Transition is a “process or period in which something undergoes a change and passes from one state, stage, form, or activity to another.” Ideally, healthcare transitions encompass safe and efficient movements of patients between different sectors or levels of care within the healthcare system and appear to be fundamental in achieving beneficial outcomes for patients. Critically ill patients in the intensive care unit (ICU) often experience multiple transitions as they move through different levels of care. The transfer of ICU patients to intermediate care units and subsequent ongoing provision of care are a daily occurrence in acute care hospitals.

In this article, we define ICU transitional care as care provided before, during, and after the transfer of an ICU patient to another care unit that aims to ensure minimal disruption and optimal continuity of care for the patient. This care may be provided by ICU nurses, acute care nurses, physicians, and other healthcare professionals.

Compromised transitional care for ICU patients may result in complications, including adverse events, readmission to the ICU, and increased rates of mortality. The...
knowledge gained by studying ICU patients, who experience a number of transitions, will provide insight and understanding of the process these patients undergo and facilitate improved clinical practices that may be applicable to other groups of patients. In this article, we review current literature on transitional care for ICU patients, with a focus on contemporary challenges, problematic clinical practices, and future research directions. Most of the literature on this topic reflects the experiences of ICUs located in the United States, the United Kingdom, and Australia.

**Theoretical Perspectives on Transitions**

The development of transition theories has been a focus of nursing and other disciplines. Although management models tend to equate transition with change, nursing theory offers broader perspectives for the conceptualization of transition. For example, in describing the strategies that organizations use to effect change, McCarthy suggested that “transitional activities” are merely strategies for change and that in order to effectively ensure that transition occurs smoothly, a transitional plan must be developed. This plan should be a “clear and tangible roadmap for change.” According to Meleis et al., however, the essential properties of a transition include awareness, engagement, change and difference, time span, and critical points and events. This conceptualization is clearly much broader than definitions of transition as change alone. Previously, Schumacher and Meleis conducted a concept analysis and concluded that transitions are processes that occur over time and that involve change in identity, role, relationships, abilities, and behaviors.

These conceptualizations build on the original definitions offered by Chick and Meleis, who defined transition as a passage or movement from one state, condition, or place to another. Although a variety of other theories may provide insight into ICU transitions, the research of Meleis and colleagues appears to have direct applicability to the transitions faced by ICU patients.

**Transition to an Intermediate Care Unit**

Admission to an ICU is often a brief but extremely notable hospital experience for critically ill patients. Their stay in the ICU may have both short- and long-term effects on their overall recovery. These patients make several healthcare transitions within the healthcare setting during their recovery. Two transitions that may have a marked impact are the moves from the ICU to an intermediate care unit and then home. However, like other hospital patients, ICU patients may be transferred to other hospitals, rehabilitation facilities, and nursing homes, all of which require a time of transitional care. Each transition represents unique challenges for patients, their family members, and the healthcare professionals involved in the patients’ care.

The physical and psychological effects of the ICU experience continue to affect many patients after discharge from the ICU. Many of the detrimental effects of the ICU are related to 3 factors: the nature of critical illness, the technological ICU environment, and the mode of care in the ICU.

Patients and their families may experience extreme anxiety as the patients are prepared for transfer to other areas of the healthcare system. The ICU environment is synonymous with critical illness and life-threatening events and naturally evokes strong emotional reactions. Initially, patients and their families may be overpowered and intimidated by the pervasive nature of the ICU. Conversely, this same invasive, technical environment often creates positive feelings of reassurance, safety, and security. Patients and their families are reassured by the presence of the complex technology and, most importantly, by the constant monitoring and care provided by the ICU staff. These 2 factors may create marked emotional problems during the first important transition into the intermediate care unit.

The physical and psychological effects of the ICU experience continue to affect many patients after discharge from the ICU.
precipitously as they were admitted. Critical care beds are a finite resource, and the decision to transfer a patient to an intermediate care unit may be based on which patient is nearest to being fit for transfer, and not necessarily at the optimal time for that particular patient.\textsuperscript{25,26-32} The effect of an abrupt transition from the ICU is compounded by the fact that staff in the intermediate care unit may not have the knowledge,\textsuperscript{25,30,32,33} the advanced clinical skills,\textsuperscript{33} or the staffing ratios\textsuperscript{30} necessary to provide complex care for the transferred patients. Goldfrad and Rowan\textsuperscript{33} suggest that the increasing trend to transfer ICU patients “after hours,” when staffing levels are reduced and the number of experienced staff on duty is limited, further confounds effective transitional care. Communication breakdowns, lack of comprehensive discharge planning, and rushed transfer processes further complicate this first transition.\textsuperscript{34}

Once transferred to an intermediate care unit, ICU patients may be the sickest patients on the new unit and may need close observation and constant nursing care.\textsuperscript{33} Some patients experience physical impairments, such as muscle weakness and neuropathies, and difficulties in eating, swallowing, chewing, coughing, moving the upper extremities, toileting, and mobilizing.\textsuperscript{35} Once in an intermediate care unit, patients may experience anxiety, panic attacks, and, in some instances, signs and symptoms of acute posttraumatic distress disorder.\textsuperscript{36-38} Patients may also withdraw emotionally or have indications of depression, paranoia, and confusion.\textsuperscript{37} The patient-to-nurse ratio of the intermediate care unit does not always accommodate the complex emotional and physical needs of these patients.\textsuperscript{38} Consequently, the patients may take much longer to achieve the goal of self-care status in this setting, further complicating this initial transition and affecting the next major transition to home.

Some of the difficulties associated with transition into an intermediate care unit are related to unrealistic expectations of patients and patients’ families. In many instances, both the patient and the patient’s family are inadequately prepared for the marked reduction in staffing ratios.\textsuperscript{3,25,30} Thus, patients and their families may feel abandoned and insecure in the intermediate care unit, lacking confidence in both the medical and the nursing staff.\textsuperscript{4,6,25,33,34} This apprehension and insecurity most likely is heightened for patients who have been long-term admissions to the ICU.

A study by Whittaker and Ball\textsuperscript{34} of nurses in 2 intermediate care units confirmed that transitional care was markedly compromised by the unrealistic expectations of patients and patients’ families. However, other influencing factors have been identified, including poor communication with a lack of clarity and uncoordinated hand-over processes,\textsuperscript{7} late notification that a patient is being transferred and consequently an inadequate lead in preparation time in the intermediate care unit,\textsuperscript{7} and insufficient resources in the new unit.\textsuperscript{4,13,34} This lack of liaison and communication between the ICU and intermediate care units has been highlighted as a major gap in the transition process.\textsuperscript{8} Thus, in addition to the complex physical care ICU patients may need in the intermediate care unit and their potentially unrealistic expectations for care, poor communication is another deterrent for smooth transitional care.

**Transition to Home**

The second major transition, from the intermediate care unit to home, may be as emotionally traumatic as the transition from the ICU to the intermediate care unit.\textsuperscript{40} The most important factor in this transition may be the responsibility of providing care without the support, supervision, and assistance of the healthcare system or friends and family.\textsuperscript{41} Many families take full responsibility for caring for former ICU patients in the home environment.\textsuperscript{30,42} These families may feel unprepared physically or psychologically to cope with this major transition and consequently may experience apprehension and anxiety. Conversely, overprotective actions by family members may frustrate former ICU patients.\textsuperscript{36} Conflicts between relatives and breakdowns in relationships are common during this transitional phase of recovery.\textsuperscript{36,43,44}

In many instances, patients and their families have just cause to struggle with convalescence in the home setting. Many patients experience a range of ongoing physical and psychological problems that make the transition to home particularly difficult,\textsuperscript{15-17,45} and these problems may persist for long periods. Although these ongoing difficulties associated with physical and psychosocial recovery from critical illness occur irrespective of the level of transitional care provided, the degree to which a patient has been educated, informed, and supported during transition and the degree to which assistance was provided during that time are criti-
chal to successful coping. In a study by Jones and Griffiths,46 at an outpatient follow-up 8 weeks after discharge from the ICU, many patients were surprised by how long it had taken to get back to normal. Patients reported that their mobility was restricted, especially in outdoor environments, where 44% could not manage steps. Furthermore, the patients often needed physical aids such as walking sticks and wheelchairs, and the need for these aids was related to the length of time they spent in the ICU.

In another study,17 patients’ normal daily activities were affected even a year after discharge from the ICU, and patients’ level of pain was higher and their overall health status was lower than population norms for patients with chronic diseases. A recent systematic review16 of outcome measures used in ICUs highlighted the range of physical and psychosocial consequences relevant to ICU survivors. Table 1 is a summary of the range of physical and psychosocial limitations that can occur after discharge from an ICU.

Jones36 suggests that at 2 months, psychologically, patients feel the need to review their time in the ICU because they often do not remember or appreciate the graveness of their episode of illness. They are often frustrated with their slow recovery, are irritable and depressed, and may have a sense of hopelessness. Jones36 further asserts that although many patients report having little memory of their ICU experience, they also experience ongoing sleep disturbances such as nightmares and hallucinations long after they have been discharged to home. Table 2 lists other psychological disturbances that may occur.

Despite the wide range of difficulties that occur during transition, the degree to which these difficulties represent a normal recovery remains

<table>
<thead>
<tr>
<th>Physical</th>
<th>Psychosocial</th>
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<tbody>
<tr>
<td>Neuropathies5,14,35,47,48</td>
<td>Amnesia/memory difficulties18,37,44,47,48</td>
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<tr>
<td>Neuromuscular weakness4,5,14,48,49</td>
<td>Paranoia/delusions14,37</td>
</tr>
<tr>
<td>Muscle wasting4,5,14,47,48</td>
<td>Anxiety/posttraumatic stress disorder6,19,22,25,28,36-38,44</td>
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<tr>
<td>Erectile dysfunction7,47-49</td>
<td>Panic attacks5,37</td>
</tr>
<tr>
<td>Difficulty swallowing14,35</td>
<td>Depression18,37,44</td>
</tr>
<tr>
<td>Joint stiffness5,14,47</td>
<td>Guilt5,36</td>
</tr>
<tr>
<td>Sleep disturbances4,14,36,47,48</td>
<td>Anger5,36</td>
</tr>
<tr>
<td>Breathlessness4</td>
<td>Recurrent nightmares4,36,37,47</td>
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<tr>
<td>Weight loss14,47</td>
<td>Concentration difficulties4,37,44,47</td>
</tr>
<tr>
<td>Pain5,17,48</td>
<td>Reduced confidence5,6,44</td>
</tr>
<tr>
<td>Fatigue14,48</td>
<td>Family conflict5,43,44</td>
</tr>
<tr>
<td>Appetite loss14,47</td>
<td>Reduced libido44,49</td>
</tr>
<tr>
<td>Changes in the ability to taste5</td>
<td>Irritability5,4,44</td>
</tr>
<tr>
<td>Hair loss44,47</td>
<td>Financial difficulties43,50</td>
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<table>
<thead>
<tr>
<th>Physical</th>
<th>Psychosocial</th>
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<tbody>
<tr>
<td>Grief reactions, which can take up to 2 years to resolve51</td>
<td>Posttraumatic stress disorder36</td>
</tr>
<tr>
<td>Social isolation, which can persist longer than 6 months37,38,52</td>
<td>Sexual dysfunction and dissatisfaction49</td>
</tr>
<tr>
<td>Psychological dysfunction47,53,54</td>
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</table>
unclear. Indeed, not all patients experience difficulties in transition, and for some, the experience may be a positive one, providing tangible evidence of recovery and improvement. Therefore, although difficulties faced during healthcare transition may be a common experience, the experience is by no means a universal one.

Furthermore, the contribution of transitional care to the experience of these difficulties remains unclear. Empirical comparisons of outcomes across populations that differ in transitional care are lacking. Regardless of the underlying causes of these experiences, however, the difficulties experienced during transition may pose significant challenges to patients and their families. Healthcare providers must strive to improve the quality of services provided to patients and improve the overall healthcare experience for each patient.

**Shifting Focus**

The accumulation of evidence clearly indicates that difficulties associated with transitions for ICU patients may have marked short- and long-term implications. This situation may be exacerbated when transitional care is inadequate or inappropriate. It is therefore imperative to identify those patients most at risk for difficulties during transition and to develop more effective transitional care strategies in the ICU context. In other healthcare contexts, coordinated systems of transitional care, such as formal discharge planning, have been associated with improved outcomes for patients, reduced costs, and decreased duration of hospital stay. The majority of these systems have been designed to address discharge difficulties similar to those identified in ICU patients. The benefit of adapting this clinical knowledge to the ICU environment is obvious. Conversely, the specific knowledge gained through ICU patients’ multiple transitions may provide more detailed insight and understanding for more generalized clinical application.

Despite the existence of transitional care models and the integral nature of discharge planning in other contexts, specific transitional care practices in ICUs are the exception rather than the norm. Several reasons have been suggested for this lack of implementation. Coakley et al. found, through a series of case studies, that ICU staff often lack awareness about the needs and outcomes of their patients after discharge, and White reported that ICU nurses rarely receive detailed feedback on patients’ outcomes after the patients’ discharge from the ICU. This lack of informative feedback and limited understanding of patients’ needs after discharge further hamper the development of effective discharge planning. The lack of policy standards and staff education for discharge planning is evident. Consequently, ICU discharge planning may be relatively fragmented and informal.

**Current Strategies for ICU Transitional Care**

A range of clinical interventions have been implemented to reduce the impact and potential complications associated with transitional care for ICU patients. In essence, 4 major interventions or “change strategies” have emerged in transitional care after the ICU. These are changes in ICU practice in discharge planning, the use of ICU liaison or discharge nurses, step-down or high-dependency units, and outpatient follow-up clinics. The first strategy is an initiative to improve discharge planning practices and patients’ preparation for discharge from the ICU. The next 2 strategies are primarily targeted at the transition from the ICU to the intermediate care unit, and the fourth is more specifically targeted at the transition from hospital to community.

**Discharge Planning in the ICU**

Increasing awareness of the transitional difficulties faced by ICU patients has resulted in practice changes within the ICU before patients are discharged from the unit. These changes have primarily centered on improved discharge planning practices and the preparation of patients for the transition to an intermediate care unit. Specific strategies have included education and in-service training on patients’ needs after discharge, the introduction of information booklets, earlier weaning from both specialized ICU equipment and one-to-one nursing care, discharge planning that begins at the time of admission with appropriate care plans, and structured protocols for educating patients.

In a review of ICU-based interventions to alleviate anxiety associated with transfer from the ICU in patients and their families, Leith outlined interventions such as presenting the ICU as temporary, informing patients and their families of transfer plans in advance, involving patients’ families in planning for transfer, planning for daytime trans-
fer, promoting transfer as a sign of progress, encouraging patients to ask questions, encouraging patients’ autonomy, and keeping patients up-to-date on their medical progress. Many of these practices have been widely adopted within ICUs even though evidence of their effectiveness is largely anecdotal. Their continued use may be justified on the basis of these anecdotal reports and on the basis that the practices are unlikely to do any harm and are relatively cost-effective. However, an evidence base for their use is essential and should be a focus for future research studies.

ICU Liaison or Discharge Nurses
The development of a specialist role, that of an ICU discharge or liaison nurse, has been forming gradually during the past several years. A primary role of an ICU liaison nurse is to provide practical and emotional support for patients and their families during patients’ transition to an intermediate care unit. A secondary role typically includes providing clinical support and resources to staff in the intermediate care unit who manage the care of patients transferred from the ICU. A major advantage of using an ICU liaison nurse is practical and economic, because the major thrust of the role is a focus on a preventive rather than a remedial approach to transitional care. In this instance, use of ICU liaison nurses may ensure continuity of care within the healthcare system. Because continuity of care is one of the most frequently cited difficulties experienced by ICU patients, the potential advantages of having a single person follow up with patients through to discharge home are obvious.

The most important reasons for the lack of widespread acceptance and use of ICU liaison nurses are related to the incomplete body of evidence supporting the effectiveness of these specialists and the focus on cost containment, particularly in the short-term. Evaluations of the role of ICU liaison or discharge nurses have been limited to date and largely descriptive, citing the frequency of specific services provided, the occurrence of adverse outcomes, and satisfaction surveys. Perhaps the strongest evidence for the role was outlined by Russell, who found that the introduction of an ICU liaison nurse decreased readmissions by 8.5% and decreased the severity of illness in the patients who were readmitted.

The cost of using ICU liaison or discharge nurses has received little attention. In addition, because of the broader healthcare focus on containing costs, particularly those related to staffing, acceptance of these specialists may be perceived as risky for administrators, especially because of the limited evidence for the overall cost of using such specialists as well as the cost-effectiveness of doing so. Broader evaluations of the use of ICU liaison or discharge nurses in multiple sites are needed.
Step-down Units

Step-down units, sometimes termed high-dependency units, play an important role in bridging the gap between the level of support available in the ICU and that available in an intermediate care unit. Although their primary purpose was not to provide transitional care and discharge planning for ICU patients, step-down units do, to some degree, address some of the transitional issues experienced by patients and patients’ families on discharge from the ICU and may be used more extensively than ICU liaison or discharge nurses in some countries. Although staffing patterns vary widely internationally and patients’ acuity and illness severity mediate nurses’ workloads, step-down units typically provide an intermediate level of care; in Australia, the ratio of registered nurses to patients is slightly less than the 1:1 ratio often provided in ICUs but higher than the ratio typically associated with intermediate care units. Step-down units may be staffed by registered nurses with past ICU experience but may also be staffed by nurses without ICU experience who may be interested in nursing patients who have more complex care needs than patients in a intermediate care unit.

Although use of step-down units can reduce the rate of unplanned readmission to an ICU, the primary function of these units appears to be related to decreasing ICU utilization by allowing ICU patients to be discharged sooner than was previously possible while still providing better nurse-to-patient ratios than intermediate care units and a higher level of critical care expertise. However, in a review of step-down units, Keenan et al questioned the evidence for the cost-effectiveness of the units, suggesting that more rigorous trials are required. Although evaluation of step-down units has been reported, the researchers typically focused on physical and medical outcomes, with some evaluation of economic impact. This approach does not encompass the scope of patients’ potential transitional difficulties and the impact of step-down units on everyone involved in transitional care.

Outpatient Clinics

As ICU patients leave the acute healthcare sector and are discharged home, their ongoing health needs have traditionally been ignored within the context of their ICU status. Current initiatives for transitional care take into account the need for and importance of follow-up care for these patients after discharge to home. Outpatient clinics are another health service initiative in the provision of transitional care for ICU survivors. These clinics may be led by either physicians or nurses. Additionally, ICU discharge nurses are involved in some follow-up clinics. The clinics operate in a manner similar to that of the outpatient departments for other specialty disciplines. The primary objective is assessment of the physical, functional, and psychosocial changes associated with recovery from a critical illness after discharge to home. Staff at follow-up clinics also provide appropriate referral options for patients experiencing ongoing difficulties.

Another successful initiative is a help-line service that provides access to specialist healthcare advice for patients and their families outside normal outpatient clinic hours.

The introduction of this ICU outreach service indicates a recognition of the specific and unique difficulties experienced by patients who have been in an ICU.

Although ICU outpatient follow-up clinics have been evaluated, the evaluations have tended to be descriptive, centering on the types of patients who attend, the problems that emerge during the visit, and the treatments provided, including the number of referrals to other healthcare providers. The cost-effectiveness of follow-up clinics has not been reported in the literature, and studies in which objective measurements were used to determine the impact of the clinics on patients’ recovery are in their infancy. Without rigorous analysis to measure end points, the exact benefit of follow-up clinics cannot be determined. In an environment of tight healthcare fiscal policy, empirical evidence must indicate the overall cost benefit of the clinics to patients, patients’ families, and the wider community. Furthermore, empirical evidence is required to support initiatives that span the variety of transitions ICU patients are likely to experience.

Because of the varied purposes of interventions and because different interventions focus on different transitions experienced by ICU patients, a number of models for outpatient clinics may emerge. For example, the combination of using an ICU liaison or discharge nurse and a follow-up clinic may be a more comprehensive and holistic method of transitional care than either initiative alone. These possibilities require much greater investigation.
to highlight their potential value to ICU patients.

**Implications for ICU Nursing**

Cumulatively, a growing body of literature supports the need for transitional care for ICU patients. Because of their inherent understanding of the complex needs of ICU patients, ICU nursing staff are in an ideal position to take steps to improve transitional care. Although a review of the literature highlights the multi-dimensional and multidisciplinary nature of transitional care and the likelihood that practices and services beyond the realms of ICU nurses are needed, individual nurses and individual ICUs can adopt practices that would be important contributions to providing transitional care. Table 3 outlines potential avenues for ICU nurses to contribute to the provision of transitional care. Not all of these suggestions can be implemented in the short-term because of the inadequate level of resources at the unit level. Nevertheless, these suggestions may be useful for ICU nurses and ICU management to consider in quality improvement initiatives.

**Conclusion**

Although many ICU patients have complex discharge planning needs, traditionally ICUs have not focused on this aspect of transitional care, with a notable paucity of research in this area. Russell suggests that the philosophical underpinnings of intensive care may account for this discrepancy. The focus in the ICU is on sustaining life during the episode of critical illness and not necessarily on the “life after life support.” As allocation of healthcare resources continues to tighten, this philosophical stance must evolve to reflect the fluidity of care boundaries. Discharge planning must anticipate care beyond the walls of the ICU.

The recognition of challenges in the transitional care of patients after their discharge from the ICU, or from any healthcare environment, has prompted researchers to develop transitional care strategies that may improve the short- and long-term physical and psychosocial outcomes for patients who have been critically ill. The future in the field of transitional care after the ICU lies in promoting a shift in the provision of hospital care and in developing a strong evidence base through rigorous research and evaluation. The knowledge gained from this highly transitional group of patients may provide much deeper understanding of the complex issues associated with transitional care, which may be adaptable for a broader range of patients, in diverse clinical settings.

<table>
<thead>
<tr>
<th>Table 3</th>
<th>Transitional care strategies for intensive care units (ICUs) to advocate or implement at the individual and system level</th>
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<tbody>
<tr>
<td><strong>Individual level</strong></td>
<td><strong>System level</strong></td>
</tr>
<tr>
<td>Early discharge planning with the development of standardized discharge policies and care plans</td>
<td>ICU discharge or liaison nurses</td>
</tr>
<tr>
<td>Education of patients about discharge, with repetition of information and promotion of realistic expectations</td>
<td>ICU follow-up clinics</td>
</tr>
<tr>
<td>Steps to encourage patients’ independence, with early weaning from equipment and one-to-one nursing care</td>
<td>Use of step-down and intermediate care units</td>
</tr>
<tr>
<td>Steps to ensure direct handover, with appropriate and adequate written documentation, of ICU patients to staff in an intermediate care unit</td>
<td>Development of an evidence base and research agendas related to transitional care</td>
</tr>
<tr>
<td>Daytime discharge with adequate warning to the intermediate care unit</td>
<td>Improvement in the resources of intermediate care units</td>
</tr>
<tr>
<td>Steps to involve patients’ families in the discharge process and to encourage questions from patients and patients’ family members</td>
<td>Improvement in staff-to-patient ratios in intermediate care units</td>
</tr>
<tr>
<td>Development of written resources</td>
<td>Improvement in access to community resources</td>
</tr>
<tr>
<td>Visits by ICU personnel to patients in the intermediate care unit after discharge from the ICU</td>
<td>In-service training for staff of intermediate care units and establishment of standardized transfer teaching programs</td>
</tr>
<tr>
<td>Improvement in knowledge of the resources of intermediate care units and the community</td>
<td>Development of protocols or mechanisms for feedback from ICU patients</td>
</tr>
<tr>
<td>Efforts to improve reciprocal communication with staff in the intermediate care unit</td>
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1. Compromised transitional care for intensive care unit (ICU) patients may result in which of the following?
   a. Delayed healing
   b. Readmission to the ICU
   c. Increased morbidity
   d. Distrust of nursing staff

2. Which of the following is not a detrimental effect of the ICU?
   a. Nature of the critical illness
   b. Technological ICU environment
   c. Mode of ICU care
   d. Physical layout of the ICU

3. Patients and their families may feel abandoned and insecure in the intermediate care unit because of which of the following?
   a. Early transfer from the ICU
   b. Absence of complex technology
   c. Inability to cope with convalescence
   d. Insufficient resources in the new unit

4. Which of the following is a major gap in the transition process between the ICU and intermediate care units?
   a. Lack of communication
   b. Complex patient needs
   c. Precipitous transfer from the ICU
   d. Reduced nurse-patient ratios

5. Which is the most important factor that patients and their families fear in the transition from the intermediate care unit to home?
   a. Inadequate financial support
   b. Family role reversal
   c. Inability to cope with convalescence
   d. Increased mortality

6. Which of the following is not a physical or psychosocial limitation that can occur after discharge from the ICU?
   a. Hair loss
   b. Weight gain
   c. Posttraumatic stress disorder
   d. Reduced confidence

7. Which of the following has been associated with improved outcomes for patients, reduced costs, and decreased length of stay?
   a. Formal discharge planning
   b. Early weaning from specialized ICU equipment
   c. In-service on patients' discharge needs
   d. Structured care protocols

8. Which of the following is not a major intervention in transitional care after the ICU?
   a. Changes in ICU discharge planning practices
   b. Use of ICU liaison or discharge nurses
   c. Step-down units
   d. Home healthcare visits

9. Which of the following ICU-based interventions may alleviate anxiety associated with transfer from the ICU?
   a. Advanced notification of transfer
   b. Planning for evening transfer
   c. Families assisting in patient care
   d. Meeting the intermediate care nurse

10. Which of the following is a primary role of the ICU liaison nurse?
    a. Coordinate discharge planning
    b. Provide support for intermediate care unit staff
    c. ICU staff
    d. Communication of transfer needs to intermediate care unit

11. To be effective, ICU liaison nurses must develop their role in collaboration with which of the following members of the healthcare team?
    a. Intensivists
    b. Case managers
    c. ICU staff
    d. Intermediate care unit staff

12. One research study found that the introduction of an ICU liaison nurse decreased readmissions by what percentage?
    a. 5%
    b. 8.5%
    c. 12%
    d. 15.5%
Transitional Care After the Intensive Care Unit: Current Trends and Future Directions
Wendy Chaboyer, Heather James and Melissa Kendall

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