ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

Intensive Care Unit Nurses' Interactions with Unconscious Patients: An Ethnographic Study

Afnan Suleiman
University of Jordan
Afnanlina68@gmail.com

Date Submitted:
July 05, 2026

Date Accepted:
July 18, 2026

Date Published:
July 29, 2026

DOI:
10.5281/zenodo.21678836

ABSTRACT

Unconscious patients in critical care units are often unable to communicate, placing them in a vulnerable position and making effective nurse-patient interaction essential for addressing their needs and alleviating their suffering. This study aimed to explore ICU nurses' interactions with unconscious patients using an ethnographic design. The research was conducted in a major private hospital in Amman, Jordan, where data were collected through participant observation and face-to-face interviews with 13 nurses caring for unconscious patients over two shifts between February and the end of March 2018. Findings revealed that nurse-patient interactions were generally inadequate and focused primarily on meeting patients' physical needs while neglecting their psychological and spiritual needs. The study also found that unconscious patients were often treated as disembodied individuals, resulting in violations of many of their rights. Interviews with nurses identified several factors contributing to these shortcomings, highlighting the need to improve the quality of care in intensive care units. The study concludes that holistic care is essential for unconscious patients and emphasizes that communication and interaction are fundamental responsibilities of ICU nurses. It recommends strengthening nurses' communication and interaction skills through continuous education and increased awareness of the rights of unconscious patients to promote more comprehensive and patient-centered care.

Keywords: *nurse- patient interaction, unconscious patients, critical care nurses, patient rights, patient space, patient boundaries, nurse patient relationship, ethnography.*

INTRODUCTION

In the past decades, researchers were trying to find the mystery behind all unconscious patients who stated that they heard and felt what happened around them. No matter what are the real facts behind these beliefs, unconscious patients are like other patients but with different circumstances. Unconscious patients should receive their rights, in particular the right of respectful interaction from intensive care unit (ICU) nurses.

Every patient should receive complete information about his/her diagnosis, treatment and prognosis. This is one of patients' bill of rights. Being unconscious does not nullify this patients' right. The degree to which nurses initiate and engage in interactions with patients still appears to be influenced by the overall responsiveness of the patient (Jesus, 2011). Thus, the overall ICU nurses interactions are directed toward the fact that whether the patient is conscious or not.

Previous literature has suggested that interactions between ICU patients and nurses were influenced by patients' severity of illness, level of consciousness, and degree of responsiveness. They described interactions as brief, nurse-initiated, informative statements about physical care, yes/no questions, reassurances, or commands (Happ, 2011).

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

Inappropriate or poor interaction between ICU nurses and unconscious patient will lead to serious complications. Ethnography is purposed to foster understanding of cultural and social constructions. Ethnographers gather data with the intent of cultural sense-making, and in this study the culture of ICU nurses will be addressed in terms of their interactions with unconscious patients.

Problem statement

Interaction is the observable behavior during communication implying a different perspective (Olivia and Redfern, 1991). Darmann (2002) define interaction as a mutual process of interpretation and construction of meaning. The achievement of an understanding of the situation or the subject is a possible result of interaction. Interactions determine the subjective experience of relationships. Fleischer (2009) describes a mutual interaction as a process of cognition and action of the people involved. These actions could be physical acts, acts of interplay, or a contact or bond of verbal or non verbal communication. These interactions could be described in terms of appropriate, professional, therapeutic and respectful. No matter what is the content or length of interactions, the effective interactions preserve the patient dignity, autonomy and privacy, and permits for the development of trust and respect (Hayden, 2014).

Inappropriate interactions will lead to serious consequences such as the negligence of patient autonomy and privacy, negative effects on patient self-esteem and identity and disrespect to human dignity. Some patients, for example, unconscious patients have barriers to interaction. Ashworth (1980) recognizes that nurses often experience difficulties in interacting with unconscious patients, primarily because the patient is unable to respond. Examples of inappropriate interactions include instances such as not explaining a procedure to an unconscious patient, not introducing self, not respecting patients' privacy by ignoring to close the curtains when he or she is working with the patient, or by not respecting patients' space or boundaries. Inappropriate or poor interaction could also include depriving those patients from reassurance and support comments because they can't respond. However nurses have to find, create and build a bridge for initiating interaction or consider appropriate interaction even if there is no response from the patient out of respect and professional attitudes. Lawrence (1995) indicates that unconscious patients have been reassured by the appropriate interaction process and that this helps to meet their psychological needs and prevents unnecessary distress, thus aiding their recovery. The researcher believes that many factors affect the process of interaction between ICU nurses and unconscious patients. Limited knowledge about unconscious patients' needs, nurses 'attitudes and perceptions toward unconscious patients, shared myths and workload could be reasons for why nurses do not interact with the patients. Intensive care nurses spend almost 5% of their time in verbal communication with unconscious patients; which is not enough (Baker, 1996). The need for interaction remains even if the patient is unconscious. Jesus (2011) claimed that reducing stress, preserving self-identity and self-esteem and minimizing social isolation could be achieved through effective interaction with the unconscious patients.

Despite all the efforts done to understand nurses' interactions with unconscious patients, however, limited studies were found to describe or explain nurses' interaction with unconscious patients in Jordan. Therefore, the aim of this study was to explore ICU nurses' interactions with unconscious patients using qualitative ethnographic design.

Purpose of the study

The aim of this study is to explore ICU nurses' interactions with unconscious patients using ethnographic design.

Objectives

- To describe ICU nurse – unconscious patient interactions in relation to physical, psychological and spiritual nursing care.
- To describe ICU nurse – unconscious patient interactions in relation to forms (verbal, and non-verbal) of interaction.

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

Ethical consideration

The main concepts of ethical issues in ethnographic research focus on the relationship between the researcher and the participants which includes main principles that should not be violated. These basic principles include doing good (beneficence), avoiding doing harm (none maleficence), and protecting the autonomy, privacy, wellbeing, safety and dignity of all research participants. Building a trust relationship and gaining consent are also important cornerstones of ethnography.

As a researcher I did not deceive the participants who agreed to participate .Consent was taken from the participants, explaining the research aim and the process of data collection. Participation was voluntary and participants have the right to withdraw from the study at anytime they want. Permission was taken to enter the selected hospital. The study was conducted after gaining an approval from the IRB committees.

In ethnography, access typically begins with a "gatekeeper," and in this study, the head nurse of ICU department and the matron were the gatekeepers. A gatekeeper is the initial contact for the researcher and leads the researcher to other participants (Hammersley & Atkinson, 1995).

As part of ethnography, researchers consider reflexivity as an important dimension of data collection procedures (Hammersley & Atkinson 1995, Denzin & Lincoln 1998). According to Denzin & Lincoln (1998 p. 278) reflexivity is the researchers ability to delineate clearly the interactions that have occurred among themselves, their methodologies, and the settings and actors studied.

The researcher in this study considered the reciprocity in the relationship between the participants and the researcher. The researcher considered what they take from research participants as well as what they give to them. So, at the end of this research, the findings of this study are the result of the interaction of both the researcher and the participants in the context or setting of the study.

This chapter provided an introduction for this research. An overview for the problem statement, main goal, significance, research objectives, implication, ethical considerations to nursing and research are explained. Inadequate communication with unconscious patients can lead to serious effects on the long run. ICU nurses should be aware of this and try as much as they can to consider communication as important aspect of the treatment plan.

Literature Review

Search strategy

The researcher identified the key words and concepts within this research topic. An electronic search was conducted using PubMed, CINAHL, and PsycINFO databases. Key words including nurse-patient interaction, unconscious patients, critical care nurses, patient rights, patient space, patient boundaries, inappropriate interactions, nurse patient relationship, and meaning of unconsciousness. Participant observation and ethnographic observation were used to determine relevant literature in relation to the research question. The researcher started considering studies in the literature review from 1987 until the most recent days.

Previous studies

Thinking through how the process of communication works, the understanding of what nurse's think about unconsciousness and the methods they use to communicate with unconscious patients is the key to know the reasons behind their interactions with these patients.

Barriers to interaction with unconscious patients

A *non-experimental, descriptive-exploratory study* was conducted by Baker, 1996. The *aim was to explore nurses' attitudes toward verbal communication with unconscious patients. A sample of five staff nurses working in an intensive care unit in Northern Ireland were included in 4-hourly observational periods and structured* interviews. Qualitative and quantitative analysis indicated that intensive care nurses spend on average 5% of their time verbally communicating with unconscious patients. The majority of

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

intensive care nurses say that verbal communication with unconscious patients is very important aspect of nursing care, and some had doubts to the unconscious patient's level of awareness. Major factors that influenced communication are the patient's level of consciousness, the amount of physical care being given and the presence of relatives.

Communication and interaction between ICU nurses and unconscious patients is controlled by the degree of patient's response. Nurses reported the need for the other person feedback in order for them to communicate. Nurses prefer working with conscious patients because they are able to tell them about their needs and give them feedback when they are satisfied (Ashworth 1984, Green 1996, Wyman-McGinty 1998). Baker (1996) stresses the idea that nurses need feedback in order to communicate with patients. In a study conducted by Magnus and Turkington in 2005 reported that sedation, intubation, tracheotomy, lack of knowledge about the importance of communication, time concerns, severity of the case and lack of knowledge about strategies and resources to facilitate communication, were considered as barriers to communication. Furthermore, the research describes an intensive care patient as being dependent upon the nurses' ability to identify his real fears and desires; however, with an acutely ill intensive care patient the presence of an endotracheal tube and lack of patient response create more difficulties for a nurse.

In another study about barriers of nurses patient communication, it was stated that religious and cultural beliefs, environmental factors as well as language are considered communication barriers (Norouzinia, Aghabarari, Shiri, Karimi, and Samami, 2015).

Despite all the conducted research, I think that the part on how nurses perceive unconscious patients and their myths of unconsciousness as barriers of communication was inadequate to understand this phenomenon.

Nurse-unconscious patient interactions

Verbal and non-verbal interaction

Happ, Garrett, Thomas, Tate, George, Houze, Radtke, and Sereika in 2017 aimed to describe 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. They described patient communication methods like head nod, gesture, mouthing words, and facial expression. Head nods and yes/no gestures were the most common communication technique used and the most common positive nurse act was making eye contact with the patient. Another study conducted by Verity (1996) described touch as another form of communication that is the 'caring' touch for unconscious patients.

Leigh, (2001) in his study, aimed to systematically characterize verbal communication that critical care nurses and families use with unconscious patients. Their results showed four main problem areas in verbal communication which are basic 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.

Non-verbal communication, such as facial expression, eye contact, posture, personal space and bodily contact, are important in social interaction. Non-verbal cues are often the first elements of communication that help us to form immediate impressions about someone (Webb 1994).

Complications of poor interactions between ICU nurses and unconscious patients

Communication at the bedside, even when the patient is unconscious or sedated, may often be recalled 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, while, information given to unconscious patients may help in reducing stress, helping patients preserve their self-identity and self-esteem and reduce social isolation.

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

Interactions methods and patient responsiveness

Leigh, (2001) stated that unconscious patients could remember what was happening during their state of unconsciousness. Patients could remember names and sometimes what nurses said near them or what they called him. Othman (2015) conducted a study to examine the effects of implementing structured communication messages (SCMs) on the clinical outcomes of unconscious patients using FOUR scale for consciousness. Verbal messages like telling the patient his or her name, talking about old stories using a familiar voice were statistically significant positive effect on the level of consciousness by FOUR scale.

Jordanian studies

One study conducted by Alasad (2004) to examine verbal communication of ICU nurses with unconscious patient in three hospitals in Jordan. Using a phenomenological approach they found that ICU nurses reported difficulties in working with unconscious patients. Nurses stated that it is important to communicate with patients but it is easily forgotten to do so.

This chapter provided what literature said about nurse's interaction with unconscious patients. Nurses reported barriers to their communication with unconscious patients. one of the reason was the patient inability to respond to their interaction. Feedback is an important element of the communication between nurses and patients. Looking at the previous studies gave the researcher the chance to recognize the need for this research to be conducted in Jordan.

METHODS

Study Design

The design of this study is qualitative, focused ethnography with overt participant observation. The researcher used qualitative research because it is primarily an exploratory research. It is used to gain an understanding about ICU nurses' interactions with unconscious patients in the ICU. It provides insights into the problem and helps to develop ideas or hypotheses for potential quantitative research studies. *The researcher used ethnographic design because* the central aim of it is to provide rich, holistic insights into people's views and actions, as well as the nature of the location they inhabit, through the collection of detailed observations and interviews.

The researcher chose focused ethnographic design because it is an applied research methodology that has been widely used in the investigation of fields specific to contemporary society which is socially and culturally highly differentiated and fragmented (Knoblauch, 2005). This methodology helped researchers to discover how people from various cultures integrate health/discipline-specific beliefs and practices into their lives and to study the practice of health and other disciplines as a cultural phenomenon using short term field visits.

Ethnography involves many qualities. The most important qualities that the researcher used it for are: *Exploring the nature of a particular social phenomenon, rather than setting out to test problem about it.*

A possibility to work in the beginning with unstructured data that is, data that have not been coded at the point of data collection as a closed set of analytical categories, Investigation of a small number of participants, Ethnographies can account for the complexity of group behaviors, discover relationships among group interactions, and provide context for patterns of behaviors and Ethnographies can notice qualities of group experience in a way that other research methods cannot (Knoblauch, 2005).

Study Sample and Settings

The study population consisted of ICU staff nurses with a bachelor degree in nursing. Nurses should have more than one year of experience. The study population consisted of the following three main aspects:

***1. Human aspect*:** ICU staff nurses in the selected hospital from which the sample will be obtained.

2. Geographic aspects: Amman – Jordan

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

***3. Time**:* Fall 2017.

The study sample consisted of 13 ICU nurses from the selected hospital. The researcher collected the data from nurses working with unconscious patients in the ICU at a private hospital in Jordan. This unit has a capacity of 20 patients. The data collection period started from the first of February, 2017 until the end of May, 2017. Creswell (2010) stated that numerous interviews and observations will be collected until the workings of the cultural group are clear. This is the key concept in sample size regarding ethnographic study. So, I continued collecting data until the data in this research were saturated, with a sample size of 13 ICU nurses' interviews and approximately 150 hours field observation.

Sampling Method

The researcher did a paired selection for the sample; that is nurses and patients together. ICU nurses were chosen using maximum variation sampling method and patients were selected purposefully. The researcher used maximum variation for the selection of nurses. This was done by including a wide range of extremes such as age, gender, years of experience in nursing and years of experience in ICU practice. The principle is that if the researcher deliberately tries to interview a different selection of people, their aggregate answers can be close to the whole population. A maximum variation sample is a special kind of purposive sample.

Inclusion Criteria for ICU Nurses:

1. Of varying number of years of experience, and not less than one year.
2. Of varying age group.
3. Work with unconscious patient at the time of data collection.

The researcher used purposive sampling method for patients' selection. During the observation period, the researcher encountered two types of patients in the ICU: the conscious and the unconscious patients, and the intubated and the non-intubated patients. Health care providers have no problems in communicating with conscious or non-intubated patients as they can easily communicate with them. On the other hand, health care providers report communication difficulties with the second type, that is patients who are unconscious whether intubated or non-intubated. It is patients who are unconscious that health care team report difficulties in communicating with. This type was the target of this research.

Observations and Interviews

In an ethnographic study, the investigator collects notes of behavior through observations, interviewing, documents, and artifacts (Fetterman, 2010). In this research, data were collected through participant observation and semi-structured interviews.

Participant observation offers possibilities for the researcher on a continuum from being a complete outsider to a complete insider (Jorgensen, 1989). The approach of changing one's role from that of an outsider to that of an insider through the course of the ethnographic study is well documented in field research (Jorgensen, 1989). So the researcher sometimes would escape to role changing whenever he/she feels that this will help the participant to trust the researcher more and work in a comfortable working environment. This will help in reducing Hawthorne effects that occurs due to being conscious about the observation.

The researcher designed an observational protocol as a method for recording notes in the field which included both descriptive and reflective notes. The researcher recorded aspects of care such as portraits of the informant, the physical setting, particular events and activities during the interaction between ICU nurses and unconscious patients. The researcher planned to describe what was happening and reflected on these events by including personal reflections, insights, ideas, confusions, hunches, initial interpretations, and breakthroughs (Appendix 2)

The researcher used two methods of observation and did alternations between these methods according to the study needs. The first one is a complete participant approach, in which the researcher was

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

fully engaged with the people he or she was observing. This method has helped the researcher in establishing a greater rapport with the people being observed (Angrosino, 2007). The researcher also used participant as observer method during the observations in which the researcher had to participate in activities done with the patient and take notes at the same time.

The researcher was participating in the activity at the site. The participant role was more salient than the researcher role. This may have helped the researcher in gaining the participants views and subjective data. However, it was sometimes distracting for the researcher to record data when the researcher was integrated in an activity; and since the data collection was in a short period of time, the researcher had to be in observer as participant role watching and taking field notes from a distance. In this role, observer as participant, the researcher recorded data without direct involvement with activities or people.

Regarding interviews, several authors have advanced the steps necessary for conducting qualitative interviews. In this research, the researcher followed the steps of Kvale and Brinkmann (2009). The Kvale and Brinkmann (2009) seven stages of an interview inquiry report a logical sequence of stages from thematizing the inquiry, to designing the study, to interviewing, to transcribing the interview, to analyzing the data, to verifying the validity, to reliability and generalizability of the findings, and finally to reporting the study. Audio-recorded accounts were obtained through interviewing 13 nurses. This was done, after taking permission from the organization and the participants themselves.

Based on the observational notes I collected about nurse-patient encounters, the researcher designed an interview guide to use as questions for interviews with ICU nurses. The interview guide helped the researcher to direct their questions toward the most important observed instances of interactions that needed further explanations by nurses themselves (Appendix 3).

Data Collection Procedure

After gaining the approval of the IRB, the School of Nursing sent a formal letter to the participating hospital to take permission to start gathering data through observation and face to face interviews. Upon the agreement of Ministry of Health the researcher accessed the hospital settings. Key persons (matrons and head nurses) from the selected hospital were approached to facilitate access to the ICU department to do the observation and interviews after explaining the purpose of the study and the method of data collection.

The in-charge nurse introduced me to the staff working in the selected units and to nurses working on the different shifts. To start data collection, I began by identifying an unconscious patient and then, I identified the nurse assigned for care to this unconscious patient. Nurses who were assigned to work with unconscious patients were approached at the beginning of a day shift before the handover and consent for participation was taken. The selected nurses were given full details of the study aim and procedures, and permission for observation and later interviews were obtained. 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 will be protected as no one other than the researcher and the advisor will have access to the recorded data and observations. All recordings will be destroyed after transcription. Nurses who were approached agreed to sign a consent form and gave their permission to be accompanied during their assignment to unconscious patients for one-to-one observation of nursing care provision. Process consent is mandatory in qualitative research and it was performed during the study. Process consent means an ongoing consensual process that ensures that the participant/nurse is kept informed at all stages of the research process.

The researcher did participant overt observation. Each nurse was observed for her or his interaction with an unconscious patient. These interactions could be in the form of doing an interventional procedure or merely routine checking on the patient health status. The researcher observer documented instances of first interaction, on-going interaction, and procedural one-to-one preparation, touch, verbal and non-verbal accounts of incidences during interventions. Observations of verbal events included words, phrases and sentences used in addressing patients' needs for care. Non-verbal interaction were documented by

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

observing handling and touch interactions, nurses' facial expressions, and gestures during performing procedures, such as smile and respect of patients' privacy and boundaries.

For field observations, the researcher accompanied a nurse participant every time she or he did a procedure or intervention to the patient. To eliminate the observer effect, the researcher stayed on the floor for a period of time and mingled with nurses on a daily basis. The researcher often took field notes in an on and off pattern, in an unpredictable pattern. Sometimes, the researcher carried the observation sheet, and some other times the researcher would not, and thus had to record the notes immediately after leaving the scene. I kept doing this until I felt that nurses are comfortable with the researcher's presence. The first two to three observations were ignored because of the possibility of nurses acting or faking their behaviors. The researcher observed nurses actions on the first hour of a working shift, and in each procedure they did to a patient such as in cannulation or sampling procedure, skin care, oral care, changing position and sometimes bathing if they had to do it in the morning. The researcher also observed nurses handover during the day and night shifts. The first two to three observations were discarded because of the possibility of acting out or changing their usual behavior. In some situations, the researcher depended on memory to help nurses believe that they are not being observed.

During observations and field notes collection, the researcher had to do role changing in order to get more data from the participants. Creswell (2010) discussed a researcher's role change in ethnographic studies. He stated that the observer could change his or her role during an observation, such as starting as a nonparticipant and then moving into the participant role, or vice versa. In the hospital, the researcher played the role of participant observer and often changed the role to participant as observer depending on the situation. The researcher anticipated that by collecting data from this hospital, where the researcher works as a nurse, I would face some difficulties ranging between resistance by colleagues and threats to my objectivity and subjectivity being knowledgeable of the simple details as an insider. However, this was contrary to my expectations. The working team knew the researcher and knew the purpose of my study. They understood that the main aim was to discover the truth and uncover what happens behind the scenes in order to improve care provided for unconscious patients. Being one of them, they felt comfortable with my presence as they knew that I would not cause them any harm and hence they were very cooperative and informative. Sometimes, I had to be in participant as observer role in order to be less engaged in nursing care delivery and focus on the points I wanted to observe.

The researcher conducted approximately 150 hours of participant observation in the hospital critical care unit. Most of the observations were during the day shifts. Each of the nurses I observed was interviewed within one to two days after the observation day. Each nurse was interviewed for 15 to 25 minutes in the head nurse room or in nurses time-off room.

Trustworthiness of Research Data

Lincoln and Guba (1985) emphasized the importance of trustworthiness for a research study to evaluate its worth. Trustworthiness involves establishing:

Credibility

For the purpose of credibility the researcher did data collection triangulation and member checking. Triangulation was accomplished by using two methods of data collection to answer the research questions which were doing field observation and conducting interviews with the participants. Member check was done by making a summary of the interview and observation notes and discussing these with the participant after finishing the interview.

Dependability

Equivalent to reliability in quantitative methods, the researcher established dependability by discussing and agreeing on data analysis with the supervisor and with nurses who gave their opinions

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

regarding the themes I concluded from the data. The research committee is considered part of the external audit done in this research.

Transferability

Transferability is similar to generalization of the study findings to other situations and contexts. Collecting data using thick description of the settings and participants as well as using two methods of data collection could help the readers be understand the context of the study and judge whether these are similar to other contexts of interest. The researcher detailed the process of data collection, data analysis, and interpretation of the data. The researcher recorded what topics were unique and interesting during the data collection, wrote down thoughts about coding, provided a rationale for merging codes together, and explained what the themes mean to help other researchers in making decisions regarding similarities or differences of contexts.

Confirmability

Confirmability, corresponding to objectivity in quantitative methods, was achieved via admitting the researcher's and the study's shortcoming and limitations of the methods utilized to overcome these. This is achieved through awareness of my role as complete participant observer and by using reflexivity whenever indicated.

Data Analysis

Ethnographic analysis uses an iterative process in which cultural ideas that arise during active involvement "in the field" are transformed, translated, or represented in a written document. It involves sifting and sorting through pieces of data to detect and interpret thematic categorizations, search for inconsistencies and contradictions, and generate conclusions about what is happening and why.

This analysis comprises two parts: (1) Field observational notes analysis and (2) analysis of interview encounters with nurses. In this analysis, the researcher used Saldaña and Omasta, 2018 methods for analyzing qualitative field notes. Saldaña and Omasta's method of analysis depends on noticing people's patterns of interactions in human constructions and concepts.

The researcher notices the repetition in human actions and thus labels them as routines, rituals, rules. Roles and relationship also maintain repetitive actions according to function and purpose. Before starting the analysis the researcher will give an explanation of the terms used in order to understand the analysis. The method of analysis chosen for the interviews was thematic analysis. Generally, thematic analysis is the most widely used qualitative approach to analyzing interviews. The conceptual framework of the thematic analysis for my interviews was mainly built upon the theoretical positions of Braun and Clarke (2006). According to them, thematic analysis is a method used for identifying, analyzing, and reporting patterns (themes) within the data. The reason I chose this method was that 'rigorous thematic approach can produce an insightful analysis that answers particular research questions' (Braun and Clarke, 2006, p.97).

Handwritten notes and memos taken from the field were transcribed and analyzed using Saldaña and Omasta's methods of writing observation comments and analysis of these notes. Then, Observational comments were transferred to the computer. The researcher wrote the descriptive notes then made the reflective notes based on the analysis of the observation note. For interviews, the researcher herself did the transcriptions and translations from Arabic to English. Translation was validated with another bilingual translator to make sure that data meaning was not lost. Codes were identified, followed by categories and themes . Decisions were discussed with my supervisor to agree on a final theme that may reflect the phenomenon on interest and that is based on my orientation with the literature.

This chapter provides an overview of the methodology and methods used in this study. It describes the study design, population and sampling methods, ethical considerations, data collection procedures and data trustworthiness.

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

RESULTS AND DISCUSSION

Descriptive Statistics

Thirteen nurses who were observed during nurse-patient interactions were selected for the interviews using maximum variation. There were six female and seven male nurses with a maximum age of 35 years and a minimum of 23 years. The mean age of nurses was 28 years. All nurses were registered nurses holding a bachelor degree and working in the intensive care units. The mean number of years of experience in nursing was six years, and a mean of five years of experience in intensive care units.

Table 1. *Demographics*

Variable	M (SD)	N (%)
Age	28.61 (4.2)	
Nurses experience in nursing	6.00(3.3)	
Nurses experience in ICU	5.15 (3.893)	
Gender		
Male		7 (46%)
Female		6(54%)

Qualitative Data Analysis/ Extraction of Themes

This analysis comprises two parts: (1) Analysis of the field observational notes and (2) analysis of interview encountered with nurses. In this analysis, the researcher used Saldaña and Omasta, 2018 methods for analyzing qualitative field notes. Saldaña and Omasta's method of analysis depends on noticing people's patterns of interactions in human constructions and concepts.

The researcher notices the repetition in human actions and thus labels them as routines, rituals, rules. Roles and relationships also maintain repetitive actions according to function and purpose. Before starting the analysis the researcher will give an explanation of the terms used in order to understand the analysis.

Actions are what a person does (e.g., thinking, speaking or moving), and in this research, it is the nurses and patients' actions and interactions in the care process.

Reactions are the responses to an action to someone else or one's own action, and in this research, it is the responses of unconscious patients to nurses' actions.

Interactions are the collective back and forth sequences of action and reaction, and in this research, it is the interaction between unconscious patients and nurses.

Routines are the actions that take care of the everyday business of living, symbolize our cultivated and socialized habits and meet our human needs to create a sense of order, and in this research, it is the routines of nursing care with unconscious patients which might include oral care, eye care, changing position, feeding and giving medications.

Rituals are the occasional non-routine moments of action that seem to suggest meaningful importance or significance to the participant or to the observer. It could be right or wrong and in this research, it is nurses' patterns of significance and caring practices pertaining to patient's spirituality.

Rules is where most routines and rituals are influenced by rules. Rules are based on traditions, morals, values, attitudes and belief systems.

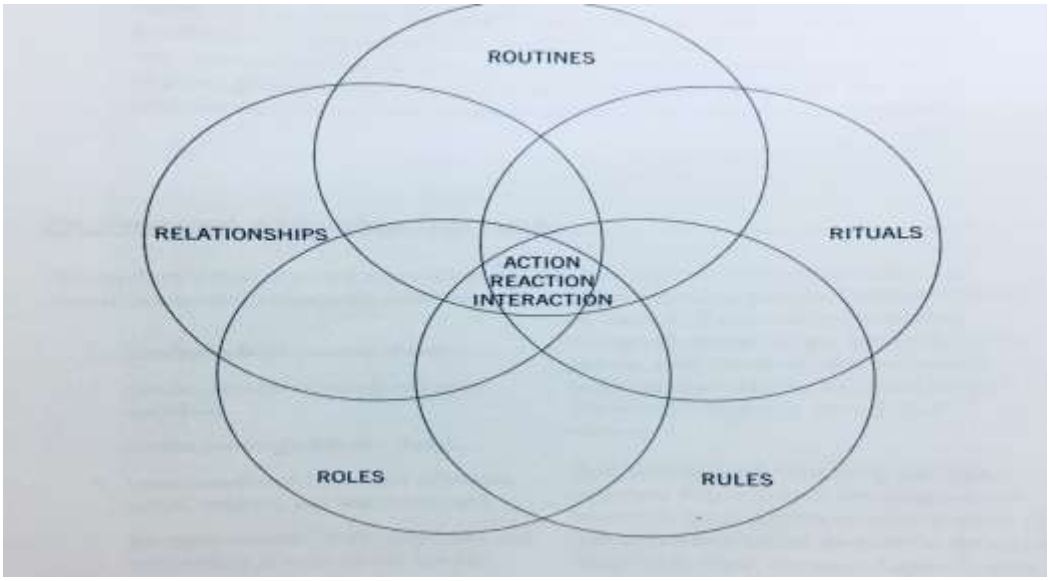
Roles are the assumed or attributed actions, personas and characteristics of individuals.

Relationships is how people act, react and specially interact with each other in various social contexts.

According to Saldaña and Omasta (2018) the individual in social interaction experiences a tightly interwoven nucleus of action, reaction, and interaction patterns within the interrelated five R's (Routines, Rituals, Rules, Roles, and Relationships (See Saldaña' and Omasta's model, 2018, p22) (Figure 1-1)

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

Adopted from Saldaña and Omasta's model, 2018, p. 22



Action-Reaction Patterns: Verbal Interaction with Unconscious Patient and its Violations

My observations of nursing actions and reactions include moments of occurrences that happened around the clock and the different types and procedural activities that took place during nurse-patient interactions. When I was mingling with nurses, I noticed that some nurses talk about their personal life while working with unconscious patients. These actions, done by nurses, come from the fact that the process of communication is usually one-way communication that is unidirectional. It seems that it is difficult, probably did not make sense, for critical care nurses to talk to unconscious patients who are not responsive to their actions. The nurses looked bored with this one-direction care, and thus, they were trying to break this silence by sharing personal information with other nearby nurses.

I heard ICU nurses say negative comments about patients, and sometimes they talked to each other about the patient's results and worsening health condition ignoring his/her presence, let alone the voice tone which signified complete disregard of the patient's feelings or existence in the room.

Unfortunately, patients were unable to show any reaction to nurses' talks, which enhanced nurses behavior and allowed them to proceed in this kind of conversation about the patient. Although the main focus of this study was the observation of nurses actions and reactions, I thought that patients' responses in interactions is also important even if I was not able to detect it as frequently as I wanted. Reactions of unconscious patients may be rare or non-existent. Not being able to see patient's reaction does not mean that it did not happen. It is documented in the literature that some patients feel and sense what happens to them and each patient has his own individualized way of expressing it Leigh (2001). Using Saldaña and Omasta's definition of reaction in this context, here I refer to an unconscious patient's response to a critical care nurse's actions. During my observations, I did not notice any reaction by patients I observed; but, as an observer, even minor gestures can be a clue to something meaningful. I have noticed that some patients got more rigid and spastic when a nurse touched their body or changed their position. Although such a reaction can be a muscular or nervous response to touch stimulus, however, this can be considered a response to an act. In my observations, I realized that some patients blinked during eye care, and others had tears in their eyes in response to suctioning procedures.

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

Routine Patterns of Nursing Care for Unconscious Patients and its Violations

According to Saldaña and Omasta, routines are the actions that we do in our everyday living. These are actions that reflect our habits and create a sense of order in our lives. It is not only the routines that matter to us, but also the violations of these routines can be a significant information for us to understand (Saldaña and Omasta, 2018). In ICU, there are routine nursing activities that I observed. Most importantly, I observed the everyday and every shift routine tasks carried out by nurses. Some of these tasks involved checking intravenous lines, gastric tubes, tracheotomies and skin care procedures. Oral care, eye care, patient bathing and hygiene, suctioning endotracheal tubes and changing position are some of the routine tasks that nurses did more frequently. Watching ICU nurses' interactions with unconscious patients in ICU triggered my interest in comparing that with nurses' interactions with conscious patients. I noticed that nurses spend more time with conscious patients in the morning. They addressed patients with their names and greeted them in the morning. They asked them about how they feel during their stay in the ICU and whether they have complaints about their stay or care. I know that this was not part of what I should be observing, but I could not help not noticing this. Also, I noticed that nurses spend good amount of time trying to explain procedures to conscious patients and answering their questions. This observation emphasized that what is a routine regarding verbal interaction with conscious patients does not apply to care with unconscious patients. Contrastingly, in giving care to unconscious patients, nurses had an entirely different approach to care starting from the moment they enter the room, until they leave. This also involved their communication with the patient's family who happen to be present during giving care.

During the shift reports, the night shift nurse would fully endorse the patient for the day shift nurse. Endorsement usually happens at the bedside and a patient would hear the nurses report. A nurse would walk towards the head of the bed, check the intravenous line, the fluids the patient is taking and the available medication without even looking at the patient. These steps do not take more than 5 to 10 minutes and she/he is gone out of the room. This also goes for all procedures they perform to unconscious patients, including taking vitals, inserting IV or withdrawing blood samples.

Nurses did not spend time the way they spent with conscious patients. For the verbal and non-verbal interactions with unconscious patients, I was confused whether to call it a routine or a ritual. Rituals happen occasionally and it doesn't have to mean something positive. Rituals can be negative and have adverse consequences. Most of the ICU nurses have ignored morning or evening greetings or introducing themselves to their assigned patients. None of the nurses I observed explained a procedure to unconscious patients as they did so for the conscious ones. When nurses were busy working with unconscious patients, I noticed that they can easily forget to do eye contact with patients during procedures. Nurses do not take notice of patient's responses and facial expressions. I do believe that they do so because they don't expect to have a response from the patient.

Doing procedures for conscious patients has its own rules. Pulling the curtains, asking for permission, asking the visitors to leave the room and then explain the procedure to the patient are examples of these rules. Doing this, usually, takes some time to complete, but this was not the same for an unconscious patient. It was done quickly, and rules such as privacy and confidentiality did not apply to them. Sometimes, Patients were left uncovered and privacy such as pulling the curtains was not maintained. Patient were treated like objects and disembodied. The nurses moved patients' arms, legs and head as if they were moving an object with no feelings. They failed to handle their patients properly. A patient was startled as they abruptly raised his/her hand for measuring blood pressure or take a blood sample. They forgot about the meaning or use of therapeutic touch with patients. Besides these uncaring behaviors, nurses showed facial expressions that manifested disgust, blank flat look, or even throwing up appearances during giving care to unconscious patients.

Ritual Patterns of Nursing Care with Unconscious Patient and its Violations

Rituals are the non-routine occasional actions that stand out as different from other everyday actions (Saldaña and Omasta, 2018). These can be ceremonial activities in time of transition, remembrance,

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

fulfillment or achievement. In the case of unconsciousness, nurses showed various non-routine caring behaviors as they provided care. Nurses attended to rituals according to patients' preferences. They showed an understanding and communicated with a patient's family based on respect of patients' religious and cultural beliefs.

On the other hand, there was some violation for those rituals. I heard families telling nurses about their patient spiritual preferences, yet, these were neglected because it was not within their plan of care or interest. I also witnessed nurses who play Quran tape recording beside the patients when the family told them that the patients likes to hear Quran and by doing this they showed respect for the patient's religious rituals.

Rules of Nursing Care for Unconscious Patients and its Violations

According to Saldaña and Omasta (2018), most of our daily life activities are controlled by underlying rules. The guidelines of nursing practice and its rules provide safe parameters within which to work, as well as protect patients from unprofessional and unsafe nursing practice. Respecting patient and families, preserving patient safety, protecting patient's rights, doing procedures according to protocols and being an advocate for the patients are rules that govern nurses' actions with unconscious patients. Some of these protocols and rules mean that you should not take calls while in patients' rooms, and you should not leave the side rails down claiming that unconscious patients do not move. These are basic safety rules that should be followed as they should be. For example, when you take a blood sample, you must explain the procedure to a patient, take permission, wipe the patient's hand with alcohol and then take the blood sample.

The violation of rules during nursing an unconscious patient was obvious when I saw some nurses neglect sterility in sterile procedures. They forget to wipe patient arms with alcohol before blood sampling. They sometimes forget to change patient position and sometimes they neglect patient hygiene. Some relatives reported that their mother smells bad and that was the time when nurses were obligated to more attention to patients' hygiene. I watched relatives who were afraid to leave their loved ones because they don't trust nursing care. I watched family who changed their father's position every two hours because the staff were busy or sometimes they forget to do it. Mouth care and eye care were often neglected.

Giving medication is one of the important roles of nurses. However, very often, nurses miss giving medication dose on time. Some nurses did not give patients their laxative medications because they wanted to avoid giving them skin hygiene care after a bowel motion.

Privacy and dignity rules were also broken by nurses when doing nursing procedures. They often forget to tell visitors and relatives to leave the room while doing a procedure. One time I heard the nurse in charge giving advice to another nurse telling her to ask the family to leave the room and come back later after she withdraws a blood sample. This advice was in order to protect the nurse from being criticized by the family in case she committed a mistake. Therefore, and for similar situations I figured out that the main safety and privacy principle in nursing care was to protect nurses first and the patient comes next.

Roles and Relationship Patterns and a Critique of these Patterns

Individuals as well as institutions have certain expected roles to play. Most of us play different roles depending on where we are. These roles can possess various levels of status (Saldaña & Omasta, 2018, p.19). Health professionals undertake a specific role that is attributed to them based on their specialty, academic level, expertise and administrative or clinical status in the health institution. In nurse patient encounters, nurses may undertake multiple roles depending on their interpretations of their roles. This role can be a consultative, helping egalitarian role where there is a belief in the equality of all people, especially in political, economic or social life, versus an authoritarian dominant role in which the nurse assumes authority over the patient. When a patient comes to critical care unit in crises situation, he or she loses the role that was taken before he got sick. This role could be a father, husband, wife, daughter, mother or son. We also have many other roles including being a teacher, a student, a doctor and many others that are earned during the course of our life in the society.

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

Interaction is how relationships get constructed. They are collection of actions and reactions in social contexts. Saldaña and Omasta (2018) explained that relationships depend on the attitude one holds toward another person, group, or institution. This relationship signifies the culturally constructed sense of community, family group, and membership, and in this case, it reflects the nurse-patient relationship with the embedded meanings held by nurses toward unconsciousness. In this study, the relationship between the nurse and an unconscious patient is poorly developed because of poor interactions. The development of this relationship is dependent in its entirety on nurses understanding of unconsciousness, because it is nurses who initiate it and end it. During my observations, I noticed the complexity and arduousness of this relationship. What I mean by complexity is the difficulty of perceiving each other's intentions and feelings without using some language or mode of communication. Nurses are more authoritarian in this relationship as they control the whole process of interaction. As for the meaning of an arduous nurse-patient relationship, here I refer to the strenuous physical and mental efforts that nurses have to use to understand their patients' needs and feelings. Nurses are duty-bound to use all measures of verbal and non-verbal methods to stimulate an unconscious patient, without despair. My observations of nurses working with unconscious patients, informed me of their perplexing feelings of helplessness and hopefulness, sympathy and empathy, exhaustion and flatness, feelings that I cannot explain.

4-4 Interview Analysis

Thirteen nurses were interviewed in their work settings using four open-ended questions to guide my inquiry. I approached each nurse after the observation period immediately or the day after the observation to make sure that I still recall the notes I jotted in my field notes. Each interview took between 15 and 25 minutes.

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?

Ten out of the thirteen nurses answered that they would choose to work with unconscious patients to avoid what most of them called a 'demanding patient'.

Nurses said: "conscious patients keep asking for trivial help such as to bring them some water to drink, their nearby phone to call their family, or their tooth brush; things that they can do on their own without assistance" (ICU nurse 1, 6, 8)

Another nurse said: "These are patients who nag very often, complain a lot, ask too many questions, and need to have nurses available immediately as they call them. This type of patients is usually anxious and is easily panicked most of the time" (ICU nurse 3. 11. 12)

Another nurse added "when you want to do a procedure for a conscious patient you have to be careful. If you failed during his cannulation even if it was your first trial they would yell at you and call the senior nurse to replace you with another nurse. Also, some of them would not respect you and most of the time he or she does not use the word 'thank you' or 'please'(ICU nurse 4, 7, 8)

The reasons given by nurses to indicate their preference for working with unconscious patients were:

1. **Not working under stress and avoiding headaches.**

"Unconscious patients can't hear you or see you, they do not exist" (ICU nurse 1, 4, 6)

"Unconscious patients don't talk so they will not cause you a headache" (ICU nurse 11, 12, 13)

"You can miss his medication time or his meals without having someone nagging on your head for his medications or meals" (ICU nurse 1, 2, 3)

"Those patients do not have emotions to be expressed so you don't have to listen to them" (ICU nurse 2, 3, 11)

"They cannot complain about a nurse to the in-charge nurse, so you can do whatever you want" (ICU nurse 6, 9, 12)

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

"During procedures, you could stick the patient as much as you want without complaints" (ICU nurse 3, 4, 7)

"I feel more relaxed and comfortable applying a cannula to an unconscious patient rather than a conscious one" (ICU nurse 5, 6, 7)

2. Care of physical needs only

"With unconscious patients, you have only physical needs to take care of; you are not worried about him whether angry or unhappy, you don't consider these because they can't express it" (ICU nurse 1, 2)

"Unconscious patients don't have emotions or feelings so you only need to provide physical care". (ICU nurse 1, 5, 9)

3. I'm free to do what I like to do, no constraints

"I can leave the patient anytime I want without complaints from the patients" (ICU nurse 4. 11, 13)

"I can take breaks as much as I want" (ICU nurse 2, 3, 4)

"I can talk to my colleagues in front of the patient without worries about being annoying to him and I can talk about my personal issues too" (ICU nurse 6, 7, 8)

My *second question* was about nurses' definition of an unconscious patient. The nurses' definitions shared emotionless meanings such as 'being non-existing people' and 'difficult to deal with'. Some of the responses are summarized under the following headings:

1. Unconscious patients are dead people, emotionless, and under our control

"Unconscious patients are dead" (ICU nurse 2, 3, 4)

" unconscious patients don't feel their presence; they don't have emotions to express or psychological needs that need to be met" (ICU nurse 2, 7, 8)

"They are dead; the only difference is that they still have blood circulation which we could end if we stopped their medication" (ICU nurse 1, 3, 5)

2. Hard to communicate with

"It's hard to communicate with unconscious patients because they can't talk back or express themselves" (ICU nurse 4, 8, 12, 13)

"I feel frustrated and emotionally overwhelmed when I work with unconscious patients because it's hard to communicate with them" (ICU nurse 2, 11, 13)

"I prefer working with conscious patients because you can communicate with them easily, and get some feedback for the things you do for them" (ICU nurse 2, 4, 12)

The *third question* was about whether nurses attended to issues of importance in nursing practice such as addressing patients by their names or explaining procedures to take patients' consent. Nurses responses ranged between feelings of embarrassment or feelings of 'being stupid' to do so in front of their colleagues, and doing this just to please the family rather than out of commitment to their ethical standards of care or for patient's sake. Some of the given reasons are explained in the following quotes:

1. Others would call me mad

"If I called a patient with his name like asking: Abu Mohammad, how do you feel today? (كيفك أبو محمد) my colleagues would laugh at me and would call me crazy" (ICU nurse 2, 3, 4)

"Relatives would appreciate it but other care health providers would say I'm stupid to do this" (ICU nurse 4, 5, 13)

2. Unconscious patients have no such rights, it's a waste of time

"Explaining a procedure to an unconscious patient is a waste of time because you don't need the patient consent for it, he has no choice but to accept it because we are trying to save his life" (ICU nurse 7, 9, 13)

"Unconscious patients have no such rights of taking their approval for doing procedures" (ICU nurse 9, 10, 13)

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

3. **Being courteous 'only' during family presence**

"When family is there, we try to make them believe of the presence of their loved one to support this family, so we call their loved one by their names, so they can feel that the patient still exists" (ICU nurse 5,7, 8)

"I call an unconscious patient by his name if the family is around him/her, so they would commend or praise me for this because they like to see this happening it" (ICU nurse 2, 3, 9)

4. **Negative peer pressure**

"When I was newly employed at the ICU, I used to call patients by their names. Nurses told me it was useless with no positive consequences. However, calling patients with their names helped me feel the humanity of nursing. On the other hand, and over time, my colleagues' discouragement of this behavior took over and I stopped acting like they do. Initially, you try to resist and fight back, but at the end you accept as it becomes a habit or routine of work" (ICU nurse 2, 3, 4)

The *fourth question* was about nurses' explanation for the reasons behind why nurses have less than adequate or poor interactions with unconscious patients. Some of the given reasons are explained in the following quotes:

1. **Workload**

"You have a lot of work. When you have three patients you can't find time for talking with unconscious patients" (ICU nurse 8, 9, 13)

2. **Lack of knowledge**

"Nurses don't recognize the importance of talking to these vulnerable patients" (ICU nurse 1, 12, 13)

"Nurses are not aware that they should communicate with those patients" (ICU nurse 6, 7)

3. **Absence of accountability/conscientiousness**

"No one is watching. I do think that if hospital administration demonstrates some emphasis on this issue and enforce the need to communicate with unconscious patients, then nursing staff would follow. It depends on administration" (ICU nurse 4, 5)

4. **Lack of administration recognition and external locus of control:**

Nurses are driven by the administration. Monitoring and sense of responsibility is externally controlled. One nurse said: "We care about what other people say about us. If we do something good we want it recognized by the head nurse or administration. So, why do good if you don't get a positive feedback to recognize your efforts in the first place" (ICU nurse 4)

5. **Lack of teaching opportunities about the importance of communication with unconscious patients**

"They did not teach us in the general orientation program about this and the department skills inventory do not include communication with unconscious patients" (ICU nurse 2, 3, 4)

"I did not learn about this at the university nor at work to guide me about how to communicate with unconscious patients" (ICU nurse 2, 3, 4, 6, 7)

The above themes discussed under the findings were explained in terms of the four questions raised during the interviews. The four questions elucidated the definitions and the meanings that nurses have toward unconscious patients and the care needed for these patients. Nurses who answered my questions were generous and honest about their feelings and needs for training to give better quality of care to unconscious patients.

This chapter provides the main findings of this research. The results showed the interaction provided by ICU nurses in the hospital for unconscious patients. Some violations were happening to the nurses' five Rs in the care process, but as the researcher discovered, the main reasons provided by all nurses were due to a lack of knowledge and workload. Hospitals and universities should focus more on the education and the nurse-patient ratio for better quality of care.

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

One of the main findings was that ICU nurses think that calling unconscious patients with their name and explaining a procedure to them is an irrational act because unconscious patients cannot hear them, and thus, no point in calling an unconscious patient with his or her name. They are afraid that they may be called mad. This conception is similar to what Elliott and Wright (1999) reported that critical care nurses did not provide any comprehensive explanations about the surrounding environment or social world or what they were going to do to their patients.

Green (1996) emphasizes the importance of effective communication, during which nurses individualize care by addressing the patient by name and meeting his or her needs. he suggests that if health professionals use patients' names in an informative and caring manner, the resulting increased levels of conversation might raise patients' consciousness levels and boost their chances of survival. Additionally, Holeckova (2006) explains that verbal communication helps to stimulate the brain's reticular activating system, which is a complex network centered on a person's arousal, thus maintaining a conscious state.

This study revealed that verbal communications between critical care nurses' and unconscious patients is not as effective as it should be. My observations showed that verbal communication was often violated by instances of nurses talking around unconscious patients about their own issues or about other patient conditions or reports of bad results about the patient situation. This result is in agreement with Baker (1996) and Elliot (1999) results who revealed situations in which nurses were conversing about doctors' plans of withdrawing treatment from the patient because he is not going to make it. They considered this as an unethical and referred this to nurses lack the understanding of the importance of communication with unconscious patients.

One important finding of this study is nurses' beliefs about unconscious patients care needs. Critical care nurses believe that physical needs are the only needs to be considered when caring for unconscious patients. During the interviews nurses said "With unconscious patients, you have only physical needs to take care of; you are not worried about him whether angry or unhappy, you don't consider these because they can't express it". This important emerging theme from the interviews is congruent with Ashworth (1980) which referred to the belief that unconscious patients do not have emotions or feelings that need to be expressed. Ashworth found that communication problems were closely linked to an emphasis on physical care, which tended to dominate at the cost of orienting patients, giving reassurance and establishing social interaction. The researcher of the current study believe that ICU nurses tend to see their patients in light of a patient's health status on admission when he or she were in critical hemodynamically challenged condition with maximum physical needs for hemodynamic stability.

In one note in my observational comments I found that nurses had more frequent verbal communication with patients when the family was around their patient. This finding was also found by Baker (1995) who stated that the major factors influencing communication are the patient's level of consciousness, the amount of physical care being given, and the presence of relatives (Baker, 1995). In his study baker indicated that nurses would communicate more when visitors and families are around. This observation needs further exploration to understand the reasons behind such a phenomenon.

My observations of the non-verbal communication used by nurses revealed less than what is considered adequate caring. Some nurses I observed showed disgusted expressions as they carried certain procedures, e.g., suctioning, oral care. Nurses avoided eye contact with the patient during these procedures. Non-verbal communication, such as facial expressions, eye contact, posture, personal space and bodily contact, are important aspects of social interaction. Non-verbal communications are often the first elements of communication that help us to form quick impressions about someone (Webb 1994). For patients with impaired consciousness, touch combined with kind and comforting words can be valuable means of providing reassurance. Elliott and Wright (1999) concluded from their studies of nurse-patient communication that the nurse's level of interaction with patients is determined by the level of the patient's responsiveness, when the patient is more conscious they were more able to communicate with them.

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

Regarding nurse-patient interactions, my observations of these encounters revealed that nurses used physical contact and touch only when providing specific nursing tasks such as changing position, washing, blood samples collection or cannula insertion. Nurses ignored the importance of using therapeutic touch as enhancing communication and providing reassurance. Verity (1996) emphasizes that caring touch, used with speech, can enhance the messages patients receive. Dyer (1995) suggest that touch should be recognized as a valuable form of communication as it reassures unconscious patients, thereby reducing psychological anxiety. Studies by Leigh, (2001) and Lawrence (1995) emphasize that tactile stimulation conveys emotional support. Others would argue that using touch is not recommended because ICU nurses who do this would invade their patients' personal space.

Territoriality is a universal human need (Hayter, 1981). An adult needs to have his/her own 'personal space' which is entered by others only with permission. Yet, in a critical care situation an individual's actual body is intruded by many others who, at least in the beginning, are strangers. Not only are patients' bodies exposed, but vital and private functions such as urination (via catheter) and cardiac function may be on constant inspection to anyone on the unit. During the observation nurses performed procedures in front of other people. Some patients were left uncovered by ICU nurses during procedure or after blood samples withdrawal.

During the short time I observed nurses through the night shift I noticed that nurses forget to turn the lights off. It may be assumed that unconscious patients do not go into sleep while in ICU, and the nursing staff act as if sleep was not essential for these patients. Disregarding patients sleep signifies ICU nurses lack the understanding of the importance of this biological rhythm for unconscious patients. There have been recommendations that lights should be dimmed at night, and activities planned as much as possible to fit a day-night rhythm. The need for patients to sleep should be better recognized (Dlin et al, 1971).

To care for a critically ill patient who is aware and conscious was not a favorable choice for most of the nurses in the current study. As reported by ICU nurses, these patients are demanding and disrespectful to nurses. These findings are consistent with a study conducted in Jordan by Alasad (2005), in which ICU nurses preferred to work with unconscious patients because they feel more comfortable and not under pressure. They also expressed that they feel un-restrained and their work is limited to providing physical care needs and nothing more.

An important observation was my note of nurses dehumanizing behavior as they moved and dealt with unconscious patients. Ashworth (1987) explained that ICU patients' self-esteem and personal identities and social integrity may not be maintained. They feel unloved and un important as they are disembodied and treated as bodies attached to machines. Ashworth also adds that unconscious patients' self-esteem is lost as they become helpless and lose control over their bodies. The ICU nurses hold the power and they control the patient.

One more need that is lacking for unconscious patients' care is the need for spiritual health care. Spiritual care includes giving a sense of hope, meaning and purpose. The current study showed that some nurses attended to the family's request and placed the Quran near to the patient's head, while some others just ignored the family's preferences. Spiritual health brings more power to our physical health when it is provided in situations of critical illness.; Doug- las, (1982) explained the importance of acknowledging patients spiritual needs and put more efforts in meeting these needs. In other words, if a person usually practice certain praying rituals or reading from holy scriptures, then ICU nurses should provide these patients and their families with the opportunity to do so.

Interviewing nurses revealed some perceived explanations for the inadequate interaction with unconscious patients. Reasons included workload, lack of knowledge, loss of control, absence of accountability, and no educational opportunities about how to communicate with unconscious patients. This result is congruent with Baker (1996) who stated that limited knowledge and lack of motivation are reasons for nurses' lack of communication with unconscious patients. It is also in congruence with Ashwarts (1980) and Nievaard (1987) who found that work environment, limited knowledge about unconscious patients

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

needs, and the importance of the communication with unconscious patients are possible reasons for why nurses don't communicate enough with their patients. During a busy shift, it can be a challenge to meet the needs of every patient. Unresponsive patients should receive equal care, including communication. Nurses should know that hearing is the last sense to disappear, and they should talk to the patient in a respectful and caring manner.

As a final note in this discussion, I would like to conclude with an important closing. I have observed that actions do not match thoughts or words always. Some of the nurses claimed that they do certain things in giving care to unconscious patients; however, this was not the case as I observed. During my data collection, three of the nurses stated that nurses should call unconscious patients by their names and it is very important; but during the observation those nurses did not call patients by their names. This may be explained as either not being used to do as a routine thing and thus forgotten about it it, or just ignored to do it because they do not believe in doing it. In reference to Baker (1996) as stated in his article 'if it was important they won't miss it even when the observer is around them'. This needs to be further researched and investigated.

Recommendations

- ***For Practice***
  - Critical care nurses should strengthen their interactions with unconscious patients by addressing not only their physical needs but also their psychological and spiritual well-being. Nurses working in intensive care units should be provided with specialized training and continuous education programs to enhance their communication and interaction skills. Furthermore, they should be made fully aware of unconscious patients' rights to dignity, privacy, safety, and confidentiality to ensure holistic and patient-centered care.
- ***For Nursing Education***
  - Undergraduate and postgraduate critical care nursing programs should place greater emphasis on communication and interaction with unconscious patients. Student nurses should receive specialized training and sufficient clinical exposure in intensive care units to develop the knowledge, skills, and competencies necessary for providing holistic care to unconscious patients.
- ***For Research***
  - Future studies should validate the findings of this research by involving larger sample sizes and employing different research methodologies. Additional research is also recommended to further examine nurses' interaction skills and determine how effective communication with unconscious patients influences their recovery, overall health outcomes, and quality of care.

Limitations of the Study

The observer effect is one of the limitations for this study. Observer effect could have some positive or negative consequences. Having previous ideas about critical care nurses in the ICU and their communication helped the researcher gain more understanding about the situation. On the other hand, the presence of an observer could affect nurse's behaviors resulting in certain biases related to observer's effect. The researcher needs to have the skills of observation and be alert at all times. Observations require good concentration span when observing and recording significant events. Furthermore, the problem of 'what to observe' is of great importance to researchers especially at the beginning. Another potential problem is the noise and the work environment. During the interviews, there were many interruptions and challenges that needed to be addressed to obtain trustworthy data.

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

CONCLUSIONS

Unconscious patients in critical care units are compromised in their ability to communicate. Generally, their inability to talk put them at a disadvantage as they cannot express their needs and thus needs go unmet, resulting in further complications of their health condition. ICU nurses spend a long time caring for unconscious patients, thus they are entitled to provide holistic care comprising physical, psychological and spiritual care including effective interactions with patients and their families.

Observation field notes and interviews uncovered nursing practices that need to be modified for the sake of protecting unconscious patients' rights to safety and dignity. Hospital administration and schools of nursing have an obligation to give more emphasis to training nurses and health professionals toward these rights and to develop policies that protect unconscious patients from malpractice and negligence.

References

Abutarbush, S. M. (2008). Saunders comprehensive veterinary dictionary [Review of the book *Saunders comprehensive veterinary dictionary*, by V. P. Studdert, C. C. Gay, & D. C. Blood]. *The Canadian Veterinary Journal*, *49*(9), 906.

Aguilera, D. C. (1967). Relationship between physical contact and verbal interaction between nurses and patients. *Journal of Psychiatric Nursing and Mental Health Services*, *5*(1), 5–13.

Alasad, J., & Ahmad, M. (2005). Communication with critically ill patients. *Journal of Advanced Nursing*, *50*(4), 356–362. https://doi.org/10.1111/j.1365-2648.2005.03400.x

Ashworth, P. M. (1980). *Care to communicate: An investigation into problems of communication between patients and nurses in intensive therapy units*. Royal College of Nursing of the United Kingdom.

Ashworth, P. M. (1984). Staff-patient communication in coronary care units. *Journal of Advanced Nursing*, *9*(1), 35–42. https://doi.org/10.1111/j.1365-2648.1984.tb00342.x

Ashworth, P. M. (1987). The needs of the critically ill patient. *Intensive Care Nursing*, *3*(4), 182–190. https://doi.org/10.1016/0266-612X(87)90008-8

Baker, C., & Melby, V. (1999). An investigation into the attitudes and practices of intensive care nurses towards verbal communication with unconscious patients. *Journal of Advanced Nursing*, *29*(6), 1412–1420. https://doi.org/10.1046/j.1365-2648.1999.01024.x

Bogdan, R. C., & Biklen, S. K. (1992). *Qualitative research for education: An introduction to theory and methods* (2nd ed.). Allyn & Bacon.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Creswell, J. W. (2010). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* (2nd ed.). Pearson Education.

Creswell, J. W. (2012). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* (4th ed.). Pearson Education.

Darmann, I. (2002). Bewegung als Interaktion – Systemisch-konstruktivistische Sichtweise von Bewegung und Konsequenzen für die Pflege [Movement as interaction – Systemic-constructivist view of movement and consequences for nursing]. *Pflege*, *15*(5), 181–186. https://doi.org/10.1024/1012-5302.15.5.181

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2011). *The Sage handbook of qualitative research* (4th ed.). Sage Publications.

Dlin, B. M., Rosen, H., Dickstein, K., Lyons, J. W., & Fischer, H. K. (1971). The problems of sleep and rest in the ICU. *Psychosomatics*, *12*(3), 155–163. https://doi.org/10.1016/S0033-3182(71)71520-2

Douglas, A. M. (1982). *The ICU environment: Directions for nursing*. Reston Publishing.

Dyer, I. (1995). Preventing the ITU syndrome or how not to torture an ITU patient. Part 1. *Intensive and Critical Care Nursing*, *11*(3), 223–232. https://doi.org/10.1016/0964-3397(95)90007-1

Elliott, R., & Wright, L. (1999). Verbal communication: What do critical care nurses say to their unconscious or sedated patients? *Journal of Advanced Nursing*, *29*(6), 1412–1420. https://doi.org/10.1046/j.1365-2648.1999.01024.x

Fetterman, D. M. (2010). *Ethnography: Step-by-step* (3rd ed., Vol. 17). Sage Publications.
Fleischer, S., Berg, A., Zimmermann, M., Wüste, K., & Behrens, J. (2009). Nurse-patient interaction and communication: A systematic literature review. *Journal of Public Health*, *17*(5), 339–353. https://doi.org/10.1007/s10389-009-0269-x
Green, A. (1996). An exploratory study of patients' memory recall of their stay in an adult intensive therapy unit. *Intensive and Critical Care Nursing*, *12*(3), 131–137. https://doi.org/10.1016/S0964-3397(96)80401-4
Hammersley, M., & Atkinson, P. (1995). *Ethnography: Principles in practice* (2nd ed.). Routledge.
Happ, M. B. (2001). Communicating with mechanically ventilated patients: State of the science. *AACN Advanced Critical Care*, *12*(2), 247–258. https://doi.org/10.1097/00044067-200105000-00010
Happ, M. B., Garrett, K., Thomas, D. D., Tate, J., George, E., Houze, M., Radtke, J., & Sereika, S. (2011). Nurse-patient communication interactions in the intensive care unit. *American Journal of Critical Care*, *20*(2), e28–e40. https://doi.org/10.4037/ajcc2011433
Hayden, J. K., Smiley, R. A., Alexander, M., Kardong-Edgren, S., & Jeffries, P. R. (2014). The NCSBN National Simulation Study: A longitudinal, randomized, controlled study replacing clinical hours with simulation in prelicensure nursing education. *Journal of Nursing Regulation*, *5*(2), C1–S64. https://doi.org/10.1016/S2155-8256(15)30062-4
Hayter, J. (1981). Territoriality as a universal need. *Journal of Advanced Nursing*, *6*(2), 79–85. https://doi.org/10.1111/j.1365-2648.1981.tb03201.x
Holeckova, I., Fischer, C., Giard, M. H., Delpuech, C., & Morlet, D. (2006). Brain responses to a subject's own name uttered by a familiar voice. *Brain Research*, *1082*(1), 142–152. https://doi.org/10.1016/j.brainres.2006.01.089
Hollinger, L. M., & Buschmann, M. B. T. (1993). Factors influencing the perception of touch by elderly nursing home residents and their health caregivers. *International Journal of Nursing Studies*, *30*(5), 445–461. https://doi.org/10.1016/0020-7489(93)90057-Q
Jesus, L. M. T. D., Simões, J. F. F. L., & Voegeli, D. (2013). Verbal communication with unconscious patients. *Acta Paulista de Enfermagem*, *26*(5), 506–513. https://doi.org/10.1590/S0103-21002013000500016
Jorgensen, D. L. (1989). *Participant observation: A methodology for human studies*. Sage Publications.
Knoblauch, H. (2005). Focused ethnography. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, *6*(3), Article 44. https://doi.org/10.17169/fqs-6.3.20
Kvale, S., & Brinkmann, S. (2009). *Interviews: Learning the craft of qualitative research* (2nd ed.). Sage Publications.
Lawrence, M. (1995). The unconscious experience. *American Journal of Critical Care*, *4*(3), 227–232. https://doi.org/10.4037/ajcc1995.4.3.227
Leigh, K. (2001). Communicating with unconscious patients. *Nursing Times*, *97*(48), 35–36.
Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage Publications.
Magnus, V. S., & Turkington, L. (2006). Communication interaction in ICU—Patient and staff experiences and perceptions. *Intensive and Critical Care Nursing*, *22*(3), 167–180. https://doi.org/10.1016/j.iccn.2005.09.009
Nordqvist, C. (2016). Coma: Causes, diagnosis and treatment. *Theory and Practice*, *37*(2), 229–248.
Norouzinia, R., Aghabarari, M., Shiri, M., Karimi, M., & Samami, E. (2016). Communication barriers perceived by nurses and patients. *Global Journal of Health Science*, *8*(6), 65–74. https://doi.org/10.5539/gjhs.v8n6p65
Oliver, S., & Redfern, S. (1992). Interpersonal communication between nurses and elderly patients: Refinement of an observation schedule. *Journal of Clinical Nursing*, *1*(2), 108–109. https://doi.org/10.1111/j.1365-2702.1992.tb00078.x
Othman, S. Y., & El-Hady, M. M. (2015). Effect of implementing structured communication messages on the clinical outcomes of unconscious patients. *Journal of Nursing Education and Practice*, *5*(9), 117–125. https://doi.org/10.5430/jnep.v5n9p117
Pinnegar, S., & Daynes, J. G. (2007). Locating narrative inquiry historically: Thematics in the turn to narrative. In D. J. Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a methodology* (pp. 3–34). Sage Publications. https://doi.org/10.4135/9781452226552.n1
Saldaña, J., & Omasta, M. (2018). *Qualitative research: Analyzing life*. Sage Publications.
Shattell, M. (2004). Nurse–patient interaction: A review of the literature. *Journal of Clinical Nursing*, *13*(6), 714–722. https://doi.org/10.1111/j.1365-2702.2004.00965.x

Slatore, C. G., Hansen, L., Ganzini, L., Press, N., Osborne, M. L., Chesnutt, M. S., & Mularski, R. A. (2012). Communication by nurses in the intensive care unit: Qualitative analysis of domains of patient-centered care. *American Journal of Critical Care*, *21*(6), 410–418. https://doi.org/10.4037/ajcc2012124

Verity, S. (1996). Communicating with sedated ventilated patients in intensive care: Focusing on the use of touch. *Intensive and Critical Care Nursing*, *12*(6), 354–358. https://doi.org/10.1016/S0964-3397(96)80603-7

Watson, J. (Ed.). (2008). *Assessing and measuring caring in nursing and health science* (2nd ed.). Springer Publishing Company.

Wyman-McGinty, W. (1998). The body in analysis: Authentic movement and witnessing in analytic practice. *Journal of Analytical Psychology*, *43*(2), 239–260. https://doi.org/10.1111/1465-5926.00019