures the researcher recognises their participation in the social world under study, potentially bringing to light personal presuppositions the researcher may not even be aware of (Finlay 2003, Jootun *et al*. 2006).

Rigour: Rigour, in qualitative research, is ensured through the transparency of research process and finding; a journey that must be easily followed by the reader. Following that advocated by McEvoy (2001) the researcher endeavoured to strengthen the trustworthiness of her findings by utilising her affinity with the ICU setting. This was facilitated by pilot interviews and subsequent intense engagement with the interview data, rejecting the use of computer software driven analysis. Furthermore, in terms of rigour, in order to ensure that the findings are transferable to other populations and settings, the researcher has made explicit the study's design (Johnson 1997, Saunders 2003).

Ethical considerations: Ethical approval was sought and obtained from Scotland A Research Ethics committee in December 2009. All data collected, processed and stored for the purposes of the study has been maintained in compliance with Good Clinical Practice guidelines and the principles of Data Protection Act 1998.

Method and data gathering: The use of in-depth interviews enables rich contextual data to be formed. According to Fontana and Frey (2000), it is one of the most powerful ways in which we try to understand our fellow human beings. As a phenomenological approach to inquiry has been chosen, the researcher used an aide memoir to prompt, but no more than prompt, the flow

of the interview. Semi structured interviews are not suited to the phenomenological approach as they serve only as a constraint to the interview flow. The phenomenological purpose is to allow the interviewee to reconstruct their own experiences and reflect on the meanings they gave them (Attinasi 1990).

All the interviews took place while the nurses were at the bedside at a time that was convenient for them and did not impact upon patient care. It was prearranged for another member of the ICU nursing team to observe and attend to the patient's care needs during the interview period. No relatives were present. The context of the interviews proved very important, allowing the nurses to point and refer to real, occurring clinical situations to complement and support their narratives and capturing relevant non-verbal gestures. To ensure anonymity the interview recordings were assigned a code number. The interviews lasted between 20 and 45 minutes, opening with the researcher asking how long they worked in ICU and what made them chose to pursue a career in a critical care setting. Probes were used to explore further points of interest. The researcher made field notes immediately following the interview, noting non-verbal body language used by the participant and, ensuring reflexivity, also noted her own feelings about the interview process and her perceived relationship with the participant both personal and professional.

Following completion of the thirteenth interview many of the same issues, notions and concepts were being repeated by the interviewees. Of note the inclusion of both the expert and the less experienced ICU nurses, provided advantageous insights into their 'worlds' set against differing knowledge and experience and different decision making approaches. Concurring with Sandelowski (2002), who argues that member checking is "arguably less useful for validating one's (that is, the researcher's) interpretation of an experience than for providing an opportunity to collect additional data about members' responses to a new phenomenon, namely, the

researcher's account" (p108), the researcher made the reflexive decision not to have the interview interpretations peer reviewed or return the transcripts for verification by the interviewees, feeling this did not fit well with the notions that underpinned phenomenological enquiry.

Data Analysis: The researcher adapted Van Manen's (1990) framework to guide the analysis process and employing the hermeneutic circle whereby the understanding of the phenomena was gained by reference to its parts and the understanding of the parts gained by reference to the whole, constantly moving between the two to gain new understandings in the form of themes (Finlay 2011). The early interview narratives were quickly reinforced in subsequent interviews unveiling potent commonalities in the nurses' perceptions, understandings and experiences. The researcher chose not to use available qualitative data management software to assist with the analysis, feeling that the abstract and constrained process of the latter prevented her full immersion in the data.

RESULTS:

The analysis revealed a number of emergent themes as the ICU nurses described the reality of their nursing 'world'.

Theme 1 – Working Priorities

The bureaucratic demands in healthcare in the 21st century are illustrated by such targets as through-put and waiting times and the challenge of working within economic constraints, whilst continuing to provide patient-centred care (WHO 2006). It has even been argued that such constraints have once again raised concerns as to the provision of individualised care (WHO 2007) with patient care seen increasingly in terms of numbers. Such concern can be evidenced

in the use of sedation holds where, despite its altruistic origins, ran the risk of being seen purely in 'target' terms of duration of mechanical ventilation, time spent in ICU and within the acute care setting.

A holistic focus

The reality of the care ethos amongst the ICU nurses, particularly in such a highly technological and potentially more 'depersonalized' setting (McGrath 2008), was, however, to encourage a holistic approach to care delivery. They appreciated the wider 'outcome' benefits of the research based evidence to achieve patient wakefulness, even for the performance of SHs as interviewee 009 describes:

"Good for the patient primarily obviously, good for the patient's family, good for us, good for em... whatever targets we might have, patients through the door,….. big 'knock on' effects, good for A & E; they can get patients up here more quickly if we have got empty beds."

However, the pursuit of both research based and holistic care, must not be mutually exclusive, if, arguably, a challenge for the nurses:

"…it has got to be holistic, so you have still got to be able to act, and …have autonomy… but at the same time have a standard protocol, so that everyone knows what to do and when to do it, and then if they understand.....other implications or other factors can be thought about…" (Interviewee 001)

They still struggled to be confident about the immediate and shorter term outcome benefits of wakefulness. Despite the 'targets' and organisational pressures on bed occupancy, the nurses could not overlook the *immediate* impact of sedation holds on the wellbeing of their patients:

"...I don't think it's nice for the patients to wake up suddenly….. I think of my patient today, he is waking up suddenly and then drifting off and it's not nice for him..." (Interviewee 004)

"Does it help the patient being woken up every day? …… Are we …getting to that stage that the patients are remembering the wakening periods...I don't know if that is helping them or not..." (Interviewee 006)

Wakefulness and workload

A more wakeful ICU population was described by the nurses as being more demanding and clearly increasing their daily 'workload'. They described spending more time calming and reassuring their patients who were regaining or had regained consciousness as a result of their sedation being reduced or halted. Here two nurses illustrate how more wakeful patients necessarily require more attention:

"For some patients if they are awake it's OK...but for agitated patients it's difficult for you having to be near to the patient all the time. You can't move away, you have to stay close to the tube..." (Interviewee 011)

"I can appreciate all the research … and I am sure it is better, of course it is, just tougher [Interviewer: Tougher for whom?] The nurse and possibly the family... For patients, if they are on the ventilator for less time… well then it's not tougher for them, it's just short term pain for long-term gain if you like… but it is probably more stressful all round..."(Interviewee 008)

Some of the nurses suggested that even for the patients they deemed as already only lightly sedated, they were still subjected to SHs as a means of avoiding unnecessary *over* sedation.

The nurses perceived this as leading to such a degree of wakefulness that patients became unnecessarily agitated and it was this type of wakefulness that the nurses described as having the greatest impact and implications on the care they are able to provide; indeed it militated against their desired quality of care. The following nurse illustrates the nursing reality she experiences:

"If they are more awake, they are going to be at greater risk...be more agitated...be more unsettled. They are probably going to cough more... It's more difficult...It's more stressful for yourself, and you can't do your things, because you need to attend to the patient, make sure they are safe... not pulling their tubes...You suction them more often, because obviously their cough reflex is much higher. Also you may be more frustrated because you feel you can't really help the patient; the tube is in there and if that is not going to change at the moment...the only real thing you can do to help the patient is give them sedation…if the tube is bothering them" (Interviewee 014)

Another nurse clearly describes how decisions to perform a SH are highly influenced by his workload each shift:

"... how busy you are definitely; how much risk you think the patient is going to be in terms of actually waking up and pulling their tube...Often the patients seem really appropriately sedated when you come on and you think…Why would I want to stop it?" (Interviewee 005)

Staffing

The problems with staffing are evident across nursing practice (Endacott 1996). Internationally there is an ageing population (Centers for Disease Control and Prevention 2003) with ever advancing technologies to preserve and prolong lives. However, alongside this, there is a

perceived diminishing nursing workforce (Hahm & Ommaya 2006) – an issue that appears in the foreseeable future will remain unchanged. It was evident from further probing that insufficient staffing levels contributed to the increased workload the nurses described:

"When patients are awake they are more likely…. more prone to reach for their tubes. You've got to watch them more but there are less staff; you're 'covering' people all the time..." (Interviewee 005)

"We are to keep an eye on, our patients but because it is getting busier, and busier in here, we have got no 'runners' a lot of the time, and are having to cover breaks involving the cubicles…It is just affecting our safety which I try and advocate all the time because ultimately you need to be able to see your patients" (Interviewee 006)

Theme 2 – Unintended consequences

The pursuit of a more wakeful ICU population has created a number of unintended consequences for clinical nursing practice. The implications of these consequences appear to have been over looked in the implementation process, arguably in detriment to its success.

Patient agitation

Patient agitation emerged as a significant concern and perceived to be linked specifically with sedation holds. The nurses not only worried about their patients' experiences during the periods of agitation, but also about the implications on their work in terms of both its 'quantity' and 'quality'.

“You are ‘stuck’ at the end of the bed when the patient is off sedation. They are continuously agitated by the fact that they are intubated and the sedation has been put off and we are just expected to get on with it and continually watch the patient all day long” (Interviewee 005)

“If you have got an agitated patient for 12.5 hours, it is very tiring and sometimes here we double up for breaks- sometimes not an appropriate double, and if you've got an agitated patient and they are not adequately sedated, but they [the doctors] don't want them [re-sedated]...it can be unsafe...” (Interviewee 007)

Emotive responses/experiences

Often associated with this agitation is the occurrence of adverse events, such as unplanned line and tube removals. Such events left the nurses feeling that they had not fulfilled their duty of care as a nurse. This nurse expressed feelings of guilt that they had let the patient down by not preventing extubation, but also expressed helplessness, having carried out everything she was able to:

“I feel guilty. It makes ...you know you have done everything you can, but you’re told they [doctors] don’t want sedation up or that they are trying to wake and wean them...” (Interviewee 007)

The nurses also questioned whether they could have avoided the adverse event occurring:

“Often you feel that you could have avoided it by….. you just take your eyes off the patient one minute and it’s gone, so you do feel a bit guilty, you do feel a bit like ‘it’s my fault’...” (Interviewee 005)

The nurses also described feeling a sense of failure and overtly dissatisfied with the nursing care they have been able to provide:

"...I feel a failure personally but that's because I am used to the days when you were there all the time; you didn't turn your back on the patient; you didn't leave the patient and so that really was a failure on your part... Everybody would have thought it was a failure on your part. So that still sticks and there are certain aspects of nursing care that I always want to be able to do. There are so many things: talking to relatives, spending more time with the patient…but we just can't do that in the same way anymore...Other people would be more pragmatic about it and think…Well that's what happened [unplanned extubation]. I couldn't see them, I was in with somebody else, that's just what happens'… I would like to be like that…but I still think that deep down you think well if I had *only* done this, if I had *only* done that...it is dangerous for the patient because they potentially then have to be anaesthetised... to have their tube put back down maybe, or have a central line inserted again."
(Interviewee 008)

The nurses feel a sense of responsibility to protect their patient from harm, something they found increasingly difficult to preserve in the current wakeful workload. The nurses perceive themselves as being blamed for adverse events occurring despite the changes in practice being driven by a national programme in their healthcare organisation. At an emotional level, they appeared reluctant to view it as a failure of the *organisational* structure. They were, however, prepared to talk openly and frankly about the fear they felt performing SHs and the consequences of them:

"It is difficult to know how your patient is going to react if they've been on a 'load' of sedation and they are as 'flat as a pancake' and then, suddenly, you switch it all off .You don't know how they are going to cope. …So knowing your patient or trying to predict what your patient is

going do is quite difficult. I think that probably plays on people's minds when they've been asked to do sedation holds..." (Interviewee 009)

"You are frightened. You don't know how the patient's going to wake…….. I wouldn't say frightened. That's the wrong choice of word; you're wary of it because you know you are turning sedation off whereas I would be used to weaning more slowly. Now you're on 10 of Propofol and turn it off, and you're wary of how that patient is going to wake up." (Interviewee 016)

"I just think that people waking up is one of the hardest things we have to witness here, because people are uncomfortable; they get a fright… It is quite nerve racking sometimes because you don't know what is going to happen…" (Interviewee 004)

DISCUSSION:

Within the context of critical care and set against the burgeoning research based evidence, healthcare organisation driven targets can increasingly being seen as determining sedation norms and practices (Dodek *et al*. 2011, Miller *et al*. 2011). However, the way in which the implementation of such new sedation practices has been approached has appeared to overlook the complexity of sedation management and, more particularly, the immediate implications that changes in sedation practice have for the ICU nurses providing the bedside care. Consideration must be given to the VAP care bundle, which embeds the SH element but clearly has distinctive implications that separate it out from other elements that appear widely accepted and comfortably complied with in practice, notably they have minimal overt physiological or psychological effect on patients and minimal impact, other than beneficial on nursing care delivery and patient outcome. In contrast, SHs are seen as driven, somewhat adversarially, by

the medical staff/system, detached from the bedside consequences, heavily reliant on nursing actions and with a direct impact and implications for nurses' care delivery and *their* patients' wellbeing. Yet, it is proposed that, despite this, the implementation of the sedation hold element is accepted and undertaken with the same level of evidence for its rationale and educational guidance on the process as with the other elements (Figure 1) (Resar *et al*. 2012, Beard *et al*. 2008). It is clearly the 'direct' impact of sedation holds that distinguishes this element from others in the VAP bundle, making compliance targets harder to achieve. In the nurses' narratives, it became explicit that they put a high premium on maintaining a holistic approach to care. The desired achievement of shorter ICU and hospital length of stay for patients through increased wakefulness and performance of sedation holds is found, unintentionally, to conflict with the critical care nurses' philosophy of 'bedside care'. The nurses are trying to preserve and protect their patients' individuality within a national drive to change aspects of care delivery. It could be argued that the changes being driven in relation to sedation management, essentially a 'one size fits all' approach, is probably more difficult to adopt in ICU where patients' illnesses are often unpredictable and dynamic. Vouzavali and colleagues (2010) study highlighted the intense relationships the ICU nurses form with their patients, supported by the nurses interviewed; they felt a need and want to treat the 'whole patient', not just achieve an organisational target. The Heideggerian perspective would be that the nurses *need* the patients to assist with their 'being–in-the-world'. Heidegger asserts that "Beings reveal themselves through *care*" (Heidegger 1962 p254). The perceived approach of the SPSP is arguably at odds with the development of the nurses' 'being-in-the-world'. It impedes the nurses 'knowing' of their patients which they require not only for their nursing development but also to facilitate the delivery of quality care. With respect to sedation practices, the nurses adopt a patient centred approach, adapting to the needs of the patient. In contrast, the SPSP is perceived as driving an *everyday* 'protocol' approach which appears to be applied to *everyone*, all patients receiving the

protocol driven care, despite the research evidence not lending itself to this type of implementation.

Furthermore, despite the research based evidence emphasis being the avoidance of over sedation and not the creation of agitation, the nurses described it as a common consequence in the pursuit of 'wakefulness'. Agitated states not only left the nurses distressed by the visible discomfort their patients appeared to be experience but also fearful of its consequences. These feelings of fear were often accompanied by feelings of guilt and blame which directly impacted upon their confidence in wakeful patient responses and particularly the performance of SHs.

It should be acknowledged that a number of other potent themes such as team work, power, conflict and leadership, emerged from the data, all undeniably embedded within healthcare organisational structures. Although beyond the scope of this paper, they will form the basis of subsequent research papers.

CONCLUSION:

The ICU nurses described the current 'target' approach to changes in sedation management as a threat to their professional obligation and personal desire to provide holistic care; it ran counter to the individualised care they want to deliver. Patients' sedation status directly impacted upon the nurses' workload and left them in a state of disequilibrium regarding the requirement to deliver research based care, the desire to deliver holistic care and the duty to deliver safe care. Ironically, an intervention aimed at increasing patient safety and wellbeing often left the ICU nurses in fear for their patient's safety.

RELEVANCE TO CLINICAL PRACTICE:

The findings have highlighted the unintended implications of a well-intentioned, research based, nationally driven target within the ICU setting. The constraints this healthcare target placed on nursing practice, arguably impaired the nurses ability to provide the desired individualised and safe patient care. The recommendations drawn from the findings include:

- The nature of targets must be considered in their entirety but also in their individual elements.
- The contextual implications of bundles of care must be explored and monitored further than purely the *measurable* benefits to the patients.
- Participation of those involved in the delivery of care decisions is of paramount importance.

CONTRIBUTIONS:

Study Design: KE, TF, TW

Data collection and Analysis: KE

Manuscript preparation: KE, TF

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BOX 1: Key components of 'ventilator care bundle'

Key components of the 'ventilator care bundle':

- Sedation to be reviewed and, if appropriate, stopped each day
- All patients will be assessed for weaning and extubation each day
- Avoid supine position, aiming to have the patient at least 30° head up
- Use Chlorhexidine as part of daily mouth care
- Use subglottic secretion drainage in patients likely to be ventilated for more than 48 hours

** Peptic ulcer prophylaxis (medication to reduce gastric acidity) and venous-thromboembolism prophylaxis (medication to reduce deep vein thrombosis), were removed from the bundle for SPSP use (Beard *et al*. 2008)

TABLE 1: Nurses' ICU experience

ICU nursing experience	Number or interviewees
3 months – 5 years	**6**
6 to 10 years	**7**
> 10 years	**3**

TABLE 2: The researcher's presuppositions

	Recognised presuppositions	**Potential bearing on interpretation**
Fore-havings	1.Clinical experience as a critical care nurse	1. The researcher's own nursing experiences may influence her interpretations
	2. For eight years, the researcher has held a research role, in the CC unit in which this research study also took place.	2. The researcher may make assumptions due to her affinity with the CC unit *or* the nurses interviewed may assume she already has certain knowledge or understanding affecting the information they offer during the interviews.
	3. The researcher is a member of a small group assisting with the development and implementation of a delirium assessment tool in the named CC unit.	3. The nurses could assume an incorrect knowledge base of the researcher – affecting the information they offer during the interviews *or* the nurses may perceive the researcher to be in a position of power.
Fore-sights	1. The researcher was acutely aware of potential biases due to her dual-role affecting the interview process and the interpretation of narratives.	1. Effort to ensure both positive and negative narratives were elicited, non-leading probes were used. Prior to the interview commencement, the researcher made clear her role as a doctoral student for this study.
Fore-conceptions	1. The researcher anticipated that staffing levels would arise as an issue.	1. The researcher ensured that she did not ask specific probing questions re staffing and was careful not to be overly empathetic towards this concept in her interpretations or let her own feelings influence the interpretation.