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RESEARCH ARTICLE

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Uncertainty experienced by the critical patient upon discharge to the general ward: Care proposals from the perspective of Mishel's theory

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Abstract

Background: The process of discharging the critical patient to the ward (discharge from critical care to the general ward—DCCW) is often described as an experience involving uncertainty which may affect the patient's quality of life and ability to cope. Coping with uncertainty is an individual response not related to the course of the illness that is dependent on external and internal resources and the ability to utilize them. Mishel's theory of uncertainty identifies aspects of care that can shape the experience of uncertainty associated with the illness.

Aim: To understand the experiences of uncertainty of critical patients associated with discharge from the intensive care unit (ICU) to glean person-centred care strategies under such circumstances.

Study Design: Qualitative study with a phenomenological approach. Between March 2017 and May 2018, 20 in-depth interviews were conducted on patients recently discharged from an ICU.

Results: The patients have been organized according to the following pre-established categories of Mishel's theory: stimulus framework, structure providers and uncertainty assessment. Based on these results, suggestions for the care of the critical patient upon discharge from the ICU are made in each of these categories.

Conclusions: Applying Mishel's theoretical perspective to care for the critical patient during the process of discharge to the ward can help identify areas for intervention and improvement. To succeed, there is a need to promote a cultural change in ICUs, empower nurses and provide the necessary resources.

Relevance to Clinical Practice: These findings are relevant and timely given the impact of the experience of critical patients discharge to the ward. Uncertainty management has been identified as an important element in the discharge experience of critically ill patients to the ward because, according to the informants' stories, it can make this transition a healthier process with less emotional impact.

KEYWORDS
care transition, discharge, ICU, Merle Mishel, uncertainty

1 | INTRODUCTION

The relocation of the critically ill patient depends on the judgement of others. It involves the transition from a familiar environment perceived as being safe to one that is less familiar and may be associated with changes in the patient's psychological status.[1,2] Moreover, the process of being transferred from the intensive care unit (ICU) to the ward is often described as involving uncertainty, which may affect the patient's quality of life and their ability to cope.[3]

Although previous studies have addressed the impact of patient discharge from critical care to the general ward (DCCW), there is still a gap between what is known about the subject and the care given during this process, considered a priority area for improvement.[4] Moreover, in the highly technified context of intensive care, there is a risk that the dominant culture of science and the rationalization of health care are excessively informing nursing practice to the point that nursing philosophy and goals may not be fundamental for its practice.[5] Thus, analysing health-illness experiences from the standpoint of a nursing theory may explain the why and the how of nursing practice and guide interventions.[6]

Despite being common among critical patients, uncertainty has been little studied to date, hence requiring more in-depth study.[7] Mishel's theory of uncertainty identifies aspects of health care that can shape the experience of uncertainty.[8] Hence, when applied to the understanding of the critical patient's process of discharge to the general ward, it can provide cues to cast light on nursing practices in what, by its very nature, is a situation of uncertainty.

According to Mishel,[8] disease-associated uncertainty arises when a person cannot adequately structure or categorize illness-related events because of a lack of sufficient cues. Although all patients will have to deal with it, coping with uncertainty is an individual response that is not related to the course of the illness.[8]

Mishel's middle-range nursing theory of uncertainty in illness[8] identifies three aspects that precede and determine uncertainty: the perception of stimuli resulting from situations of illness—*Stimuli frame*; the individual's *Cognitive capacity* to process the information reaching them; and the external resources available to interpret it—*Structure providers*.

In turn, the stimuli frame consists of three components: the symptom pattern, and the familiarity and congruency of the event. The former refers to the predictability or arbitrariness of symptom onset and the latter two to prior knowledge of or familiarity with the illness and how the experience matches the idea of what would be expected to be experienced in such a situation.

The social support available to the individual, their level of education and the patient's trust in the personnel caring for them—*Credible authority*—are considered structure providers, and together with the individual's cognitive capacity contribute to shaping the experience of uncertainty.

Mishel's theory of uncertainty[8] conceives uncertainty as a neutral state that is not associated with emotions until it is appraised. Two mechanisms come into play in appraising uncertainty: inference and illusion. Inference refers to the evaluation of uncertainty based on personality dispositions, general experience, knowledge and contextual cues. Illusion refers to the construction of beliefs with a positive perspective based on the situation of uncertainty. Adaptation to the situation depends on the capacity to reduce uncertainty when it is perceived as a threat or to maintain it when it is seen as an opportunity.[9]

The purpose of this study was to understand the experiences of uncertainty among critical patients associated with discharge from the ICU in order to glean person-centred care strategies under such circumstances.

What is known about the topic

- Critically ill patients often experience anxiety and depression upon discharge to the ward.
- Mishel's theory identifies care to address chronic patients' uncertainty.
- The highly technologized context of ICU may overly inform nursing practice.

What this paper adds

- Critically ill patients often experience uncertainty upon discharge to the ward.
- Mishel's theory identifies aspects of care to address critical patients' uncertainty.
- There is a need for a cultural change, to empower nurses and provide resources to care for the critical patient.

2 | MATERIALS AND METHODS

2.1 | Design

Qualitative study with a phenomenological approach. The phenomenological approach provides information about how critically ill patients experience discharge and allows the identification of practical care strategies to facilitate their transition.[10] It also promotes reflective clinical practice and humanizes care by addressing patients' existential needs.[11]

2.2 | Setting

The setting was a polyvalent ICU of a hospital in Barcelona. Data were collected between March 2017 and May 2018.

2.3 | Sample

Consecutive sampling was performed. Participants were ICU patients aged over 18, hospitalized for medical, surgical or trauma conditions with a stay of longer than 48 h. At discharge and during the interview, they required a Glasgow Coma Score (GCS) of 15, a negative result in the Confusion Assessment Method for the ICU (CAM ICU), no vasoactive drugs, stable heart rate, oxygen saturation ≥95%, no pain (Visual Analogue Scale score of 0) and the ability to provide coherent, valid data. Patients with language barriers, delusional psychiatric disorder, previous ICU admission or assigned to the principal investigator were excluded. Those who met the inclusion criteria and gave their consent were interviewed, but 13 patients were excluded a posteriori because of non-fluent and/or incoherent speech.

2.4 | Study subject recruitment

All patients who, according to the medical team, met the criteria for discharge from the ICU were awarded a GCS and a CAM ICU by the nurse responsible for their care. Patients with a GCS = 15 and a negative CAM ICU were informed of the study by the principal investigator and were invited to participate and sign their informed consent. Patients who consented were reminded that, once in the hospital ward, a member of the investigating team would visit them to confirm that the inclusion criteria were maintained and to agree on a date, time and place to hold an interview.

2.5 | Data collection tools and methods

Demographic (age, sex) and clinical data (diagnosis, ICU stay, ventilation days, social support and destination) were collected. Discharge experiences were explored in interviews covering ICU, discharge and ward experiences (see SM1), conducted by the principal investigator, audio-recorded and held at an agreed location.

2.6 | Reflexivity

The principal investigator acted as a nurse in the unit and as a principal investigator. To avoid skewing the patient's account and hindering the objective analysis of the aspects studied, it was decided to exclude from the study patients assigned to the principal investigator when the latter acted as a nurse in the unit.

2.7 | Data analysis

The audio recordings were transcribed verbatim. A thematic content analysis was conducted by identifying predefined categories from Mishel's theory of uncertainty in the text following a deductive strategy.[12,13] For encoding, Atlas Ti v 22.0 data analysis software was used. After reviewing all assigned codes, redundant codes were gathered and new codes were entered until data saturation. The codes were organized by themes and were assigned to pre-established categories of Mishel's uncertainty theory. The analysis was conducted by four researchers. An initial independent pairwise analysis was performed. Subsequently, the results of this first analysis were shared at group meetings by the four researchers. At these meetings, the themes and sub-themes and a single denomination for each of them were agreed upon. A total of eight face-to-face meetings were held to reach unanimous consensus on each theme.

2.8 | Rigour

To minimize bias in the analysis of events transpiring in the same unit where the principal investigator was a practising nurse, it was decided to triangulate the data analysis.

Transcripts were returned to the interviewees, so they could validate their content and rectify or elaborate on them if they deemed fit.

2.9 | Ethics statement

This study was conducted according to the Helsinki declaration.[14] The study was approved by the Research Ethics Committee of the hospital (CEIC Hospital Santa Creu i Sant Pau) where the investigation was conducted (Ref: 16/176, 13th October 2016). Data confidentiality and anonymity of all participants were ensured by coding the interviews. Participants signed written informed consent and were aware that they could withdraw from the study at any time and for any reason without any adverse consequences. The recordings of the interviews were destroyed after transcription and content analysis.

3 | FINDINGS

Twenty interviews were conducted. Respondents' clinical and demographic characteristics are summarized as Supplementary Materials 1 and 2.

The results presented are organized according to the elements of Mishel's Theory of Uncertainty to which the statements refer, that is: *Stimuli frame*, *Structure providers* and *Uncertainty appraisal*.

3.1 | Stimuli frame

This section, grouped as by Mishel in her theory, presents the experiences that for various reasons may give rise to uncertainty in the subject. Uncertainty is expressed explicitly through the account of events or implicitly through the perception of fear or anxiety associated with it.

3.1.1 | Symptom pattern: How do I feel?

Upon discharge to the general ward, the critical patient hardly speaks of their symptomatology related to the illness that led to their admission, and if they do, it is to integrate it into the discharge process as a threat that affects the experience of being on the general ward because it makes them feel vulnerable: 'I had to sleep, sleep without oxygen, and I didn't want to fall asleep, I didn't want to fall asleep, because I thought… well, if you fall asleep, you won't be able to breathe or whatever, and you'll be lying here stiff' (I1), or dependent.

Dependency is a recurring issue that affects some patients who, after a prolonged period spent in the ICU or because of the actual illness they have suffered, are discharged from the unit with a degree of autonomy below the habitual level for them. Uncertainty as to who will cover these self-care shortcomings in an environment of less support than the ICU is a common source of concern among these patients: 'You're always afraid, let's see who I'll find or how I can do it by myself now' (I19).

In other cases, the uncertainty that arises surrounding the uncertain future of the transition can have negative emotional and physical effects on patients: anxiety and fear.

The next respondent experiences symptoms of anxiety that she attributes to general uncertainty about being discharged from the ICU.

> I remember when I was on the trolley when they took me to the other place, I was on the trolley and was saying, 'oh goodness, where am I going now?' I could feel my heart going boom, boom, you know? Oh goodness where they were taking me, will my family find me later? Where will I be? What will they be like there? Will they treat me the same? Will they care? (I1).

The new setting, the need to adapt to new operating codes and the perception of vulnerability cause fear and a feeling of helplessness.

> I was scared, I mean, I was scared, I was shitting myself, shitting myself. I thought… you'll see how something happens to me, and here no-one finds out. That's all I was thinking, let nothing happen to me. Yes, yes, because of course I rang the bell or whatever, because I needed a pee and 'we'll be there in a tick!', 'cos here it's one [nurse] to four [patients]. (I3)

3.1.2 | Unfamiliar stimuli: Leaving the intensive care unit, reaching the ward

The lack of information on the discharge process and leaving the ICU intensifies the perception of uncertainty:

> They don't tell you what you'll see, why you're going, they don't tell you: 'right, you're going there', I had never been here [in a ward] either. (I2)

Furthermore, discharge from the ICU involves a change in routines, staff and physical location, and the lack of references concerning the destination unit can generate false expectations about the new setting and difficulty in interpreting the environment in terms of safety:

> I thought it would be like the ICU, and of course I saw it wasn't, and so, on seeing it wasn't, I don't get in a state because I say 'oh, if they're not watching me, I don't know if I'm alright', because I don't know what's in here [pointing to her chest], if I really am fully cured. I don't know, you know? I, I'm afraid something might happen to me, it's a fear of… yes, of, of… [sighs] psychological. (I1)

3.1.3 | Lack of coherence: The unexpected

In other cases, despite having received information about discharge, there has been no warning of a possible change of plans because of unforeseeable circumstances. In the case in hand, the frustration of expectations that were assumed to be immovable caused emotional distress when the patient was told that his discharge to the general ward had been postponed due to a lack of beds: 'The next day, until I was told that there was a bed, which was no easy task, I had another anxiety attack' (I9).

Some respondents describe discharge from the ICU as a precipitated, strange process, out of keeping with previous care experiences:

> It was the worst thing of all. They quickly ripped out everything I had, I had a couple of lines, they ripped them out, rip, rip, out, out, out, dressings and little else,

> I had always been treated with great affection and there seemed to be a rush here, suddenly I became a person out of the place where I belonged. (I5)

Often, once the respondents have reached the general ward, they feel that the care received is deficient and not in keeping with their health status, blaming this on the poor conveyance of information among practitioners:

> Since everything happened so quickly in my case, they didn't bother to find out what had happened to me and I got there and… 'You can lift your leg! Yes, you…!' and I said 'I can't', and there were things that I couldn't do, and that they, not knowing, not being informed—I guess because of the speed or whatever it was about my situation—well it distressed me. (I1)

3.2 | Structure providers

This refers to resources that, in the patients' opinion, help interpret and understand events and, therefore, according to Mishel's theory, shape uncertainty.

3.2.1 | Credible authority: Trust in health workers

Health workers have been identified as credible authority-generating figures. Confidence in health workers' decisions keeps avoidable sources of uncertainty under control:

> I trusted that those people thought more than me, because I don't know anything about medicine. If they said I was ready to leave, I was ready to head for the ward. (I7)

According to the study informants, care for the critical patient in the process of discharge to the general ward requires personalization, planning, information and continuity of their care.

The planning of the discharge cannot be dissociated from the information about the discharge itself. The respondents ask to receive information about it and the respondents ask to receive information about the time of discharge, the planning of time during the process, where they are going, the type of care they will receive in the new location and, in addition, they demand they be informed of the possibility of unexpected events that may alter this planning:

> Take the medical history, collect it, talk to the patient, 'we're going to move you, maybe this afternoon, we don't know, but as soon as we do, we'll tell you. There you will receive care with, uhm, that's not as thorough as here'. (I5)

> It was not a disaster either, but hey, yes it is true, I would have liked […]: 'at 6, doctor such-and such or nurse such-and-such will come. Try to rest and the next day the nurse or the assistant or whoever, will take you to the second floor and there you will begin this treatment'.(I4)

The coherence and familiarity provided by the continuity of care according to changes in patients' health status would help to control the uncertainty inherent in the change of location of the critical patient. For this, the conveyance of information among practitioners is essential:

> for example: watch out, sepsis. Such and such a thing. Infection. All that: diet. They didn't know anything here, they didn't know anything about how I swallowed, they began to ask me everything again […] then, it made me react angrily, hell, they should put this in writing. (I9)

The continuity of care demanded by patients starts upon admission and goes beyond discharge to the general ward as it extends to discharge from the hospital and is based on a practitioner of reference who provides a familiar stimuli frame, because he/she accompanies the patient in this change and provides the patient with comprehensive care.

> From the time a… a patient is admitted until he/she leaves, for this person to be like a reference, from the beginning to the end, like a companion. I think it would be a, a good idea because having a face, you know that takes you from one place to another, it's like holding your hand on, on your first day at school or any… You feel better.
>
> (I20)

The reference nurse is proposed as a practitioner, that is, a reference in their care, who provides emotional support and boosts their own resources by promoting trust and security.

> What I do miss greatly is a connection, perhaps a vital, stronger connection is missing between the ICU patient and a nurse who is responsible for that patient, because even if he/she isn't there for you, if they have any doubts or whatever, the doctor or the nurse: 'Hey we don't know', 'well… Call the ICU and talk to nurse María who was in charge of me'. (I4)

3.2.2 | Social support: Unconditional care

Family of patients admitted to the ICU often play an important role during the transition because they provide the patient with care and support.

> During the day my mother's here. You know she's here [in the ward] all day, poor woman. […] My mother bathes me each morning, they don't bathe me here. She bathes me, she gets me out of bed, she does everything. Everything. (I1)

When the family integrates the dual role of family and practitioner, it can provide social support and, at the same time, exercise credible authority. In this case, besides providing an example of a dual structural provider, it shows the value of promoting discharge to the ward as a positive event for the health:

> It is true that my daughter made me understand [silence, becomes emotional]-sure, she's a nurse—she tells me: 'Dad, the sooner you get out of here [from the ICU], the better'. (I11)

3.2.3 | Education: Learning in the ICU—and about the ICU

Some interviews have highlighted a process of active learning by the critical patient focusing on understanding their surroundings. This understanding has served to create the illusion of hopeful uncertainty.

The support of the professional in interpreting the surroundings is crucial for fostering hope in view of a clinical decision that, though based on objective elements, is still uncertain. Of course, the honesty of the professional and trust in them are also fundamental. They both encourage progress along an uncertain but necessary path if the aim is to make headway in the health-illness process.

> I was able to breathe on my own, I could start to swallow pills, and the doctor helped me greatly with this, she took the decision to extubate, because there was a risk and we were both aware of it, but we also knew that the time had come to take a step forward despite risking a reversal, right? (I9)

Also, the unmet need to know interferes in the assessment of contextual cues and can bring about the onset of avoidable uncertainty:

> I was really worried, that I didn't know why, why I couldn't talk, I mean, with the tube I couldn't speak and of course […] how do I know if it's because it is supposed that you know [about it]. (I18)

3.3 | Appraisal of uncertainty

The experience of uncertainty takes on a meaning of danger or of hope, as of the moment the person appraises it. In this section, we match the mechanisms to appraise uncertainty used by the informants of this study with the mechanisms described in Mishel's theory.

3.3.1 | Inference: The keys to overcome uncertainty

Personality is one of the main arguments of the informants on which the control of uncertainty associated with DCCW was based. Being willing or seeing yourself as a resigned, confident or optimistic person with a desire to live are personality traits that have helped improve expectations of an uncertain situation. Let us see an example:

> No, the transfer was very good […] I can't complain about anyone, anywhere, because I have been fine everywhere, it is also true that I have a way of being, I have a way of being that, everything is going well for me, then, anything is a joke, anything is a joy. (I2)

The experience of having gone through similar situations: 'I've had my father admitted, my mother admitted, friends who have been, I mean, life of what it can be like to be in the ward I more or less know what…' (I6) or through highly demanding situations: 'I have a series of problems like everyone else, but I have had to wise up since I was 15 years old' (I7), has also been a help.

And finally, seeing the surroundings as a friendly, safe environment. Friendly because it has been able to personalize the care through emotional support or signs of interest perceived as discretionary:

> [The fact that] when I went up from the ICU they were waiting for me. I felt like, like someone important […] because they welcomed me, the nurses came here: 'Hey? we were looking forward to seeing you in the ward, we have been following your progress, we know about your case, congratulations!' of course you say 'but who am I? If I'm a patient wow, what a welcome!' (I3)

And safe because it is able to offer objective criteria on which to base decision-making: '[The fact that] I was stable, that I no longer needed intubation, that they had removed it all and I could go to the ward' (I13). Conversely, when the person perceives that the health professionals caring for him/her are unable to argue the decision with credible arguments, uncertainty becomes strong: 'Not knowing or not having a clear idea about where I'm going, but above all, not having a clear idea about the step, well, I've been afraid to rush, no, afraid of being rushed, okay?' (I14).

3.3.2 | Illusion: The optimistic look at uncertainty

While uncertainty is inevitable, it is also true that it opens a window of opportunity, in that not all is yet said and done. The informants highlight two strategies employed by nurses to create the illusion that what is yet to be defined does not necessarily have to be bad.

One of the strategies is to create an unexpected situation of welfare, capable of giving strength and encouragement to face future

situations of uncertainty. One patient explains the effects of a nurse's decision to take her out of the ICU box and take her to the nurse's office to see the sun:

> They have given me everything that the bad days spent in the ICU took away from me, seeing a bit of sun makes up for it [...] I was crying with emotion. [...] This air, this sun, what I have felt made me get very zen, to say, well, I have no TV, no problem, it seems that I am better, I am recovering. (I18)

And the other is a call to reinforce the positive sense of the experience: 'There should be someone who, when they come to discharge you from the ICU, could explain that you are going there, to a place which may not be as good as the ICU but it's for the better, not for the worse' (I10). Insisting on this assessment prevents erroneous thoughts arising from uncertainty regarding the still not well-defined future. However, failure to do so anticipates suffering and sweeps illusion away: 'I got anxious but not in the sense of leaving the team and all that, it's because I didn't know if I was, [if] I was taking a step backwards' (I15).

3.4 | Proposals for improvement

In the light of the results of this study, how can we nurses help improve the management of the uncertainty associated with DCCW? A correspondence between the results of this study and the care proposals drawn from these same results is established in Figure 1.

4 | DISCUSSION

To date, the DCCW process has been extensively studied; however, we have not found any recent work analysing the patient experience based on Mishel's Uncertainty Theory. The findings of our study align with recent research emphasizing the need for tools to improve transitions of critically ill patients from ICU to ward. Plotnikoff et al.[15] highlight discharge planning and continuity of care, reinforcing the need for clear criteria, family involvement and improved communication. This is in line with our Mishel-based proposals to reduce uncertainty and facilitate patient adjustment, now expressed as the need to modify the stimulus framework, create an environment of trust for the patient and family, educate to interpret contextual cues and influence the appraisal of uncertainty.

Regarding the stimuli frame and, in particular, the management of pre-existing symptoms, the promotion of autonomy prior to discharge is a strategy of preparation for discharge that has so far been disregarded.[16] Preparing the patient to perceive themselves as being capable of successfully overcoming decreasing levels of support could counteract the feeling of vulnerability and dependence prior to discharge (Häggström, 2014).[17]

We have only identified two recent papers that explicitly recommend early mobilization as an activity specific to preparation for DCCW.[18,19] Most papers study the relationship between early mobilization of the critical patient and long-term functionality. Despite this practice neither being widespread[19,20] nor providing conclusive results,[21,22] early mobilization of the critical patient is considered a safe practice[21,22] with likely utility in promoting autonomy.[22] However, its promotion in the ICU would require a cultural change. While promoting autonomy is an important foundation of care, it might be thought that ICU nurses, accustomed to caring for extremely fragile and labile patients, have difficulty in undertaking this aspect of care.[18,23] In this same line, although our informants have not found it lacking, some authors propose a progressive decline in critical patient monitoring as a strategy to prepare them for discharge.[24] The truth is that nurses welcome this proposal ambiguously, which is why some authors propose establishing prior team discussion on how to establish strategies for a safe, structured transition towards a progressive decrease in the technological support in monitoring critically ill patients.[24] In this regard, Kauppi et al.[25] suggest that intermediate care units could meet this need. However, it is not known whether the discharge of the critical patient to a semi-critical unit improves the experience, as it has been poorly studied.[26] Participants discharged to intermediate care did not report better outcomes than those sent to a conventional ward, largely because of poor information transfer between professionals. However, we propose intermediate care as a potential solution for a more gradual discharge, as long as proper communication between nurses during unit transitions is ensured.

Trust is one of the pillars on which nurses' credible authority is based (Mishel, 2018).[27] Trust starts from professional skills, knowledge and experience and grows through the development of a meaningful professional–patient relationship.[28] A relationship based on honesty, empathy and commitment to act in the person's best interests (Hendren & Kumagai, 2019).[29] A customized relationship in which the patient is recognized as the leading expert on themself and their life (Hendren & Kumagai, 2019).[29]

Planning discharge, information on the process and the continuity of care are strategies present in almost all DCCW protocols.[16] However, patients[30] and nurses[31] continue to complain about the lack of personalization of these interventions. Identifying and meeting the specific needs of each patient allows the creation of nurse–patient bonds and fosters mutual trust (Hendren & Kumagai, 2019).[29] Intra- and extra-hospital monitoring of the critical patient has been proposed as a strategy for personalizing their care[32] and, in fact, our informants have asked to be assigned a reference nurse right from the moment of admission until they are discharged to home, because they have found this recognition of who they are in the middle of the hospital structure or system and what they need during this transition. So far, critical patient follow-up experiences have been highly heterogeneous[33] with no clear evidence on their physical and psychological effects[33] and with very irregular deployment,[32,34] probably for financial and organizational reasons.[32] Given the circumstances, and without renouncing more comprehensive monitoring activities where

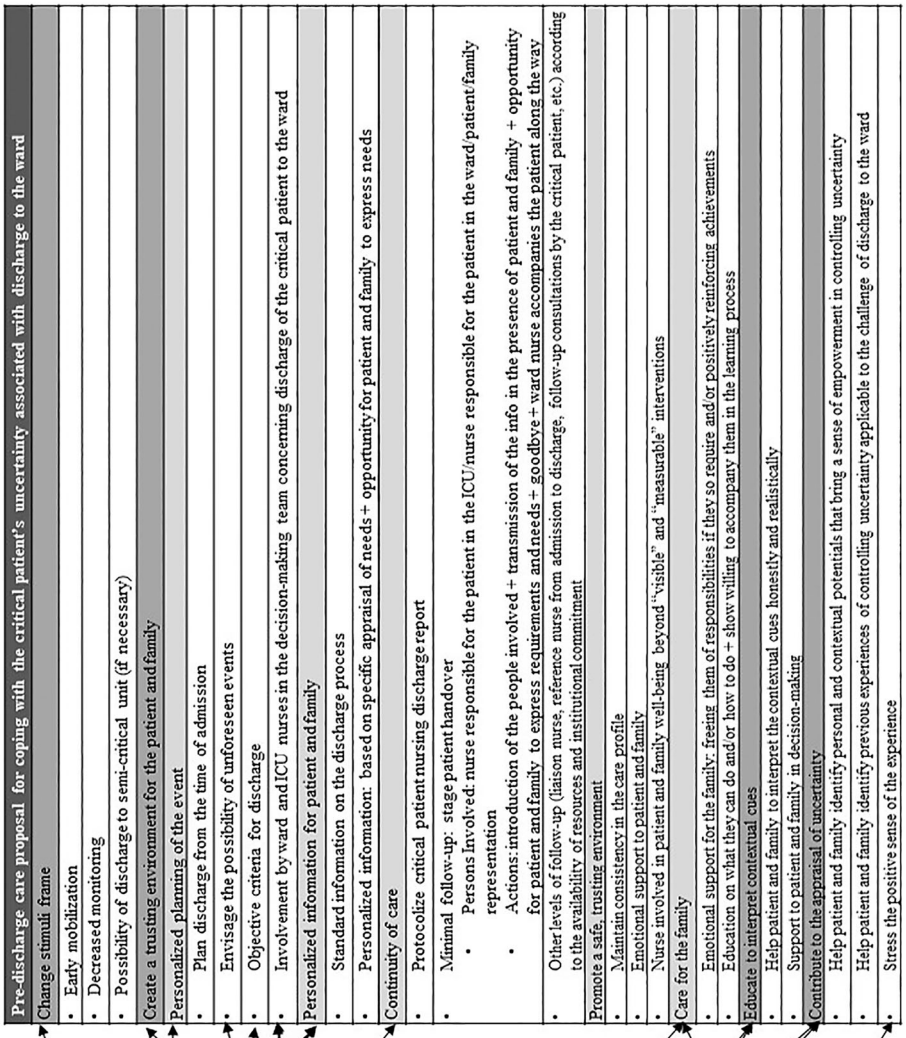

FIGURE 1 Correspondence between the results of this study and the care proposals extracted from these same results. Arrows leaving or coming to conceptual families or conceptual family grouping affect all conceptual units or conceptual families included in higher ranking groups.

possible, we propose minimal intervention that guarantees the active participation of all parties involved in the DCCW process, as other studies have already called for.[18] The staging of handing over of the critical patient to the general ward nurse could counteract the uncertainty of a patient with specific information needs, who must adapt to new staff and who is concerned for the continuity of their care in a context of decreasing support.[18] However, hasty and inattentive behaviour by professionals at the time of DCCW hinders coping with uncertainty because it presents an unprecedented image of professionals that does not fit with the idea that the patient had until now. Undoubtedly urgent and extemporaneous discharges that often need to be dealt with in ICUs are part of the problem; however, the adoption of objective discharge criteria agreed to by a multidisciplinary team and the formal participation of nurses—of the ICU and of the ward—in decision-making on DCCW rationalizes the discharge process,[35] supports the need to initiate it at the time of admission,[1,18] guarantees the availability of resources to cope with the transition[35] and advocates for patient rights and preferences.[18,36] All in all, it would foreseeably reduce the incidence of unplanned discharges, improve the transfer experience and facilitate coping with associated uncertainty.

In line with our study, the literature argues that the family is a cornerstone during ICU stay and during transitions to complete rehabilitation.[30,37] Participants frequently rely on family feedback to make sense of their ICU experience. Freeman et al.[38] also highlight that family members offer valuable insights, as patients' memories are often confused, blending reality and perception.

For Mishel, the family is the social support that reduces the perceived complexity of the new situation and can help the subject to interpret the significance of events.[8] Despite uncertainty being a common experience among critical patients and in their environment (Enger et al., 2018),[7,37,39] Cypress,[7] in her work on uncertainty in ICUs, surprisingly found that the family of the critical patient was free of uncertainty. And the reason for this was their confidence in the good work of the professionals. Therefore, the effort to create an environment of trust must be extended to the family for two reasons. First, so that it does not experience its involvement in care as a loss of security and protection, and secondly so as not to fail in the task of collaborating in the support and care for the patient undergoing DCCW. Even more so when it has been seen that the family can play the dual role of social support and credible authority and, as occurs with professionals, contribute to fostering illusion.

According to Mishel,[8] the experience of uncertainty is neither positive nor negative until it is given a significance. Therefore, and with regard to the appraisal of uncertainty, it is crucial that the nurse should help patient and family to identify their own or contextual resources capable of generating inferences that provide a sense of power in coping with uncertainty or that confer a sense of opportunity on it. Also, with regard to the creation of illusion, insisting on the idea of discharge as a sign of improved health status and an opportunity to minimize risks could help build a positive, rather than a negative significance to discharge.

So far, we have examined proposals for improving the DCCW process arising from the analysis of the experience according to Mishel's perspective. Because there is not enough evidence on the value of some of our proposals, in order to support their validity, we would need to undertake well-designed studies to help clarify doubts about their short- and long-term effects. To this end, hospital management and the interdisciplinary team should recognize nurses as leaders in managing uncertainty, following their guidance in patient relations and communication, and supporting their role in making discharge decisions for critically ill patients. Incorporating nursing assessments into discharge criteria would enhance holistic care by considering the emotional state and readiness of both patient and family, empowering them as active participants in the recovery process. Also, to keep up nurses' motivation, recognition of a job well done would be required, especially with regard to 'unmeasurable' or 'invisible' activities, which, despite being disregarded, certainly improve the quality of care.[36] And finally, and needless to say, the necessary resources should be provided to fuel the 'motivation >> research >> change' cycle.[23,31,36]

Without this, any declaration of intent is but empty rhetoric.

5 | LIMITATIONS

Phenomenology effectively uncovered emotional and psychological responses, aligning with our goal of exploring the personal meaning of participants' experiences. However, we remain cautious of potential bias, fearing overly positive appraisals of care because of the favourable outcome—discharge—or the interviewer being a nurse from the patient's care team.

This project focuses on pre-DCCW care. Future research should investigate post-discharge improvements and strategies for coping with uncertainty in the general ward.

Cognitive capacity shows no results as it was an inclusion criterion.

We did not collect information on participants' level of education; however, we have mentioned the data that inform of the process of learning about the ICU and the hospital environment in general as an element on which care might act.

6 | IMPLICATIONS AND RECOMMENDATIONS FOR CLINICAL PRACTICE

The present study highlights that some patients experience uncertainty on discharge from the ICU and the importance of the nurses' management of this uncertainty during the transition to a clinical ward.

Based on Merle Mishel's theory of uncertainty, proposals are made for care to be carried out by critical care nurses during the preparation for discharge highlighting the need for a cultural change in the care offered by nurses to encourage patient autonomy, the

decalibration of support according to the individualised needs of each patient and the preparation for discharge from admission.

Additionally, the study highlights the need for increasing institutional resources to enable the implementation of these changes.

7 | CONCLUSIONS

Applying Mishel's theoretical perspective to care for the critical patient in the process of discharge to the general ward can identify areas for intervention and improvement. Preparation for discharge must take place right from the moment of admission because adaptation to uncertainty is a gradual process that develops on the basis of a relationship of trust that grows day by day. To help the critical patient cope with uncertainty, it is necessary to promote cultural change in ICUs, empower nurses and provide the necessary resources.

DATA AVAILABILITY STATEMENT

The data that supports the findings of this study are available in the supplementary material of this article.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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