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Intensive Care Units Nurses' Perceptions and Experiences of Communication with Unconscious Patients

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ABSTRACT

Unconscious patients in critical care units are compromised in their ability to communicate. It is vital that ICU nurses' communication with unconscious patients be as effective as possible to address their needs and help them in their suffering. Improving communication deepens the dignity and humanity of unconscious patients, supports families, and contributes to more ethical and holistic ICU care. The purpose of this basic qualitative study, guided by Watson's human caring theory, was to explore the perceptions and experiences of ICU nurses of PCC with unconscious patients. Twelve ICU nurses who worked in a large metropolitan city in the central region of Saudi Arabia were included; they held a bachelor's in nursing, had at least one year of ICU experience, and had previous experience working with unconscious patients. They were interviewed using audio recording. Thematic analysis revealed five themes which were perceived as (a) ease of workload, (b) greater control over procedures and interventions, (c) time efficiency, (d) avoiding demanding patients, and (e) avoiding bad treatment. Recommendations for future research include exploring how to provide emotional and psychological support for ICU nurses and include a more diverse group of nurses in multiple ICUs across varied geographical regions. Understanding factors affecting nurses' communication with unconscious patients will help formulate strategies to improve communication and the quality of care for unconscious patients, which affects positive social change.

Keywords: *nurses' communication, communication barriers, nurse-patient communication, unconscious patients, critical care nurses, patient rights, patient space, patient boundaries, inappropriate interactions, nurse-patient relationships, unconsciousness.*

INTRODUCTION

Communication is the exchange of information, ideas, emotions, and attitudes between two or more individuals via verbal or non-verbal means (Hasanat, 2020). Communication between nurses and critically ill patients is sometimes limited by sedation, alteration in the patient's level of consciousness, mechanical ventilation, and the presence of an endotracheal tube, affecting the communication process. Effective communication is important for conveying patients' psychological and physiological needs and making an appropriate care plan (Espinoza-Caifil et al., 2021).

However, effective communication is challenging when patients are unconscious. Unconscious patients are not uncommon in the intensive care unit (ICU) setting. Patients who recovered from unconscious status stated that they were able to hear nurses and relatives talk in the ICU. Nurses in the ICU should humanize their experience and not simply perform a series of tasks. Every patient should receive complete information about his/her diagnosis, treatment, and prognosis (Kvande et al., 2022).

The difficulty of talking during an acute illness is a source of unhappiness and disappointment for patients. Unconscious patients have an essential need for information and support through communication. Therefore, verbal and nonverbal communication can provide meaningful sensory involvement to these patients. Communication with unconscious patients may help reduce stress, preserve self-identity and self-esteem, and reduce social isolation (Lawrence et al., 2023).

This study addresses the quality of care through communicative acts. Findings may show the importance of ICU nurses' communication with unconscious patients and be a basis for creating educational programs to help ICU nurses improve their communication skills with unconscious patients. Improving the quality of care through communication for unconscious patients affects positive social change acts.

Communication is an essential part of the nursing process, which can eliminate anxiety or distress when dealing with unconscious patients who are unable to respond. Evidence shows that some patients in a comatose or unresponsive state can hear and understand what is being said in their environment. Interviews with previously unconscious patients and electrophysiological techniques show that awareness occurs in patients thought to be unconscious. Despite the patient's ability to listen or feel, the need for the nurse to communicate with the unconscious patient persists (Lawrence et al., 2023).

Patient-centered communication ("PCC") is defined as communication between the nurse and the patients that acknowledges patient preferences, values, and needs. Communication is an important aspect of nursing care that focuses on ensuring high-quality care is provided to different patients. Communication ensures optimal health outcomes, reflecting long-standing nursing principles that care must be individualized and responsive to patient health needs (Kwame & Petrucka, 2021). It focuses on acknowledging the whole person, their personality, life history, and social structure to develop a shared understanding of the problem, the goals of treatment, and the barriers to that treatment and wellness (Naughton, 2018). Non-verbal communication, including facial expression, eye contact, posture, personal space, and therapeutic touch, are important forms of patient social interaction (James et al., 2020). Inappropriate or lack of communication may lead to severe consequences such as the negligence of patient autonomy and privacy, adverse effects on patient self-esteem and identity, and disrespect to human dignity (Lawrence et al., 2023). Examples of inappropriate communication include not explaining a procedure to an unconscious patient, not introducing oneself, not respecting patients' privacy by ignoring closing the curtains when working with the patient, or not respecting patients' space or boundaries. Inappropriate or poor interaction could also deprive patients of reassurance and support comments because they cannot respond.

Adequate and appropriate PCC is an important part of nursing care in the ICU. The importance of caring communication in the ICU with patients and their families by being with them, listening and responding to their needs, and involving them in decision-making should not be underestimated (Shamaly, 2022). Therefore, a nurse's communication with their patient depends on their ability to respond and express their needs. The most frequent difficulties reported by the nurses are insomnia, the inability of patients to speak, the presence of a tracheal tube, and the nurse's lack of skills needed to communicate with unconscious patients (Espinoza-Caifil et al., 2021). Although some nurses felt less motivated by the unexpected communication difficulties with patients and their families, they realized they could address these challenges by improving their communication skills through experience and learning (Yoo et al., 2020).

Nurses and patients find PCC challenging and may experience negative feelings of frustration and anxiety when communication fails (Al-Shamaly, 2022). PCC, which comes from nurses' attitudes and practice, is considered an essential component of ethical care to understand and meet the needs of patients with a diminished level of consciousness (Pooyanfard et al., 2023).

Problem Statement

Currently, there is a lack of information about ICU nurses' perceptions of PCC with unconscious patients, to what extent they believe that communication with them is essential regardless of the patient's

response, and how nurses' attitudes, experiences, and thoughts affect their communication interactions with unconscious patients (Al-Shamaly, 2022). The inability of patients to speak and express themselves is one of the main sources of anxiety for the patients in the ICU. Providing information and assurance to the patients by the ICU nurses improves anxiety and needs satisfaction (Livingston & Krishnan, 2023). Although there have been several studies that have focused on the perceptions and the experiences of nurses in communicating with critically ill patients who have barriers in communication, such as mechanical ventilation, there is a lack of information about the nurses' perceptions of communicating with unconscious patients in the ICU (Kwame & Petrucka, 2021; Magnus, & Turkington, 2006; Yoo et al., 2020). Some nurses perceive PCC with critically ill patients as problematic due to their lack of understanding of how to communicate with unconscious patients. A lack of understanding of how to communicate with unconscious patients creates feelings of helplessness and frustration in patients and nurses. Other nurses showed no interest in communicating with critically ill patients with unstable states of consciousness, possibly due to a lack of knowledge about nonverbal communication due to the condition of the patient (Espinoza-Caifil et al., 2021).

Purpose of the Study

The purpose of this study was to explore the perceptions and experiences of ICU nurses' PCC with unconscious patients using a basic qualitative methodology. The phenomenon of interest was the ICU nurses' perceptions of PCC with unconscious patients and to what extent they believe that communication with unconscious patients is essential. This is accomplished regardless of the patient's response, nurses' attitudes, and both of their perceived experiences.

Research Question

The research question for my study was: What are the perceptions and experiences of ICU nurses of PCC with unconscious patients?

Theoretical Framework for the Study

Watson's caring theory guided my study. Watson's theory of human caring focuses on the caring relationship between the nurse and the patient. The nurse's awareness and heart-centered existence in the caring instant affect the transpersonal aspects of a caring moment, which affects the whole field. Watson's caring theory includes the ten caritive factors that nurses should use with their patients, which nurses use during their practice with patients. According to Watson, the nurse participates in the healing journey with their patient; the two parties are linked. Nurses can help patients gain autonomy, become knowledgeable about their own health, and make healthy changes in their lives. (Watson, 2018).

These carative factors involve educating the practice of loving-kindness and equanimity toward self and others; being authentically present; enabling, sustaining and honoring the faith, hope, and the deep belief system; cultivating one's spiritual practices and transpersonal self, going beyond the ego-self; developing and sustaining a helping-trusting, caring relationship; being present to, and supportive of, the expression of positive and negative feelings; creatively use the self and all ways of knowing as part of the caring process; engaging in the artistry of caritas nursing, and engaging in genuine teaching-learning experiences that attend to the unity of being and subjective meaning (Watson, 2018). Watson pointed out that caring is the moral ideal of nursing, whereby the end is the protection, enhancement, and preservation of human dignity (Ajnkihar et al., 2017). Providing a supportive, protective, and (or) corrective mental, physical, societal, and spiritual environment is one of the important caritive factors nurses should consider when working with unconscious patients (Elsayed et al., 2023).

The logical connections between the framework presented and the nature of my study laid in the fact that using the Caritive factors and Caritas processes facilitates healing, honor, and wholeness and contributes to the evolution of humanity. Caring behavior by nurses can aid in patients' satisfaction and well-being, regardless of their responsiveness level, and it also affects the performance of the healthcare

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facility as a whole. When caring is absent, non-caring consequences and dissatisfaction with nursing service can happen, and the patients could also feel like they are being treated as objects. Caring behaviors are critical when it comes to unconscious patients because they are already vulnerable and cannot communicate their default needs. Caring must be done in practice and research, as a lack of caring is a significant hazard to healthcare quality (Pajnkihar et al., 2017).

Creating a healing environment at all levels means that ICU nurses should prepare a caring, healthy environment for unconscious patients, which means that nurses should address the physical and non-physical aspects of care with unconscious patients. Creating a healing environment includes handling the patients gently, explaining procedures, and, when able, obtaining permission for touch. For the nonphysical aspect, the nurse encourages the family to talk to their loved ones, and nurses should be careful about what they say near the patients (Norman et al., 2016).

Nature of the Study

I conducted a basic qualitative study. Data collected in basic qualitative studies focuses on people's beliefs, perceptions, and emotional responses. During a basic qualitative research study, a researcher can ask about the experiences of participants through interviews, along with what the participants' experiences mean to them. The researcher can also inquire about the participant's attitudes, beliefs, ideas, and opinions (Oranga & Matere, 2023).

I conducted interviews to collect data for my planned research and to recruit ICU staff nurses with bachelor's degrees in nursing. Nurses had more than one year of experience because of the assumption that with more experience, nurses will develop more knowledge to build their attitudes and perceptions upon. I targeted nurses from one hospital in Saudi Arabia using purposive sampling. The inclusion criteria for ICU nurses were:

I. At least one year of ICU experience;
II. Possessing a bachelor's degree in nursing;
III. 1+ years of experience working with unconscious patients.

I analyzed my data using thematic analysis and transcription software, Otter. I used a summative coding table to organize the data, which made it easier to identify patterns and codes.

Literature Review

The difficulty of communicating during an acute illness can be a source of unhappiness and disappointment for patients. Unconscious patients have an essential need for information and support through communication. They are also in need of dignity and for nurses and other members of the healthcare team not to assume their patients cannot hear or feel touch when in an unconscious state. Therefore, verbal and nonverbal communication can provide meaningful sensory involvement to these patients. Communication with unconscious patients may help reduce stress, preserve self-identity and self-esteem, and reduce social isolation (Lawrence et al., 2023).

There have been several studies that have focused on the perceptions and the experiences of nurses' communicating with critically ill patients who have communication barriers, such as mechanical communication (Kwame & Petrucka, 2021; Magnus, & Turkington, 2006; Yoo et al., 2020) There remains a lack of information about the nurses' perceptions of communicating with unconscious patients in the ICU. Both nurses and patients find communication challenging and may experience negative feelings of frustration and anxiety when communication fails (Al-Shamaly, 2022). Patient-centered communication, which comes from nurses' attitudes and practice, is considered an essential component of ethical care to understand and meet the needs of patients with a diminished level of consciousness (Pooyanfard et al., 2023). One barrier to ICU nurse-patient communication is nurses' undesirable attitudes toward communicating with patients with a reduced level of consciousness (Dithole et al., 2017; Wojnicki-Johansson, 2001).

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Most studies critical care nurses' communication have been quantitative and evaluated work performance and barriers to ICU nurses' communication with patients (Kwame & Petrucka, 2021; Magnus & Turkington, 2006; Yoo et al., 2020). Factors such as the patient's level of consciousness, the amount of physical care being given, and the presence of relatives could encourage or prevent nurses' communication with ICU patients (Yoo et al., 2020). Still, there is a lack of studies focusing on nurses' perceptions of communicating with unconscious patients. The purpose of this study is to explore ICU nurses' perceptions of communication with unconscious patients in two private hospitals in a large metropolitan city in the central region of Saudi Arabia.

Literature Search Strategy

I used PubMed, Ebsco, and Walden library databases like CINAHL and Ovid. I also used ProQuest Nursing Journal and Science Direct. The terms used were *nurses' communication, communication barriers, nurse-patient communication, unconscious patients, critical care nurses, patient rights, patient space, patient boundaries, inappropriate interactions, nurse-patient relationships, and the meaning of unconsciousness*. I also used a combination of terms in the search, such as *critical care nurses' communication with unconscious patients, nurses' perceptions of communication, barriers of communication, and complications of poor communication with patients*. I searched for studies from 1987 through 2024, and types of literature included seminal and current peer-reviewed literature.

Theoretical Foundation

I used Watson's caring theory to guide my study, focusing on the caring relationship between the nurse and the patient. According to Watson's theory, the main concerns of nursing are promoting health, disease prevention, caring for the sick, and renovating patients' health (Watson, 2007). Watson's caring theory includes the ten carative factors nurses should use with their patients. Caring is grounded on a set of worldwide humanistic noble values. Humanistic values include kindness, empathy, concern, and love for self and others (Watson, 2007). The nurse and patient are linked as the nurse participates in the healing journey with the patient. Nurses can help patients gain autonomy, become knowledgeable about their health, and make healthy life changes (Watson, 2007).

Patient-centered communication is essential in improving patient-centered care and demands that patients and their caregivers engage in the caring process. In nursing care, patient-centered care must focus on patients' experiences, stories, and knowledge and provide care that respects patients' values, preferences, and needs (Kwame & Petrucka, 2021). This is considered the essence of Watson's caring theory.

These carative factors involve educating the practice of loving-kindness and equanimity toward self and others; being authentically present; enabling, sustaining, and honoring the faith, hope, and the deep belief system; cultivating one's spiritual practices and transpersonal self; going beyond the ego-self; developing and sustaining a helping-trusting, caring relationship; being present to, and supportive of, the expression of positive and negative feelings; creatively use the self and all ways of knowing as part of the caring process; engaging in the artistry of Caritas nursing, and engaging in genuine teaching-learning experiences that attend to the unity of being and subjective meaning (Ajnkihar et al., 2017).

Watson stated that caring is the moral ideal of nursing, whereby the end is the protection, enhancement, and preservation of human dignity (Ajnkihar et al., 2017). Providing a supportive, protective, and (or) corrective mental, physical, societal, and spiritual environment is one of the important carative factors nurses should consider when working with unconscious patients (Elsayed et al., 2023).

The Caritas Processes (CP) are set against the original Carative Factors. They have evolved as an extension of the Caratis factors and are meant to offer a more straightforward language for understanding Caratis factors (Watson, 2007).

Figure 1 explains the effect of controlling critical care nurses' knowledge, attitudes, and perceptions, external and internal environmental factors, the holistic health status of the patients, and the protection of patients' rights by nurses on the quality of care provided for the unconscious patients in the ICU.

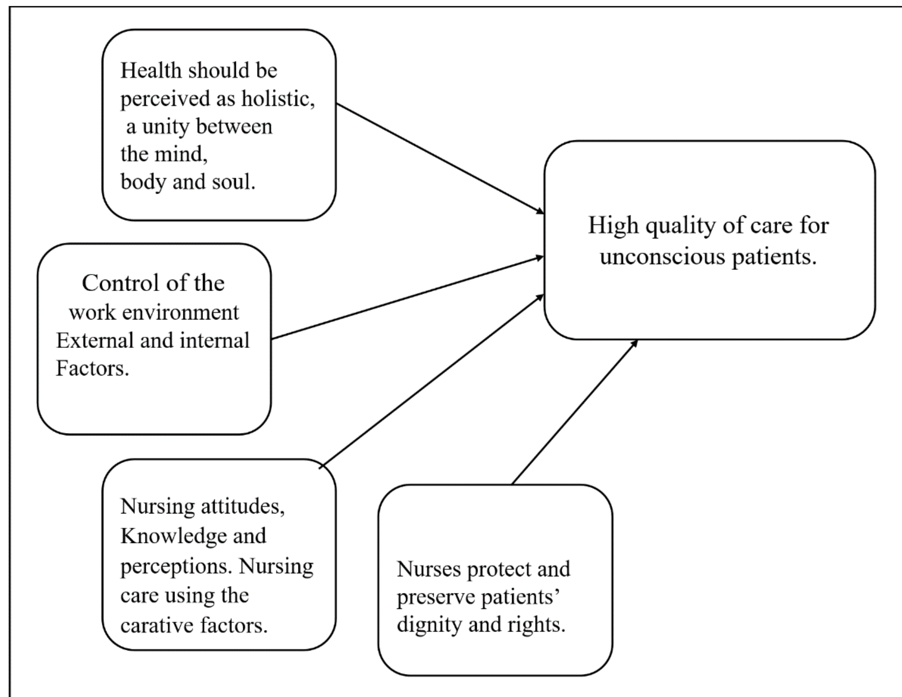

Figure 1. *Factors affecting the quality of care for unconscious patients based on Watson's theory assumptions*

Durgun Ozan et al. (2020) conducted research that aims to examine the effect of education programs focused on Watson's theory of human caring on the coping and anxiety levels of nursing students using a randomized control trial design. A healing environment was created during a caring instant. The results showed that the clinical education program based on Watson's theory was effective in increasing the coping capacity of students with stress and reducing their anxiety levels. Creating a healing environment and using a caring approach with unconscious patients could help reduce their anxiety levels and improve the quality of care provided for them.

The logical connections between the framework presented and the nature of my study lie in the fact that using the carative processes facilitates healing, honor, and wholeness and contributes to the evolution of humanity. Caring behavior by nurses can aid in patients' satisfaction and well-being despite their responsive level, and it also affects the performance of the healthcare facility as a whole. When caring is absent, non-caring consequences and dissatisfaction with nursing service may occur, and the patients could also feel like they are being treated like objects. Caring behaviors are critical when ICU nurses provide care for unconscious patients because unconscious patients are vulnerable and cannot communicate their basic needs of privacy and dignity. Caring has to be done in practice and research, as a lack of caring is a significant hazard to healthcare quality (Pajnkihar et al., 2017).

Creating a healing environment at all levels means that ICU nurses should prepare a caring, healthy environment for unconscious patients, which means that ICU nurses should care about the physical and non-physical aspects of care with unconscious patients. The physical and non-physical aspects of care with unconscious patients include handling patients smoothly, explaining procedures, and obtaining permission.

For the nonphysical aspect, the nurse should always encourage the family to talk to their loved ones, and nurses should be careful about what they say near the patients (Norman et al., 2016).

Review of Literature Related to Key Concepts

How the process of communication works, understanding what nurses think about unconsciousness and the methods they use to communicate with unconscious patients are the key to knowing the reasons behind their interactions with these patients.

Patient-centered communication

Patient-centered communication is defined as communication between the nurse and the patients that acknowledges patient preferences, values, and needs. It is an important aspect of nursing care that focuses on ensuring high-quality care is provided to different patients. Patient-centered communication ensures optimal health outcomes, reflecting long-standing nursing principles that care must be individualized and responsive to patient health needs (Kwame & Petrucka, 2021). Patient-centered communication focuses on acknowledging the whole person, their personality, life history, and social structure to develop a shared understanding of the problem, the goals of treatment, and the barriers to that treatment and wellness (Naughton, 2018).

Poor or inadequate communication is one of the communication problems in the ICU. Poor communication instances between nurses and patients, such as not explaining a procedure to an unconscious patient, not introducing oneself to the patient, and depriving those patients of reassurance and support comments because they cannot respond, could result in serious complications (Al-Yahyai et al., 2021; Yoo et al., 2020)

Happ et al. (2017) described communication interactions with patients who cannot talk, and the methods and assistive techniques used between nurses and non-talking critically ill patients in the intensive care unit like thump up for yes, shake head for No, use OK, or point to body parts, pictures and the use of technology devices. They described patient communication methods such as head nods, gestures, mouthed words, and facial expressions. Head nods and yes/no gestures were the most common communication techniques used, and the most common positive nurse act was making eye contact with the patient.

There are four main problem areas in verbal communication: fundamental difficulty in communicating with a patient who cannot respond, pressures of the working environment, limited knowledge about unconscious patients' needs, and limited detailed knowledge of why or how to communicate with unconscious patients (Jesus et al., 2013). As a reference for the previous points, we know that healthcare providers might face a problem of communication with unconscious patients. However, one crucial point is that a part of our responsibility is to humanize their experience and not simply perform a series of tasks. Lack of knowledge is considered one of the problems concerning verbal communication with nonconscious patients. ICU nurses should always talk directly to the patient during all interactions, treat their patients like they would do with anyone else, and explain what they will do before they do it (turning, blood draws, mouth care) (Kleber, 2023).

Barriers to ICU nurse's communication

Communication between ICU nurses and unconscious patients is controlled by the degree of the patient's response. Many factors influence nurses' communication with patients. The patient's level of consciousness, the amount of physical care being given, and the presence of relatives are factors that affect nursing communication in the ICU. The presence of an endotracheal tube and the lack of patient response were barriers to nurses' communication in the ICU (Salem & Ahmad, 2018). Other barriers to nurses' patient communication include religious and cultural beliefs, environmental factors, and language (Norouzinia et al., 2015).

Nurses reported the need for the other person's feedback to communicate. Nurses prefer working with conscious patients because they can express their needs and give them feedback when they are satisfied

(Yoo et al., 2020). Sedation, intubation, tracheotomy, lack of knowledge about the importance of communication, time concerns, the severity of the patient's illness, and lack of knowledge about strategies and resources to facilitate communication were considered communication barriers (Karlsen et al., 2023; Perelló-Campaner et al., 2023).

Complications of inadequate communication between ICU nurses and unconscious patients

Communication with unconscious or sedated may often be remembered by critical care survivors and leave a long-term psychological impact (Leigh, 2001). Inadequate nurse-patient communication could cause an increased level of stress and anxiety. Conversely, information given to unconscious patients may help reduce stress, help patients preserve their self-identity and self-esteem, and reduce social isolation. Increased levels of frustration, depression, stress, and anxiety, and decreased family and patient satisfaction levels are known to be severe complications of poor communication (Baumgarten & Poulsen, 2015).

Othman (2015) conducted a study to explore the effects of using a structured communication message on the outcomes of unconscious patients using the FOUR scale for consciousness. Verbal messages like telling the patient their name and talking about old stories using a familiar voice had statistically significant positive effects on the level of consciousness on the FOU scale.

Education relationship with communication with patients

Kheta and Ali (2022) and Pooja (2023) confirmed the importance of education in improving nurses' communication and positively improving nurses' communication with unconscious patients. McMillan (2017) used a pre-post method to create a profile of nurses who utilize Watson's Caritas processes and recognize caring by forming transpersonal caring relationships with their patients. This study shows the importance of education to create a culture surrounded by caring behaviors and promoting nurses' consumption of caring attributes in Watson's theory.

Despite all the research conducted on communication of critical care nurses, most of it was quantitative and has evaluated nurses' performance and knowledge, communication with patients on mechanical ventilators, barriers of communication, the effect of education on nurses' communication burnout, and barriers of communication patients (Kwame & Petrucka, 2021; Magnus, & Turkington, 2006; Yoo et al., 2020) . Shortage of nursing staff, high workload, burnout, and limited time in one complex institutional and healthcare system are considered barriers to effective care delivery and patient-centered communication (Kwame & Petrucka, 2021). Norouzinia et al. (2016) had similar findings when they found that a shortage of nurses, work overload, and insufficient time to interact with patients were significant barriers to effective nurse-patient interactions. On the other hand, Yoo et al., 2020 talked about urgency as a barrier to communication in the ICU, for example, in hemodynamically unstable patients.

The inability of patients to speak and express themselves is one of the main sources of anxiety for the patients in the ICU. Providing information and assurance to the patients by the ICU nurses improves anxiety and needs satisfaction (Livingston & Krishnan, 2023). Unmet informational and assurance needs impact family and patient satisfaction and mental health in the ICU (Scott et al., 2019).

Few studies have been conducted on nurses' communication with unconscious patients, especially the part that aims to study nurses' perceptions' effect on nurses' communication with unconscious patients. Mulyati et al. (2023) explored the nurses' perceptions as 24-hour care providers for unconscious patients and their experiences observing patients and family interactions during the critical phase of unconsciousness. They found out that the nurses' psychological reactions might include anxiety, increased workload, and the possibility of working extra. ICU nurses reported working under pressure and increased stress levels. Therefore, there is a need for a study to explore nurses' perceptions of how nurses communicate with unconscious patients in a large metropolitan city in the central region of Saudi Arabia.

In this chapter, I provided literature about nurses' communication with unconscious patients. I provided an exhaustive literature review on barriers to nurses' reports concerning communication with unconscious patients. One of the reasons for inadequate communication by the ICU Nurses was the patient's

inability to respond to their communication and lack of knowledge about the importance of communication with unconscious patients. I also described the theory to be used in the study. I used Watson's caring theory to guide my study, focusing on the caring relationship between the nurse and the patient. I also provided details about complications of poor communication and the effect of education on nurses' communication with unconscious patients. I also provided details about Watson's caring theory as a theoretical framework for this research.

Key concepts that supported my study are the concept of caring, which is the moral ideal of nursing, and the end is the protection, enhancement, and preservation of human dignity. The second one is providing a supportive, protective, and (or) corrective mental, physical, societal, and spiritual environment, which is one of the important carative factors that nurses should consider when working with unconscious patients. The concept of Holistic health, which should be perceived as a unity between body, mind, and soul, is also a key concept nurses should consider.

METHODS

The purpose of this research was to explore the perceptions of ICU nurses regarding PCC with unconscious patients using a basic qualitative methodology. In this chapter, I presented the methodology I used in this study, including research design, population and participants, sampling methods, instruments, and data collection and analysis methods. I also presented the ethical considerations for my study.

Research Design and Rationale

The main research question was: What are the perceptions and experiences of ICU nurses regarding patient-centered communication with unconscious patients? The phenomenon of interest was ICU nurses' perceptions of PCC with unconscious patients and to what extent they believe that communication with them is essential regardless of the patient's response, and how nurses' attitudes, experiences, and thoughts affect their communication interactions with unconscious patients.

I used a basic qualitative research design because I conducted exploratory research. Exploratory research is used to understand the chosen phenomenon, provides insights into the problem, and helps develop ideas or hypotheses for potential quantitative research studies. Qualitative research designs are used to understand a phenomenon's unique and particular aspects rather than seeking generalizable findings. I decided to use qualitative research rather than a quantitative design because the data in basic qualitative studies focuses on people's beliefs, perceptions, and emotional responses, which aligns with the study's purpose (Creswell & Poth, 2018).

Data in basic qualitative studies focuses on people's beliefs, perceptions, and emotional responses. During a basic qualitative research study, a researcher can ask about participants' experiences through interviews and what the participants' experiences mean to them. The researcher can also inquire about the participant's attitudes, beliefs, ideas, and opinions (Merriem, 2009).

Role of the Researcher

My role in my study was as a researcher and interviewer. I used a semi-structured interview guide (see Appendix A) to collect data for my research and recruited ICU staff nurses with a bachelor's degree in nursing. Nurses had more than one year of experience because of the assumption that with more experience, nurses will develop more knowledge and build their attitudes and perceptions. I had no personal or professional relationships with the participants.

A poor interviewer may consciously or unconsciously influence the participant's responses. In either circumstance, the research findings will be influenced and might be biased. As an interviewer, I worked on my skills of monitoring the length of the interview, giving the interviewee cues or prompts to encourage them to consider the question further, and avoiding giving leading questions. Another challenge was controlling my attitudes, opinions, and preconceived perceptions to avoid biased data (Galdas, 2017). I wrote a reflective journal to overcome this.

I followed Braun and Clarke's (2006, p.97) steps for thematic analysis. After receiving the organization's and participants ' permission, I obtained audio-recorded accounts through the interviews.

Participant Selection Logic

I conducted the study in Saudi Arabia, in a one hospital with a large ICU capacity. The sample included ICU nurses with a bachelor's in nursing, at least one year of ICU experience, and previous experience working with unconscious patients. After securing approval from hospital administration and receiving the IRB approval, I obtained the emails of the ICU nurses from the CNO who were approved to participate in the study and met the inclusion criteria. I emailed them and took their approval. I recruited 12 ICU nurses from the selected hospital. Guest et al. (2006), cited in Sharma et al. (2024), specified that 6–12 interviews are usually enough for a single research study. However, the adequacy rests on purposive sampling, data quality, and research complexity. I used inductive thematic saturation to determine the number of participants, using a baseline of 10 participants to ensure that I capture all emerging themes.

The study population consisted of ICU staff nurses in the selected hospital, from which the sample was obtained, in a large metropolitan city in the central region of Saudi Arabia. The sample size in any research should be adequate for scientific quality and ethical standards. One of the most appropriate standards in qualitative research is to achieve data saturation during data collection. Data saturation is not about the numbers but the depth of data. Fundamentally, data saturation is about the quality of data, not the quantity of data. To ensure the quality of data saturation, additional interviews may be conducted (Sarfo et al., 2021).

Instrumentation

I collected data through semi-structured interviews. I developed the research questions based on literature resources and expert opinions. Several studies discussed ICU nurses' communication with critically ill patients (Kwame & Petrucka, 2021; Magnus & Turkington, 2006; Yoo et al., 2020); reviewing previous literature added more understanding to the intended phenomena, which led to the interview questions. Content validity shows how representative the questions are in measuring the intended construct. A tool is considered content valid when the items appropriately measure the idea (Roebianto et al., 2023). I depended on the feedback received from my committee as an expert opinion. An interview guide (Appendix A) was developed and submitted to my committee. Revisions of the interview guide were completed using feedback from my committee chair, a second committee member, and the ICU consultant in my previous hospital.

Procedures for Recruitment, Participation, and Data Collection

I used purposive sampling for the selection of nurses. Purposeful sampling is largely used in qualitative research to identify and select information-rich participants related to the phenomenon of interest (Palinkas et al., 2015).

Recruitment

After I received the IRB approval and the hospital's permission, I asked the nursing manager to share the ICU nurses' work emails with me. Then, I emailed all the nurses with an invitation email (Appendix B).

If the individual was interested in participating, they emailed me to indicate their interest in arranging an interview. I contacted them to arrange a convenient interview time.

I shared the consent form with the interviewee prior to the interview (usually at the time the interview was scheduled). I then sent it to the invited interviewee in the body of an email (Appendix C in the Manual).

When I met the participant, I reviewed the consent form with them. For interviews, documentation of consent was done by just audio-recording verbal consent at the beginning of the interview.

Study Data Collection

At the interview, I helped the participant complete the demographic data sheet by asking them the questions. After completing the demographics form, I began the interview.

I interviewed each participant via face-to-face and audio recording each interview to allow for verbatim transcription and subsequent data analysis. I used an audio recorder program called Otter.

Each individual interview lasted no longer than 35 minutes. The interview questions are in Appendix A.

I did a member check with each interviewee after each interview. I verified the accuracy of the transcript with the participants. The participants needed approximately 10 to 15 minutes for member checking. I offered $30 as an incentive for the participants in the study.

Data Analysis Plan

Data analysis involved the planning, organization, transcribing, storing, and analyzing the content of the interviews and transcribing the taped interviews verbatim. In addition, I needed to reach a high level of trustworthiness. I used both audio and handwritten records for the interviews and documented the date, time, and location of each interview (Adhabi & Anozie, 2017). Analysis of the qualitative data started after the completion of each interview with the participants. For the data transcription, I used Otter software. Then, for the interview analysis, I used thematic analysis, which is the most widely used qualitative approach to analyzing interviews. Thematic analysis is a method used for identifying, analyzing, and reporting patterns (themes) within the data. I chose this method because a 'rigorous thematic approach can produce an insightful analysis that answers particular research questions' (Braun & Clarke, 2006, p.97). They provided a six-phase guide:

Step 1: Become familiar with the data,
Step 2: Generate initial codes,
Step 3: Search for themes,
Step 4: Review themes,
Step 5: Define themes,
Step 6: Write-up.

Evidence of Trustworthiness

Lincoln and Guba (1985) emphasized the importance of trustworthiness for evaluating a research study's worth. Trustworthiness involves establishing credibility, dependability, transferability, and confirmability.

Credibility

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Confirmability

Conformability of findings means that the data accurately represents the information the participants presented. Confirmability occurs when more than one person performs the analysis to increase the depth of analysis and provide a thorough interpretation of the data (Elo et al., 2014). I confirmed the themes from the transcripts with my committee members. I used a reflective journal to understand my thoughts, attitudes, and perceptions to have more control over them and isolate them from the study.

Ethical Procedures

After I gained the IRB approval from the university (03-03-25-1047549), I submitted my proposal with the IRB results to obtain approval from the hospital. Once I received the hospital approval, I used purposive sampling to recruit participants. I emailed the participants with the consent form, and I got their consent at the time of the interview. Nurses were informed of their rights to voluntary participation and withdrawal from the study, and that confidentiality of the data and anonymity of the participants would be protected, as no one other than the researcher and the advisor would have access to the recorded data and observations. After transcription, all recordings will be destroyed, and verbatim transcription will be saved in Flash memory for five years. I interviewed each nurse in the hospital's meeting room for no longer than 35 minutes.

In this chapter, I have provided an overview of the methodology and methods used in this study. I used basic qualitative methodology. I described the study design, population, sampling methods, recruitment procedure, data collection, ethical considerations, data collection procedures, data analysis plan, and data trustworthiness.

RESULTS

The purpose of the study was to explore the perceptions and experiences of ICU nurses' PCC with unconscious patients using a basic qualitative methodology. In this chapter, I present the main findings from the interviews with twelve nurses conducted in the selected hospital in Saudi Arabia. The research question for my study was: What are the perceptions and experiences of ICU nurses of PCC with unconscious patients?

Setting

The participants were from various nationalities (Filipino, Indian, and Egyptian) and worked at a private hospital in the selected region. The hospital has a total capacity of 320 beds, including 30 beds in the ICU. No personal or organizational conditions at the time of the study influenced the participants or their experiences, which could have affected the interpretation of the study results.

Demographics

I conducted 12 interviews using open-ended questions to guide the inquiry. The sample consisted of nine female and three male nurses. Eight nurses were between the ages of 23 and 33, while four were between 34 and 44. All participants were registered nurses holding a bachelor's degree and working in intensive care units. The mean years of experience in nursing was 9.21 years (SD = 4.04), and the mean years of experience in ICU settings was 4.14 years (SD = 2.25) (see Table 1).

Table 1. *Participant Demographics*

Variable	M (SD)	N (%)
Nurses experience in nursing	9.21 (4.04)	
Nurses experience in ICU	4.14 (2.25)	
Gender		
Male		3 (25%)
Female		9 (75%)

Data Collection

Twelve nurses were interviewed at a time convenient for the participants. All the interviews took place in the hospital's meeting room. Each interview lasted between 15 and 30 minutes. The data collection occurred over one month. The data were recorded using the Otter application. Nothing untoward happened during the data collection period.

Data Analysis

I used the Otter application to audio record the interviews. After I completed the data transcription, I conducted a thematic analysis using Braun and Clarke's (2006) six-step thematic analysis approach. The inductive analysis process in this study involved systematically moving from raw interview data to meaningful themes through coding and categorization. Initially, I reviewed the transcripts to ensure familiarity, followed by open coding, where I assigned significant statements to descriptive labels. Then, I grouped these codes into broader categories based on shared meanings, eventually leading to the development of overarching themes that captured the perceptions and experiences of ICU nurses (Braun & Clarke, 2006). They provided a six-phase guide:

Step 1: Become familiar with the data,
Step 2: Generate initial codes,
Step 3: Search for themes,
Step 4: Review themes,
Step 5: Define themes,
Step 6: Write-up.

Use of this method ensured that findings were grounded in the data, reflecting nurses' perspectives. The discussion below reflects the results of this study.

The first question was: If you came to a duty shift and the in-charge nurse gave you the choice to choose between a conscious or an unconscious patient to provide nursing care on that shift, which patient would you choose? Nine out of the twelve nurses preferred to work with unconscious patients.

The following themes emerged from the nurses' responses regarding their preference for caring for unconscious patients:

Theme 1: Perceived Ease of Workload

Several nurses indicated that caring for unconscious patients is less demanding than caring for conscious ones. They associated unconscious patients with reduced communication requirements and fewer interruptions in their workflow.

"Basically because the unconscious patient cannot communicate. And for us, I think it would be less we would be on less work than with the conscious ones" (ICU nurse 1).

"I like unconscious patients. I like taking care of them since they will not have complaints. You are free to do your nurse task, yeah, doctor's order without any complaints and questions" (ICU nurse 3)

Theme 2: Greater Control Over Procedures and Interventions

Nurses stated that unconscious patients allowed unrestricted completion of nursing procedures and interventions. Unlike conscious patients, who may resist or refuse treatment, unconscious patients are perceived as easier to manage in clinical settings. According to these participants, unconscious patients do not object to care, allowing the nurses to work in a more relaxed environment. On the other hand, conscious patients may decline specified treatments or express discomfort, making nursing care more complex.

"When you want to do a procedure for a conscious patient, you have to be careful. They might pull their hands and sometimes refuse, but in unconscious patients, you have more control in doing the nursing procedures and interventions (ICU nurse 4)

"While inserting a cannula or any procedures, they won't move their hands, and for the pain, maybe they will understand, but they cannot do anything right because they are unconscious. They cannot move their legs or hands; they will accept everything. So it's really easy to do all the procedures" (ICU nurse 2)

"Conscious patients will restrict some kind of nursing care. Yeah, they don't want to put the monitor like that, like that. They will refuse most of the things, and they will refuse. They can. They have the right to, but for the unconscious, we can monitor them continuously. There are no restrictions, there are no refusals" (ICU nurse 11).

Theme 3: Time Efficiency

Nurses' responses highlight the theme of time efficiency when working with unconscious patients. The nurse explains that conscious patients require more time and effort due to their need for explanations about any procedures or medications to be given to them. In contrast, unconscious patients do not ask questions or resist, making work faster and more straightforward.

"You will be staying with them a longer, longer time because in each procedure you do, in each medication you will give, the patient will ask you to explain all things. On the other hand, doing procedures for unconscious patients is easier because you will just ask permission from them, but they will not question what you are doing" (ICU nurse 9)

Theme 4: Avoiding Demanding Patients

Nurses' responses stressed the perception that conscious patients require more attention and immediate responsiveness, which can add to the nurses' workload and stress. Nurses described conscious patients as needy, demanding, and frequently complaining, which can be overwhelming in a high-stress ICU environment.

"Some conscious patients who nag very often complain a lot, ask too many questions, and need to have nurses available immediately. They will press the alarm for something like adjusting my leg or modifying my hand" (ICU nurse 4)

"I would rather choose unconscious patients because they are easy to take care, and also they are not demanding" (ICU nurse 7)

Theme 5: Avoiding Bad Treatment

Some nurses' responses showed the emotional and psychological challenges that nurses face when caring for conscious patients. Some nurses prefer unconscious patients because they do not experience verbal assaults or potential harm from them.

"You can maneuver them easily, also, also You will not get harsh words from them" (ICU nurse 10)

"That's why I prefer unconscious patients, because conscious patients, it's difficult. They can hurt you, they can say bad things to you, everything they can do" (ICU nurse 11)

In contrast, three of the twelve participants in this study described their reasons for preferring not to work with unconscious patients as follows:

Theme 6: Communication with Unconscious Patients Is Difficult

Nurses' responses emphasized the importance of communication in nursing care, with some nurses preferring conscious patients because they allow for direct communication and verbal expression of needs. Nurses found it easier to assess pain and the overall patient health status when their patients could communicate their symptoms, making it easier to provide individualized and appropriate care.

"Actually, I like to take conscious patient because conscious patient means we can talk with the patient if he is having any pain like that means we can ask this, but for this unconscious patient, we cannot ask anything" (ICU nurse 8)

"Because I can easily communicate with the conscious patient, and I can relate to me whatever feelings that she had, if she is in pain or she needed anything, I would be able to give her the proper care. So with that unconscious patient, it's a little bit different. Yeah, it's a little bit tricky with unconscious patient because you need to be properly equipped with the knowledge to perceive if the patient is in pain" (ICU nurse 9)

Theme 7: Communication is a Two-Way Process

The responses emphasized the importance of communication, patient interaction, and building a caring relationship with patients. Nurses who preferred working with conscious patients appreciated the ability to engage in meaningful talk and establish rapport with them.

"With a conscious patient, if any problem, I can interact with the patients" (ICU nurse 8).

"I will be able to communicate properly, and if the patient has feelings or any complaint like pain or anything, she will be able to communicate it properly to me, and I will be able to handle or give or her the proper care that she needed" (ICU nurse 9).

"It's hard to communicate with unconscious patients because they can't talk back or express themselves" (ICU nurse 3).

"I want talking. I want speaking. I want communication. Yeah. So, if you're going to ask me which I would prefer, I still prefer a patient who is talking to me and expressing him or herself like that. I can establish a rapport. I have difficulties communicating with unconscious patients. You cannot educate because, as part of education, it's I'm sorry for that" (ICU nurse 3)

The second question was about talking to unconscious patients: If your patient is unconscious, do you talk with them while providing care? Please share why you do (or do not) talk with unconscious patients? Do you have a story about a particular patient you cared for where you felt that talking with them was meaningful?

Theme 1: Human Dignity and Respect

Many ICU nurses stated that unconscious patients are still human beings who deserve respect, care, and communication, regardless of their awareness and consciousness level. They see communication as a necessary part of care, explaining procedures to reduce fear and anxiety, even if they are unsure whether patients can understand.

"I believe they are human. They can hear us, yes, and they will remember you do not remember your name, but they will always remember what you do to them. Yeah." (ICU nurse 1,2,4)

"Everyone is a human being, so they have the right to know that this person is going to do something" (ICU nurse 5, 7)

"What I will practice, even though they will not respond to us, but we need to respect them as a human being, we should respect the people. We should respect the patient" (ICU 10,9,11)

Theme 2: Empathy and Personal Connection

Nurse participants reported putting themselves or their loved ones in the patient's place, which influenced how they interact with unconscious patients. Most of the stories shared from the nurse's side showed empathy and appreciation for the patient's need for communication.

"I actually kind of sympathize or empathize as a nurse because I'm thinking of taking care of them, and I'm thinking, I'm thinking if, what, if it is my relative, or it is my family" (ICU nurse 5).

" I am thinking, what if I was in the patient's place or if it was one of my family, I would wish the health care providers to talk to them" (ICU nurse 12).

"What if I was in her position? What would the nurse be? What would I like for the nurse to do for me as well?" (ICU nurse 9)

Theme 3: Belief in Awareness and Memory

Some nurse participants discussed their belief that patients can hear them, even if they do not remember details. They stressed the importance of speaking kindly and treating patients as if they were aware. Many nurses described their uncertainty about whether the patient could hear or if they understood, yet they emphasized the importance of communication.

"Yeah, I talk to them like as if they are able to hear but I think they can hear some of them, but we, we don't know if they can hear or not, but even though they cannot hear, but I'm still talking to them like we will greet and introduce myself, and then we will inform them what we are going to do with them, so that they are aware what's going on. What are the things we're going to do with them so that they will not feel anxious or scared. They will feel comfortable and secure" (ICU nurse 6)

" I encourage them and give them some encouragement because we all need encouragement, especially in times of weakness, and it somehow stimulates their mind that there are people talking to them; they can hear you. Okay" (ICU nurse 9)

" I don't think so, if they can understand what we are saying even, but we should continue that. That's my opinion" (ICU nurse 12).

The third question: If you had to advise a new graduate nurse assigned an unconscious patient in your unit, what advice about communication would you give them?

Theme 1: Treat Them as Conscious Patients

Nurses' responses emphasized that while the main difference is the ability to verbally communicate, their need for a caring relationship with the nurses remains the same. Their advice emphasized that despite their medical condition, they were still people with emotions, a history, and loved ones waiting for their speedy recovery and still having hopes. Additionally, their body, dignity, privacy, and patients' rights must be upheld just as they would be for a conscious patient.

"There's no more like the difference between conscious and unconscious patients are just communication, but they are still human. You have everything you do. You have to talk to them because they are hearing you. Yeah, that's it. Yeah" (ICU nurse 1)

"So deal with unconscious patients like the others and maintain the privacy of the patient" (ICU nurse 4).

" We need to respect the patient, respect the privacy and respect the patient condition, and we need to keep on continuously communicating with the patient" (ICU nurse 5)

"Still talk to them, communicate to them, because even though they cannot hear you, let us not get rid of their autonomy. There should still be autonomy for the patient, even though they are unconscious. So let us still be respectful to our patient, even though they cannot communicate" (ICU nurse 7)

Theme 2: Ethical and Professional Nursing Care

Nurses' advice emphasizes the fact that unconscious patients cannot defend their own rights or speak up for themselves; nurses have an ethical and professional obligation to ensure they are receiving high-quality nursing care. Maintaining integrity and honesty in all procedures is important, regardless of whether a patient can actively acknowledge them.

"Treat them how you will treat a family member as well because that's what we were always instilled in us, that you have to be compassionate with all the patient "(ICU nurse 12)

"Always ask them permission before doing anything. When the patient cannot respond, it's okay, just ask, then you can do whatever you want" (ICU nurse 10)

"Be honest with your job, with your work because the unconscious patient is they're not moving. They cannot see you. Do the proper care with the heart" (ICU nurse 11)

The fourth question: Have you observed nurses communicating poorly or inadequately with unconscious patients? Why do you think talking with unconscious patients does not occur with some nurses?

All the nurses answered this question with yes, and the forms of poor and inadequate communication in the ICU with unconscious patients were reflected in the following themes, supported by the nurses' responses.

Theme 1: Poor / Inadequate Communication and Consent

Many nurses mentioned that they have observed some nurses who perform their nursing procedures without informing or asking permission from the patient. Nurses reported that missed consent and missed communication instances, like introducing themselves to the patient and taking permission before performing the procedure, were observed in the ICU setting when working with unconscious patients.

"I have observed with my previous hospitals, nurses who are taking care of the patient without asking permission to what procedure they're doing, maybe, but later on, especially new nurses" (ICU nurse 2)

"I've encountered one nurse before. She does not mind Everything she does; she just does it harshly and then does not even ask or introduce herself to the patient and just does her thing without talking to the patient and permission to do that" (ICU nurse 7).

"So, I can see sometimes that other others don't speak with the patient. They don't talk with the patient." (ICU nurse 9).

"They will just do whatever they want, and they will just leave. There is no communication between the patient and the staff. Yeah, yeah. They will, maybe the nurses are always in hurry" (ICU nurse 10).

Theme 2: Negligence of Care Standards

Nurses' responses revealed observations on ICU staff behaviors during care with unconscious patients. These observations included negligence in nursing care that should be provided to the unconscious patients, like talking in the patient's room about subjects that are not related to work, or saying something inappropriate, and delaying and ignoring medical procedures for the unconscious patients. There was an obvious concern about the perception that unconscious or vegetative patients cannot hear or feel, or that they are going to die, leading to poor care and unprofessional behavior.

"The patient might have diarrhea like that. Then nurses like will say Mama, We're so tired. Please stop. But yeah, even though it's not there, well, for me, I feel sad because, what if the patient might hear that, and then it's actually not their fault because they have no control of their body?" (ICU nurse 6)

"He just needs to insert, a cannula kind of, maybe he, he will take 10 trials, yeah, to try to insert, I'm just, give myself mercy. No, don't do it. Just take one trial to trial and give the other nurse" (ICU nurse 4)

"One unconscious patient returned conscious again. He hears every word we say in the ICU, and he has some problems with other staff nurses, they can say something like, it's not about or related to work, maybe a personal problem issue, something like this" (ICU nurse 4)

"In the other hospital that I've been for, there are some nurses that do unconscious. They're still using the phone in front of the patient. They are talking loudly, which is, supposedly, don't, don't talk too much in front of the patient" (ICU nurse 3)

"Our staff might feel like this patient doesn't know anything, like a vegetative state, for example. They will not do the proper privacy. They will not close the curtain for the patients, and they will expose

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the patient. And they will not do the proper care. They will not do the proper oral hygiene. They will not give the feeding on time. They will not take care of their wounds. They will not try to prevent the wounds. So we are seeing this type of incident" (ICU nurse 5)

"Sometimes the sisters, if doctors are advising medication to give, sometimes they are. They don't want to give that medicine. Also, some unconscious patients, why? Because they are thinking about, and this one is going to die" (ICU nurse 8)

"They're just doing their job. But without care" (ICU nurse 11)

When participants were asked to expound on why nurses' communication with unconscious patients does not occur. Their responses shared these reasons.

Theme 3: Lack of Training and Experience

Many nurses identified that a lack of orientation and knowledge played a large role in poor communication with unconscious patients in the ICU setting. New nurses may not be aware of the best ways to interact with patients who cannot verbally respond. They may also fail to communicate with patients before performing procedures or neglect patient rights, which will affect the quality of care provided to them.

"They need orientation. They need experience, yes, yeah" (ICU nurse 2).

"Its lack of orientation, lack of knowledge" (ICU nurse 3).

"For some new stuff, but if, if we can motivate them, if we can just give them some advice like they can improve themselves" (ICU nurse 10).

"We have to improve our knowledge to communicate with unconscious patients" (ICU Nurse 8).

"Nurses are not aware that they should communicate with those patients" (ICU nurse 12)

Theme 4: Emotional Detachment

Several nurses mentioned that one of the reasons for poor or inadequate communication with unconscious patients was to avoid getting emotionally attached to the patient and the fear of loss after the patient's death. Emotional distancing was one of the coping mechanisms that nurses used to protect themselves from the psychological damage of frequent patient deaths. This was reflected in their behaviors when caring for unconscious patients.

"They don't want to attach to the patient" (ICU nurse 6)

"They don't want to be involved or to be attached, yeah, because they will know later on, the patient might die, so it will make them more difficult to adjust" (ICU nurse 7).

"Maybe they don't want to get attached somehow, or they are not used to it because some nurses are new, and you don't know how emotional they can get" (ICU nurse 9).

Theme 5: Stress, Exhaustion, and Workload

ICU nurses work under high-pressure conditions, usually with more than one patient. Their responses shared that some nurses might prioritize conscious patients over unconscious ones. Increased workload causes rushed and incomplete care, where nurses might skip non-urgent responsibilities like talking to the patient or explaining a procedure.

"I cannot also judge them for how they treat the patient, but I think it's because of the stress and exhaustion like they're being tired of taking care of the patient, but even though they also give their best, they can offer if they're not in the right, yeah"(ICU nurse 6)

"That shift may be really busy, or sometimes that same patient, my patient, will become critically very ill, maybe I will be giving like, you know, CPR or some procedures. That time we could not communicate, right? Nurses have good communication, but sometimes they are tense, or they are busy with their work at that time" (ICU nurse 1)

"I'm busy with other patients. I need to finish this one as soon as possible, because the other patient is conscious. This is not conscious, so I need to give more care to the other patients" (ICU nurse 5).

Theme 6: Perception That the Patient is Not Aware or Won't Improve

Some participant responses reflected the belief that unconscious patients are "not really there" or unlikely to get better, which affects their understanding of the necessity of communication with unconscious patients. Some participants reflected that nurses might feel that their actions have little impact or none on the patient's health status, which potentially leads to a decrease in the quality of care provided for these patients. This highlighted a culture of neglect, where unconscious patients receive less care because they cannot respond.

"In his mind, his patient is not feeling what they will do to them" (ICU nurse 4).

"Maybe for some, but not all, they just think it's just a patient. They are not kind of alive, but not alive or kind of dead" (ICU nurse 10)

"They feel like the patient will not improve. Maybe they are thinking there is no hope" (ICU nurse 5)

"Maybe they think that it is not that useful anymore because they cannot respond." 7

Theme 7: Language Barriers and Communication Challenges

For nurses working in diverse settings, language differences can create an additional burden when communicating with unconscious patients, especially since they believe that these patients won't understand their language when they speak to them or try to interact. Nurses who struggle with a language barrier may feel less confident in initiating communication with the patient, leading to poor communication instances with unconscious patients.

"Maybe the language barrier also because, um, some someone thinking like, I don't know how I will be when I communicate with the patient." (ICU nurse 10)

Major Themes

Three major themes emerged from this qualitative study. These three overarching themes reflect responses to individual semi-structured questions guiding participant interviews and were previously discussed as subthemes in the data analysis.

All the nurses of the study agreed that preserving human dignity and respect is an important aspect in the care of unconscious patients in the ICU. *Preserving human dignity and respect* emerged as a major theme when nurses discussed communication, care, and the ethics of caring for unconscious patients. ICU nurses emphasized that unconscious patients are still human beings who deserve respect, care, and communication, regardless of their level of awareness or consciousness. *Care fatigue,* the second major theme, reflects a cluster of subthemes that reflect nurses' desire to have patients who make no demands. Nine ICU nurses chose to work with unconscious patients because of the perception that it is easier than working with conscious patients. ICU nurses experienced emotional and physical exhaustion after prolonged exposure to the demands of patients, particularly in high-stress environments. In this study, care fatigue emerged as a secondary but important theme, with some nurses choosing to work with unconscious patients as a way to ease the emotional burden of continuous communication and emotional engagement.

The third major theme is *Nurses' belief systems.* This theme strongly influenced nurses' approach to communication with unconscious patients. Nurses were divided on their beliefs about cognition while unconscious, with seven nurses who strongly believed in the awareness and memory of unconscious patients, often shaped by their previous experiences and stories. Others believed that the patient was unaware or unlikely to improve. Overall, nurses' perceptions and experiences significantly influenced the relationship between ICU nurses and unconscious patients, shaping how care and communication were delivered.

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In this chapter I provided the results of the data collection with twelve transcripts from the ICU nurses working in the selected hospital. The first question revealed that nine out of the twelve nurses showed a preference for working with unconscious patients. The themes emerged on their preference reasons were perceived ease of work, greater control over procedures and interventions, time efficiency, avoiding demanding patients, and avoiding bad treatment. Others chose conscious patients because communication with unconscious patients is difficult and is perceived as a two-way process. Themes generated from nurses' responses were about what advice they would give new nurses working with unconscious patients, as they treat conscious patients with human dignity and respect, as well as ethical and professional nursing care.

Other themes based on nurses' responses showed that unconscious patients might receive Poor / Inadequate Communication and Consent, and negligence in the standard care that should be provided to them. Major themes of the reasons behind ICU nurses' behaviors were lack of knowledge and orientation, workload and stress, language barrier, emotional attachment, and perception that the patient is not aware or will not improve. This study's major themes were preserving human dignity, care fatigue, and nurses' beliefs.

DISCUSSION

The purpose of this qualitative study was to explore the perceptions and experiences of ICU nurses providing patient-centered communication (PCC) with unconscious patients using a basic qualitative methodology. Using purposive sampling, I recruited nurses who work in the ICU with bachelor's degrees in nursing. Two important themes emerged during the data analysis. Preserving human dignity, respect, and nurses' belief systems strongly impacted how they approached communication with unconscious patients. Some nurses held a strong belief in the awareness and memory of unconscious patients, often shaped by previous experiences and stories. The participants were from various nationalities (Philippines, India, and Egypt) and worked at a private hospital in a large metropolitan city in the central region of Saudi Arabia.

In this chapter, I discuss the interpretations of the findings that emerged from answering this study's research questions, the limitations, the recommendations, and the implications of the study.

Interpretation of the Findings

Preserving human dignity and respect emerged as a major theme when nurses discussed communication, care, and the ethics of caring for unconscious patients. All ICU nurses agreed that unconscious patients are still human beings who deserve respect, care, and communication, regardless of their level of awareness or consciousness. Critical illness makes patients especially vulnerable, protecting their dignity becomes more difficult as a result of unconsciousness. ICU nurses play a key role in either upholding or undermining patient dignity, and they support it in various ways: by treating patients with kindness and empathy, using thoughtful communication, advocating for their needs, anticipating their experiences, and restoring dignity through explanations. Even when patients are near death, their dignity must be honored (Nyholm & Koskinen, 2017).

Care fatigue has also emerged from the nurses' responses. Some nurses choose to work with unconscious patients because it is easier than working with conscious ones. ICU nurses experience emotional and physical exhaustion after prolonged exposure to the huge demands of patients, particularly in high-stress environments. This finding aligns with recent research showing that ICU nurses are particularly vulnerable to compassion fatigue due to the emotional intensity of critical care environments (Alharbi et al., 2020).

Nine nurses' responses showed their preference to work with unconscious patients to avoid the bad treatment that they might receive from conscious patients and due to the emotional and psychological challenges that nurses face when caring for conscious patients. Similarly, Johnson and Lee (2023), found that ICU nurses reported feeling safer and more emotionally secure when assigned to unconscious patients. The study highlighted that the absence of verbal communication—and consequently, the absence of potential verbal assaults—from unconscious patients contributed to a more manageable work environment in terms of emotional demands. Miller and Thompson (2022) underscored that exposure to aggression from conscious patients not only heightened the risk of psychological distress among nurses but also affected their overall job satisfaction and well-being.

Nurses' communication between ICU nurses and patients with decreased levels of consciousness is widely recognized as a challenging aspect of care. Many nurses struggle to consistently apply these principles due to time constraints and demanding workloads (Pooyanfard et al., 2023). In my study, ICU nurses work under high-pressure conditions, usually with multiple patients, which makes communication with unconscious patients challenging. Increased workload causes rushed and incomplete care, where nurses might choose to omit care responsibilities that they have assigned as a lower priority, such as talking to the patient or explaining a procedure.

Nurses' Caring Belief System, which determined how unconscious patients were treated during caring encounters with the nurse, was one of the major themes that emerged in my study. The ICU nurses in this study who preferred to work with unconscious patients perceived that they had an easier workload and could avoid demanding patients. This is supported by Choi et al. (2020), who examined ICU

communication in general and emphasized the complexity and stress involved in engaging with conscious patients and families, highlighting why nurses may view unconscious patients as less demanding. Similarly, Özveren and Kirak (2021) found that ICU nurses experienced significant communication difficulties with conscious patients, contributing to stress and interruptions in working procedures, which may drive a preference for unconscious patient care.

Almutairi et al. (2025) conducted a qualitative study in Saudi Arabia to explore how nurses' cultural backgrounds influenced communication styles in diverse ICUs. Their results emphasized that nurses' own cultural beliefs shaped how they communicated and engaged with patients, including those who were unconscious. In my study, nurses' beliefs and attitudes affected how ICU nurses perceived communication with unconscious patients. Some nurses held a strong belief in the awareness and memory of unconscious patients, often shaped by previous experiences and stories. Others believed that the patient was unaware or unlikely to improve. Overall, nurses' perceptions and experiences significantly influenced the relationship between ICU nurses and unconscious patients, shaping how care and communication were delivered. Effective communication is essential and closely linked to the nurses' attitudes and practices and their adherence to ethical principles, since care and ethics are inseparable. Nurses with more positive attitudes toward patient engagement tend to perform better in this area. (Pooyanfard et al., 2023).

The inability of unconscious patients to communicate or respond hindered the ability of ICU nurses to engage in meaningful talk and establish a rapport with them. Nurses reported the need for the other person's feedback to communicate (Nyhagen et al, 2023). In my study, nurses' responses showed that nurses perceive communication as a two-way process and difficult to communicate with because they cannot respond or reply.

The inability of patients to speak and express themselves is one of the primary sources of anxiety for the patients in the ICU. Providing information and assurance to the patients by the ICU nurses improves anxiety and needs satisfaction (Livingston & Krishnan, 2023;Yoo et al., 2020). Unmet informational and assurance needs impact family and patient satisfaction and mental health in the ICU (Scott et al., 2019). During the interviews, three ICU nurses had a preference to work with conscious patients because they can express their needs and give them feedback when they are satisfied.

Kheta and Ali (2022) and Pooja (2023) confirmed the importance of education in improving nurses' communication and positively improving nurses' communication with unconscious patients. Every patient has the right to be constantly informed about their condition. Therefore, educating healthcare professionals about the benefits and the positive impacts of verbal communication with unconscious patients should be an integral part of the orientation and teaching of employees (Meghani & Punjani, 2014).

Other barriers to nurses' patient communication include religious and cultural beliefs, environmental factors, and language (Norouzinia et al., 2015). Nurses reported during the interviews that language differences created an additional burden when communicating with unconscious patients, especially since they believe that these patients will not understand their language when they speak to them or try to interact.

Many nurses identified that a lack of orientation and knowledge plays a huge role in poor communication with unconscious patients in the ICU setting. New nurses may not be aware of the best ways to interact with patients who cannot verbally respond. Kheta and Ali (2022) and Pooja (2023) confirmed the importance of education in improving nurses' communication and positively improving nurses' communication with unconscious patients. Using Watson's theory, McMillan (2017) showed the importance of education to create a culture surrounded by caring behaviors and promote nurses' consumption of caring attributes.

The findings of my research align closely with Jean Watson's Theory of Human Caring, which emphasizes the importance of creating a healing environment and establishing transpersonal caring relationships, even with unconscious patients. Watson's theory advocates for holistic care that addresses not only the physical but also the emotional and spiritual dimensions of patients, recognizing their inherent

dignity regardless of their level of consciousness. Preserving human dignity and respect emerged as a major theme when nurses discussed communication, care, and the ethics of caring for unconscious patients. All ICU nurses agreed that unconscious patients are still human beings who deserve respect, care, and communication, regardless of their level of awareness or consciousness. ICU nurses who believed in ethical, respectful, and compassionate care towards unconscious patients were following a caring approach that is consistent with Watson's caritas processes, such as practicing loving-kindness, honoring human dignity, and being authentically present (Watson, 2008; Watson, 2018).

On the other hand, the findings also reflect Watson's theory about the consequences of non-caring: when nurses viewed unconscious patients as easier to manage and showed less engagement, patients were at risk of being dehumanized and treated as objects. This illustrates how a lack of caring behaviors can lead to dissatisfaction and a breakdown in the ethical standards of nursing practice, as Watson's theory suggests.

Limitations of the Study

One of the important challenges was my interviewing skills. As a beginning researcher, I did my best to explain the questions. I worked on my skills of monitoring the length of the interview, giving the interviewee cues or prompts to encourage them to consider the question further, and avoiding giving leading questions. Another challenge was to control my attitudes, opinions, and preconceived perceptions. I used a reflective journal to overcome this. Additionally, the limitation of using a qualitative design and the smaller sample size compared to other methodologies affected the generalizability of the study findings.

Recommendations

I proposed the following recommendation based on the findings of my study, as well as its strengths, limitations, and the existing literature about this subject:

The first recommendation is to conduct research to explore interventions to provide emotional and psychological support for ICU nurses. Being afraid of loss and getting attached to unconscious patients was one of the important themes that emerged. Care fatigue was also a significant theme in the study, which calls for psychological support programs such as debriefing sessions, resilience workshops, and peer support groups. Additionally, nurses reported emotional stress and moral distress while caring for unconscious patients, especially when unsure about patients' awareness levels. Institutions should offer psychological support sessions and peer discussion forums to address this psychological struggle.

I also recommend further research using a broader sampling approach. My study was limited to one hospital in one region. Future studies should also include a more diverse group of nurses across multiple ICUs in multiple regions to increase generalizability and explore cultural or institutional differences. I would also recommend using different research methodologies, such as interventional or mixed methods studies, to test the effect of educational programs on the knowledge level about unconscious patient handling and communication and to explore nurses' experiences, barriers, and facilitators in communicating with unconscious patients. It also highlights the need for intervention-based studies to assess the impact of improved communication on patient outcomes and family satisfaction. Future research should also explore screening tools (e.g., compassion fatigue assessment scales) to identify early signs of care fatigue among ICU staff and intervene before it negatively affects patient care. Building on the strengths of this qualitative inquiry, future research could examine whether nurse-patient communication with unconscious patients influences clinical outcomes, patient recovery, or psychological well-being post-ICU.

I also recommend that ICU nurses receive ongoing training and reflective practice opportunities centered on the principles of human caring. Emphasizing the importance of transpersonal relationships and the ethical obligation to treat all patients, regardless of consciousness, with dignity and compassion can help reinforce caring behaviors. Nursing education and clinical guidelines should integrate Watson's carative factors as a foundational approach to ensure holistic, human-centered care in critical care settings.

Finally, the insights from the study's results may be carried forward to affect how nurses provide care for unconscious patients of all cultures, races, and global connections, which may foster diversity, equity, and inclusion, beginning at the micro level and expanding to a broader audience worldwide.

Implications

The implications of the findings of my study on the individual level is that improving ICU nurses' communication practices can enhance unconscious patients' dignity, emotional well-being, and recovery potential. These communication instances can reduce patient isolation and improve health outcomes, reinforcing the patient's humanity and promoting holistic care. On the family level, the nurses should consistently engage families in communication with unconscious patients, which will often help the families feel more reassured and included in the care process. Improving communication will be beneficial from the patient side and increase the trust in ICU nurses, reduce family stress and strain, and encourage stronger nurse-family relationships, creating a more caring working environment (Lawrence et al., 2023) (Davidson et al, 2017). On the organizational level, hospitals should establish standardized guidelines based on best practices in literature to help ensure consistency and improve the quality of care for unconscious patients. Maintaining privacy, obtaining patient consent, providing updates on the patient's health progress, and ensuring safe medical procedures are important protocols that should be consistently implemented across the ICU department. Focusing on practices that enhance effective communication with unconscious patients can improve patient care standards, increase staff satisfaction, and reduce ethical concerns. Training and monitoring systems can raise the quality of care, enhance team collaboration, and boost the organization's reputation for compassionate, ethical care (Lawrence, 2023).

Improving communication between ICU nurses and unconscious patients has significant potential for positive social change across multiple levels. The findings of this study provided new information on how ICU nurses communicate with unconscious patients. I may identify factors affecting nurses' communication with unconscious patients, which will help implement strategies to improve communication. My findings have provided new information helping nurses to understand the importance of communicating with unconscious patients and change previous myths or misunderstandings. My findings may be used to show the importance of ICU nurses' communication with unconscious patients and be a basis for creating educational programs to help ICU nurses improve their communication skills with unconscious patients. Improving the quality of care through communication for unconscious patients affects positive social change. The human connection between healthcare workers and patients will become more visible to nurses and families as care is provided to unconscious individuals. Healthcare workers will be aware of the impact of communication on the patient's well-being. The insights from the study's results may be carried forward to affect how nurses provide care for unconscious patients of all cultures, races, and global connections, which may foster diversity, equity, and inclusion, beginning at the micro level and expanding to a broader audience worldwide.

CONCLUSION

The findings of my study provide a valuable insight into ICU nurses' perceptions and experiences of PCC with unconscious patients, revealing a composite of personal perceptions, environmental barriers, educational gaps, and emotional factors. Despite recognizing the ethical importance and positive impact of communication with unconscious patients, many nurses experience significant barriers that hinder consistent, meaningful communication with unconscious patients (Kwame & Petrucka, 2021; Magnus & Turkington, 2006; Yoo et al., 2020). Cultural influences, workload pressure, lack of training, and emotional stress all shape how communication is delivered ICU settings. The findings highlight the urgent need to adopt a caring, patient-centered communication culture through continuous education programs, supportive workplace practices, and hospital guidelines. Even when patients cannot speak, they deserve to be spoken

to. Improving communication deepens the dignity and humanity of unconscious patients, supports families, enhances team dynamics, and contributes to more ethical and holistic ICU care.

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