

Holistic Care Practices of Intensive Care Unit Nurses in Private Hospitals of Cauayan City: Foundation for Nursing Professional Development Plan

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ABSTRACT

This study assessed the holistic care practices of intensive care unit (ICU) nurses in selected private hospitals in Cauayan City and used the findings as the foundation for a nursing professional development plan. A descriptive research design was employed. The respondents were 78 conscious ICU patients or patients' significant others from three private hospitals, all included through total enumeration during the three-month data-gathering period. Data were collected using a validated and reliable 25-item questionnaire adapted from an established holistic care instrument and organized into physiological, sociocultural, psychological, spiritual, and developmental domains. Frequency and percentage described respondent profiles, mean scores determined the level of holistic care practice, and the

Mann-Whitney U and Kruskal-Wallis H tests examined differences across profile variables. Holistic care was highly practiced overall ($M = 3.85$). Physiological care obtained the highest domain mean ($M = 3.94$), followed by sociocultural and psychological care (both $M = 3.90$), developmental care ($M = 3.77$), and spiritual care ($M = 3.74$). No significant differences were found in assessments when respondents were grouped according to age, sex, case or disease, and highest educational attainment. The findings indicate that ICU nurses consistently delivered multidimensional and patient-centered care across diverse respondent groups. A professional development plan was proposed to sustain clinical and sociocultural strengths while further enhancing spiritual support, developmental education, psychological care, and evidence-based critical care competencies.

Keywords: *critical care nursing, holistic care, intensive care unit, nursing professional development, patient-centered care, private hospitals*

INTRODUCTION

Holistic nursing is a comprehensive, patient-centered approach that addresses the interconnected physiological, psychological, sociocultural, spiritual, and developmental needs of the person. It extends beyond the treatment of disease by recognizing that healing and adaptation are influenced by the patient's physical condition, emotional responses, beliefs, relationships, developmental stage, and capacity to participate in care. This approach is especially relevant in intensive care units, where critical illness can threaten not only bodily function but also personal identity, dignity, family roles, and a sense of meaning.

Critical care nursing demands specialized knowledge, rapid clinical judgment, technical competence, and sustained compassionate engagement. ICU nurses continuously monitor unstable patients, perform complex interventions, support families, and respond to life-threatening changes. Although technology is indispensable in this environment, a predominantly task-oriented focus may leave psychosocial, spiritual, cultural, and educational

needs insufficiently addressed. Evidence therefore emphasizes the need to integrate clinical expertise with whole-person care so that patient safety, comfort, communication, dignity, and family participation remain central to ICU practice (Marshall et al., 2017; Poncette et al., 2020).

The delivery of holistic care may be constrained by high patient acuity, limited time, inadequate staffing, resource shortages, emotional strain, and competing responsibilities. Ambushe et al. (2023) found that organizational and professional factors influence nurses' ability to provide holistic nursing care, while Bruyneel et al. (2024) showed that staffing and work-environment conditions are associated with unfinished care, perceived quality, and nurse well-being in intensive care settings. These conditions suggest that professional competence alone is insufficient unless institutions provide systems that enable nurses to translate holistic principles into consistent bedside practice (Mousazadeh et al., 2019).

In selected private hospitals in Cauayan City, preliminary accounts from nurses indicated challenges related to high patient acuity, workload, emotional stress, time constraints, staffing, and resources. Despite these challenges, little local evidence documented how ICU patients and their significant others perceived nurses' holistic practices across multiple care domains. Assessing these perceptions is important because patient and family experiences provide direct evidence of whether whole-person principles are visible in actual care delivery.

Accordingly, this study assessed the holistic care practices rendered by ICU staff nurses in private hospitals in Cauayan City in terms of physiological, sociocultural, psychological, spiritual, and developmental aspects. It also examined whether assessments differed according to respondent age, sex, case or disease, and educational attainment. The findings were used as the foundation for a nursing professional development plan intended to sustain effective practices and strengthen areas requiring further enhancement.

Literature Review

Holistic nursing and critical care

Holistic care recognizes the patient as an integrated person rather than a collection of symptoms or organ systems. Frisch and Rabinowitsch (2019) described holistic and integrative nursing as approaches that combine attention to body, mind, relationships, environment, and meaning. Similarly, Jasemi et al. (2017) emphasized that holistic care involves awareness of the interdependence of biological, psychological, social, and spiritual dimensions. Within nursing, this perspective supports care that is technically competent while remaining responsive to the patient's values, preferences, coping patterns, and lived experience.

The study was guided by Faye G. Abdellah's 21 Nursing Problems Theory, which frames nursing as patient-centered problem solving directed toward physical, emotional, and sociological needs. The theory is consistent with the study's five domains because it views the nurse-patient relationship, common care needs, and the patient's total response to illness as interrelated. In an ICU, this orientation helps ensure that technological monitoring and life-sustaining treatment do not displace communication, comfort, dignity, family relationships, and individualized support.

Critical illness often places patients in unfamiliar and highly technical surroundings, where fear, dependence, isolation, pain, and uncertainty can intensify vulnerability. Marshall et al. (2017) described ICUs as settings that combine specialized care, continuous monitoring, and multiple forms of organ support. Because patient needs in these units are complex and rapidly changing, holistic practice requires nurses to integrate clinical surveillance with relational, emotional, cultural, and educational interventions.

Physiological and sociocultural dimensions of care

Physiological care is the foundation of critical care nursing. ICU nurses monitor vital functions, identify subtle deterioration, manage pain, perform physical assessments, administer treatments, and maintain continuity and safety. Albaqawi et al. (2017) emphasized that nurses' awareness of holistic practice supports the integration of physical care with broader patient needs. However, immediate clinical demands may dominate the work environment, make organizational resources and staff essential for sustained comprehensive care (Gurses & Carayon, 2007).

Holistic physiological care therefore extends beyond completing technical procedures. It includes accurate identification, careful assessment, comfort measures, pain recognition, timely response, and sufficient attention to basic physical needs. When these practices are performed consistently, they provide the stability necessary for patients and families to engage in communication, coping, decision-making, and recovery.

The sociocultural dimension requires respect for cultural beliefs, family structures, communication preferences, autonomy, and the social context of illness. Humanistic care involves recognizing the patient's individuality and preserving dignity within clinical interactions (Taghinezhad et al., 2022). In critical care, family-centered communication and sensitivity to cultural practices can strengthen trust and help patients and significant others participate meaningfully in decisions without compromising safety.

Psychological and spiritual dimensions of care

Psychological care is essential because ICU patients may experience anxiety, confusion, helplessness, loss of control, and distress related to uncertain outcomes. Nurses can reduce these burdens through clear explanations, therapeutic communication, emotional reassurance, orientation, and support for coping. Caring touch and relational presence can also preserve dignity and communicate safety when verbal interaction is limited (Sandnes & Uhrenfeldt, 2022).

The psychological well-being of nurses also affects the consistency of patient support. Moradi et al. (2021) documented the emotional and occupational challenges faced by ICU nurses during high-pressure care, while Vogt et al. (2023) discussed workforce pressures, exposure to trauma, ethical dilemmas, and burnout in critical care nursing. These findings support professional development activities that strengthen communication, debriefing, resilience, teamwork, and organizational support.

Spiritual care addresses meaning, hope, beliefs, prayer, silence, presence, and access to pastoral or religious support. It does not require nurses to impose a belief system; rather, it involves respectfully recognizing what gives the patient strength and allowing safe spiritual practices. Zamanzadeh et al. (2015) identified personal, educational, organizational, and cultural factors that influence the delivery of holistic care. Spiritual support may therefore be strengthened through assessment tools, referral pathways, and training that increases nurses' confidence in responding to diverse beliefs.

Developmental care and professional competence

Developmental care adapts communication, education, involvement, and support to the patient's age, readiness, cognitive condition, and capacity for self-care. In the ICU, patients and families often need explanations about procedures, equipment, changes in condition, transfer, and continuing care. Nurses must therefore assess readiness to learn, provide information in understandable forms, and verify comprehension rather than assuming that information has been understood.

Competence in critical care develops through formal education, continuing professional development, mentorship, simulation, reflective practice, and exposure to evidence-based guidelines. Fulbrook et al. (2012) emphasized the importance of adequate critical care knowledge among ICU nurses, while Poncette et al. (2020) highlighted opportunities to improve monitoring practices through user-centered technological development. Professional development should therefore address both technical innovation and the communication and relational capabilities required for holistic care.

The literature indicates that comprehensive ICU care depends on the interaction of nurse competence, organizational support, patient-centered communication, and respect for the patient's total experience. The present study operationalized these principles through five domains and used patient and significant-other assessments to identify strengths and development priorities in the participating hospitals.

Conceptual Framework

The study used an Input-Process-Output framework. Inputs included respondent profiles and assessments of physiological, sociocultural, psychological, spiritual, and developmental care practices. The process involved administering the survey questionnaire and statistically analyzing the responses. The output consisted of proposed measures that served as the foundation for a nursing professional development plan.

The feedback component indicates that findings from implementation and evaluation may be used to refine future professional development activities. This cyclical structure connects empirical assessment with continuous improvement in ICU nursing practice.

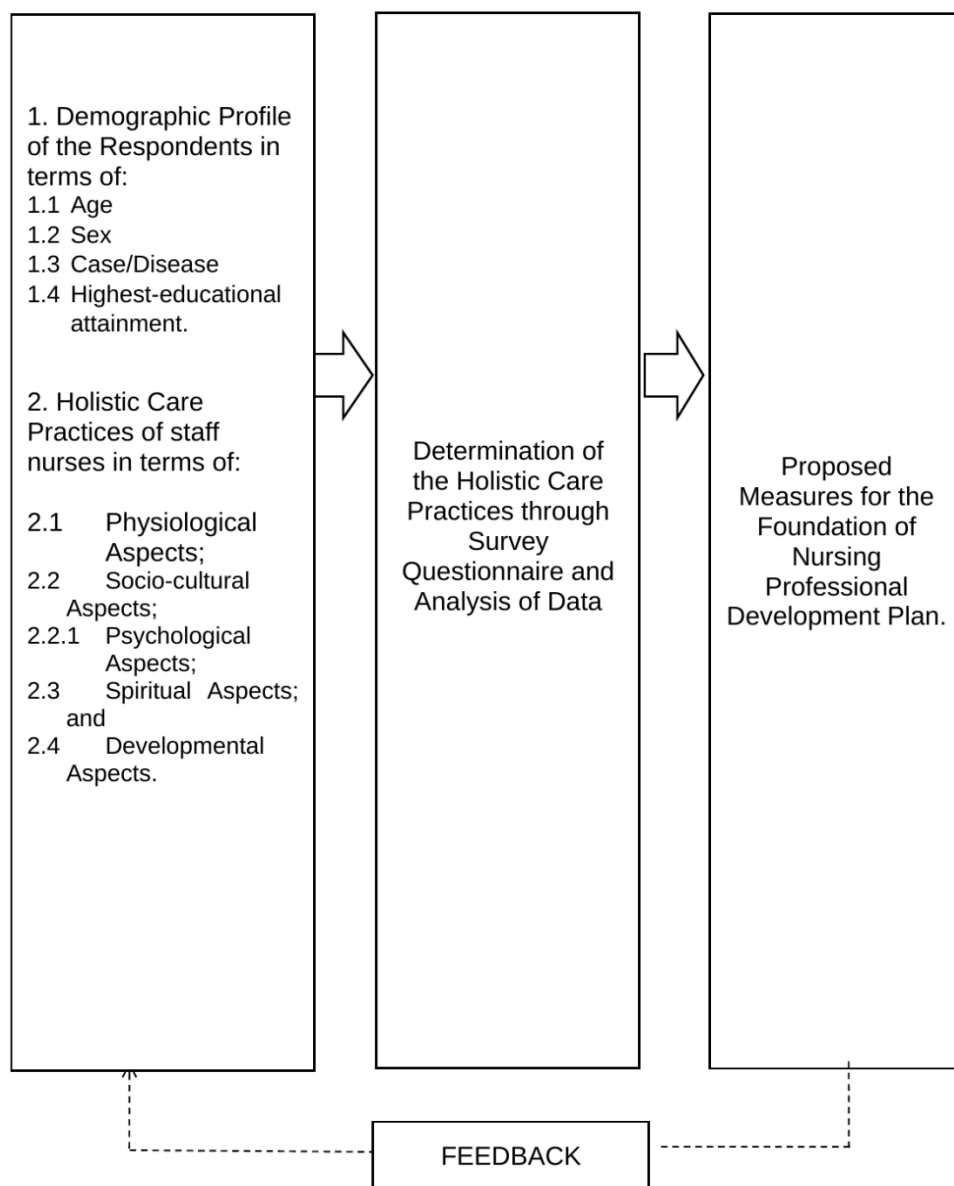


Figure 1. *Conceptual Framework of the Study*

METHODS

Research Design

The study employed a descriptive research design to determine the profile of the respondents, assess the level of holistic care practices rendered by ICU staff nurses, and test differences in assessments across profile variables. The design was appropriate because the variables were observed and described as they occurred without manipulation.

Research Locale

The study was conducted in three selected private hospitals in Cauayan City, Isabela. The participating hospitals-maintained ICU capacities of five beds in Hospital A, 10 beds in Hospital B, and 12 beds in Hospital C. The institutions provided critical care services to patients with varied acute and chronic conditions.

Participants and Sampling Technique

The respondents were conscious patients admitted to the ICU or significant others of patients admitted to the ICU in the three participating hospitals. A total of 78 respondents were included during the three-month study period: 18 from Hospital A, 28 from Hospital B, and 32 from Hospital C. Total enumeration was used because all eligible respondents during the period were invited to participate.

Research Instrument

Data were collected using a two-part survey questionnaire. Part I obtained age, sex, case or disease, and highest educational attainment. Part II assessed holistic nursing practices through 25 items divided equally into physiological, sociocultural, psychological, spiritual, and developmental domains. The instrument was adapted from the holistic care questionnaire used by Albaqawi et al. (2017) and modified to suit the local hospital context. Responses were recorded on a four-point scale: 4 (always), 3 (often), 2 (rarely), and 1 (never). Mean scores from 3.25 to 4.00 were interpreted as highly practiced, 2.50 to 3.24 as moderately practiced, 1.75 to 2.49 as rarely practiced, and 1.00 to 1.74 as not practiced.

The questionnaire was translated into Filipino to support accurate comprehension. Expert reviewers, including a chief nurse, head nurse or supervisor, and ICU staff nurse, evaluated its content, usefulness, clarity, and completeness using the validation approach described by Oducado (2021). The modified tool obtained a validation rating of 4.00, interpreted as highly valid. Pilot testing outside the target population yielded a Cronbach's alpha coefficient of 0.92, indicating high internal consistency.

Data Gathering Procedure

Approval was obtained from the Dean of the Graduate School, the Research Director, and the hospital administrators before data collection. After institutional permission was granted, the researcher explained the study to eligible respondents and obtained written informed consent. Questionnaires were administered face-to-face and required approximately 15 to 20 minutes to complete. Number codes were used instead of names. Completed instruments were retrieved, tallied, and submitted for statistical treatment and analysis.

Data Analysis

Frequency and percentage distributions summarized the respondent profiles. Mean scores determined the level of holistic care practice for each indicator and domain. The Mann-Whitney U test examined differences according to sex, while the Kruskal-Wallis H test examined differences according to age, case or disease, and highest educational attainment. Statistical significance was evaluated at the 0.05 level.

Ethical Consideration

Participation was voluntary, and respondents were informed of the study's purpose, procedures, confidentiality protections, and right to refuse or withdraw without penalty. No identifying information was reported. Completed questionnaires were coded, secured in a locked cabinet, and destroyed after the completion of the research. Findings were reported in aggregate to protect privacy and prevent harm.

RESULTS AND DISCUSSION

Profile of the Respondents

Table 1. *Demographic Profile of the Respondents*

Profile Variable	Category	Frequency	Percentage
Age	20 and below	3	3.8
	21-30	9	11.5
	31-40	19	24.4
	41-50	27	34.6
	Above 50	20	25.6
Sex	Male	35	44.9
	Female	43	55.1
Case/Disease	Cardiac problem	24	30.8
	Respiratory problem	19	24.4
	Hypertensive urgency	13	16.7
	Liver problem	3	3.8
	Pesticide poisoning	1	1.3
	Cerebrovascular accident	18	23.1
Educational Attainment	Elementary undergraduate	5	6.4
	Elementary graduate	18	23.1
	High school undergraduate	20	25.6
	High school graduate	7	9.0
	College undergraduate	8	10.3
	College graduate	20	25.6

Among the 78 respondents, the largest age group was 41-50 years old (34.6%), followed by those above 50 years (25.6%) and those aged 31-40 years (24.4%). Females comprised 55.1% of the sample. Cardiac problems were the most common ICU condition (30.8%), followed by respiratory problems (24.4%) and cerebrovascular accidents (23.1%). Educational backgrounds were diverse, with high school undergraduates and college graduates each accounting for 25.6%.

The profile indicates that the assessments largely reflected the experiences of middle-aged and older patients or their significant others who were managing serious cardiovascular, respiratory, hypertensive, neurologic, and other conditions. The diversity in educational attainment underscores the importance of clear, adaptable communication and patient education. These characteristics support the use of holistic approaches responsive to health literacy, disease complexity, family participation, and age-related needs.

Level of Holistic Care Practices

Table 2. *Holistic Care Practices of ICU Nurses by Domain and Indicator*

Domain	Indicator	Mean	Interpretation
Physiological	Clarified patient data and identification	3.90	Highly Practiced
	Continuously provided care	3.92	Highly Practiced
	Recognized patient pain and provided relief	3.97	Highly Practiced
	Performed physical assessment	3.92	Highly Practiced
	Provided sufficient care for physical needs	3.99	Highly Practiced
	Physiological category mean	3.94	Highly Practiced
Sociocultural	Respected patient culture and beliefs when safe	3.91	Highly Practiced
	Facilitated coping with the family	3.88	Highly Practiced
	Promoted patient well-being	3.88	Highly Practiced
	Protected patient autonomy	3.88	Highly Practiced
	Focused on patient and family needs	3.92	Highly Practiced
	Sociocultural category mean	3.90	Highly Practiced

Psychological	Considered level of consciousness and orientation	3.83	Highly Practiced
	Provided clear information about the condition	3.90	Highly Practiced
	Helped develop coping mechanisms	3.92	Highly Practiced
	Managed the patient's emotional state	3.90	Highly Practiced
	Enhanced capability to manage the condition	3.94	Highly Practiced
	Psychological category mean	3.90	Highly Practiced
Spiritual	Prayed for or with the patient	3.77	Highly Practiced
	Provided quiet time and sat with the patient	3.78	Highly Practiced
	Supported the patient's belief structure	3.79	Highly Practiced
	Fostered communication and instilled hope	3.68	Highly Practiced
	Allowed safe pastoral care or spiritual practices	3.69	Highly Practiced
	Spiritual category mean	3.74	Highly Practiced
Developmental	Assisted with health learning needs	3.87	Highly Practiced
	Assessed readiness to learn	3.78	Highly Practiced
	Assessed ability to commence learning	3.76	Highly Practiced
	Provided equipment or resources for learning	3.69	Highly Practiced
	Provided education on self-care techniques	3.74	Highly Practiced
	Developmental category mean	3.77	Highly Practiced
Overall	Overall holistic care practice	3.85	Highly Practiced

Holistic care was highly practiced overall, with an overall mean of 3.85. Physiological care ranked highest ($M = 3.94$). The strongest physiological indicator was the provision of sufficient care to meet physical needs ($M = 3.99$), followed by pain recognition and relief ($M = 3.97$). These findings indicate strong clinical attentiveness, continuity, assessment, and comfort management. They are consistent with the expectation that ICU nursing must integrate vigilant physiologic monitoring with responsiveness to the patient's total condition (Albaqawi et al., 2017; Marshall et al., 2017).

Sociocultural and psychological care both obtained category means of 3.90. Nurses were particularly recognized for focusing on patient and family needs ($M = 3.92$), respecting culture and beliefs ($M = 3.91$), enhancing the patient's ability to manage the condition ($M = 3.94$), and helping patients develop coping mechanisms ($M = 3.92$). These results demonstrate that family-centeredness, autonomy, emotional support, and communication were integrated with clinical care. Such practices reflect the humanistic and relational components of holistic nursing described by Taghinezhad et al. (2022) and Sandnes and Uhrenfeldt (2022).

Developmental care was also highly practiced ($M = 3.77$). Assistance with health learning needs received the highest developmental score ($M = 3.87$), while providing equipment or resources for learning obtained the lowest score within the domain ($M = 3.69$). The findings suggest that nurses regularly assessed readiness and provided education, but additional structured materials and teaching tools could further strengthen patient and family learning during ICU care and transition.

Spiritual care obtained the lowest domain mean ($M = 3.74$), although it remained within the highly practiced range. Support for belief structures ($M = 3.79$), quiet presence ($M = 3.78$), and prayer ($M = 3.77$) were frequently recognized. Communication that instilled hope ($M = 3.68$) and facilitation of pastoral services or other spiritual practices ($M = 3.69$) received relatively lower scores. This pattern does not indicate an absence of spiritual care; rather, it identifies a priority for structured assessment, culturally respectful referral, and skill development. Organizational and educational support can help nurses respond more confidently to spiritual needs without imposing personal beliefs (Zamanzadeh et al., 2015).

Taken together, the results show a balanced and consistently high standard of care, with pronounced strength in physiological, sociocultural, and psychological dimensions. The comparatively lower spiritual and developmental scores provide constructive priorities for professional development while preserving the strong baseline performance of ICU nurses.

Differences in Holistic Care Practices According to Profile Variables

Table 3. *Statistical Differences in Holistic Care Assessments by Profile Variables*

Profile Variable	Physiological p	Sociocultural p	Psychological p	Spiritual p	Developmental p	Decision
Age	0.06	0.07	0.06	0.07	0.06	Not Significant
Sex	0.32	0.30	0.39	0.42	0.41	Not Significant
Case/Disease	0.81	0.70	0.27	0.16	0.20	Not Significant
Educational Attainment	0.30	0.36	0.58	0.82	0.66	Not Significant

No statistically significant differences were found in the assessments of holistic care across any domain when respondents were grouped according to age, sex, case or disease, and highest educational attainment. All p-values exceeded 0.05. Although age-related p-values were close to the threshold in several domains, they did not meet the criterion for significance. The null hypothesis was therefore not rejected for all profile variables and care domains.

The consistency of perceptions indicates that ICU nurses delivered holistic care in a generally equitable and standardized manner. Patients and significant others with different backgrounds and clinical conditions reported comparable experiences of physiological, sociocultural, psychological, spiritual, and developmental support. This finding is important in critical care, where diagnosis and treatment intensity vary but dignity, communication, emotional support, cultural respect, and family involvement should remain consistent. Standardized systems, adequate work environments, and continuing education can help sustain this uniformity (Bruyneel et al., 2024; Gurses & Carayon, 2007).

Proposed Nursing Professional Development Plan

The professional development plan was designed to sustain highly practiced areas while directing additional support toward the relatively lower spiritual and developmental domains. It also recognizes that high-quality holistic care depends on both individual competence and institutional systems.

Table 4. *Proposed Nursing Professional Development Plan*

Focus Area	Objective	Key Activities	Expected Outcome
Spiritual Care	Build confidence in non-denominational, patient-centered spiritual support.	Conduct training with pastoral-care experts; integrate the FICA spiritual history tool; strengthen referral pathways to appropriate spiritual or religious support.	More confident spiritual conversations and consistent documentation of spiritual needs.
Developmental Care	Strengthen patient and family education and readiness for transition.	Use standardized ICU-to-ward teaching checklists; train nurses in the teach-back method; develop accessible educational materials.	Improved comprehension, self-care readiness, and continuity during transfer.
Psychological Support	Sustain emotional support and reduce ICU-related distress.	Strengthen therapeutic communication, de-escalation, post-crisis debriefing, peer support, and referral for psychological assistance.	Sustained patient satisfaction and reduced emotional strain among patients, families, and staff.

Sociocultural Care	Sustain culturally responsive and family-centered practice.	Provide annual cultural-humility updates; use individualized communication; involve families in bedside discussions when clinically appropriate.	Continued alignment of care with patient and family values and preferences.
Physiological Care	Maintain clinical excellence and evidence-based critical care skills.	Conduct simulation on emergencies and monitoring; hold evidence-based journal reviews; update pain, agitation, delirium, and rapid-response protocols.	Sustained clinical competence, safety, and responsiveness to changing critical-care standards.

The plan prioritizes spiritual care because it obtained the lowest domain mean, while developmental and psychological activities reinforce patient education, coping, and transition. Sociocultural and physiological components are maintained through cultural-humility development, simulation, evidence-based review, and family-centered practice. This combination reflects the literature's emphasis on continuing competence, supportive work environments, and whole-person care in intensive settings (Ambushe et al., 2023; Fulbrook et al., 2012; Moradi et al., 2021).

CONCLUSION

ICU nurses in the selected private hospitals of Cauayan City delivered a high level of holistic care across physiological, sociocultural, psychological, spiritual, and developmental dimensions. Physiological care was the strongest domain, while spiritual care obtained the lowest mean but remained highly practiced. Patient and significant-other assessments were consistent across age, sex, case or disease, and educational attainment, indicating equitable and standardized care delivery among the participating hospitals.

The study demonstrates that holistic critical care can be maintained even in complex and technology-intensive settings when nurses combine clinical vigilance with communication, respect for culture, emotional support, spiritual sensitivity, and patient education. The proposed professional development plan provides a structured approach for sustaining existing strengths and enhancing spiritual assessment, developmental education, psychological support, culturally responsive practice, and evidence-based clinical competence.

Recommendation

The participating hospitals should institutionalize the proposed professional development plan through regular competency-based training, simulation, reflective practice, patient-feedback review, and monitoring of holistic care indicators. Spiritual care training and clear referral procedures should be strengthened, while patient and family education should use standardized materials and teach-back techniques. Psychological support for both patients and ICU personnel should include debriefing, peer support, and access to appropriate services. Hospital administrators should sustain adequate staffing, balanced workload distribution, teamwork, and resources needed for comprehensive care. Nursing schools may integrate holistic critical care competencies into clinical instruction. Future studies should include additional hospitals, larger and more diverse samples, direct observations, and longitudinal evaluation of professional development interventions.

References

- Albaqawi, H. M., Butcon, V. E. R., & Molina, R. R. (2017). Awareness of holistic care practices by intensive care nurses in north-western Saudi Arabia. *Saudi Medical Journal*, 38(8), 826-831. <https://doi.org/10.15537/smj.2017.8.20056>
- Ambushe, S. A., Awoke, N., Demissie, B. W., & Tekalign, T. (2023). Holistic nursing care practice and associated factors among nurses in public hospitals of Wolaita Zone, South Ethiopia. *BMC Nursing*, 22, Article 390. <https://doi.org/10.1186/s12912-023-01517-0>

- Bruyneel, A., Bouckaert, N., Pirson, M., Sermeus, W., & Van den Heede, K. (2024). Unfinished nursing care in intensive care units and the mediating role of the association between nurse working environment, quality of care, and nurses' wellbeing. *Intensive and Critical Care Nursing*, 81, 103596. <https://doi.org/10.1016/j.iccn.2023.103596>
- Frisch, N. C., & Rabinowitsch, D. (2019). What's in a definition? Holistic nursing, integrative health care, and integrative nursing: Report of an integrated literature review. *Journal of Holistic Nursing*, 37(3), 260-272. <https://doi.org/10.1177/0898010119860685>
- Fulbrook, P., Albarran, J. W., Baktoft, B., & Sidebottom, B. (2012). A survey of European intensive care nurses' knowledge levels. *International Journal of Nursing Studies*, 49(2), 191-200. <https://doi.org/10.1016/j.ijnurstu.2011.06.001>
- Gurses, A. P., & Carayon, P. (2007). Performance obstacles of intensive care nurses. *Nursing Research*, 56(3), 185-194. <https://doi.org/10.1097/01.NNR.0000270028.75112.00>
- Jasemi, M., Valizadeh, L., Zamanzadeh, V., & Keogh, B. (2017). A concept analysis of holistic care by hybrid model. *Indian Journal of Palliative Care*, 23(1), 71-80. <https://doi.org/10.4103/0973-1075.197960>
- Marshall, J. C., Bosco, L., Adhikari, N. K. J., Connolly, B., Diaz, J. V., Dorman, T., Fowler, R. A., Meyfroidt, G., Nakagawa, S., Pelosi, P., Vincent, J.-L., Vollman, K., & Zimmerman, J. (2017). What is an intensive care unit? A report of the Task Force of the World Federation of Societies of Intensive and Critical Care Medicine. *Journal of Critical Care*, 37, 270-276. <https://doi.org/10.1016/j.jcrc.2016.07.015>
- Moradi, Y., Baghaei, R., Hosseingholipour, K., & Mollazadeh, F. (2021). Challenges experienced by ICU nurses throughout the provision of care for COVID-19 patients: A qualitative study. *Journal of Nursing Management*, 29(5), 1159-1168. <https://doi.org/10.1111/jonm.13254>
- Mousazadeh, S., Yektatalab, S., Momennasab, M., & Parvizy, S. (2019). Job satisfaction challenges of nurses in the intensive care unit: A qualitative study. *Risk Management and Healthcare Policy*, 12, 233-242. <https://doi.org/10.2147/RMHP.S218112>
- Oducado, R. M. F. (2021). Survey instrument validation rating scale. SSRN. <https://doi.org/10.2139/ssrn.3789575>
- Poncette, A.-S., Mosch, L., Spies, C., Schmieding, M., Schiefenhövel, F., Krampe, H., & Balzer, F. (2020). Improvements in patient monitoring in the intensive care unit: Survey study. *Journal of Medical Internet Research*, 22(6), e19091. <https://doi.org/10.2196/19091>
- Sandnes, L., & Uhrenfeldt, L. (2022). Caring touch in intensive care nursing: A qualitative study. *International Journal of Qualitative Studies on Health and Well-Being*, 17(1), 2092964. <https://doi.org/10.1080/17482631.2022.2092964>
- Taghinezhad, F., Mohammadi, E., Khademi, M., & Kazemnejad, A. (2022). Humanistic care in nursing: Concept analysis using Rodgers' evolutionary approach. *Iranian Journal of Nursing and Midwifery Research*, 27(2), 83-91. https://doi.org/10.4103/ijnmr.IJNMR_156_21
- Vogt, K. S., Simms-Ellis, R., Grange, A., Griffiths, M. E., Coleman, R., Harrison, R., Shearman, N., Horsfield, C., Budworth, L., Marran, J., & Johnson, J. (2023). Critical care nursing workforce in crisis: A discussion paper examining contributing factors, the impact of the COVID-19 pandemic and potential solutions. *Journal of Clinical Nursing*, 32(19-20), 7125-7134. <https://doi.org/10.1111/jocn.16642>
- Zamanzadeh, V., Jasemi, M., Valizadeh, L., Keogh, B., & Taleghani, F. (2015). Effective factors in providing holistic care: A qualitative study. *Indian Journal of Palliative Care*, 21(2), 214-224. <https://doi.org/10.4103/0973-1075.156506>