

**Communication and the Therapeutic  
Relationship in Intensive Care: Improving the  
Patient's Voice**

**Harriet Smithies**

A Dissertation Submitted for the Degree of

Masters of Health Sciences

at the University of Canterbury, Christchurch

27<sup>th</sup> November 2015

# Acknowledgements

First and foremost I would like to thank my supervisor Natalie Conley. The amount of time, effort and energy that she has put into my work has been astounding. To have someone with a wealth of knowledge show as much interest in and enthusiasm for my topic has been the greatest support that anyone could ask for.

Secondly, I would also like to thank Doctor Alison Dixon for her guidance, motivation and being only an email away. Thank you also for all of the effort you have put into creating a fantastic course that I have thoroughly enjoyed being a part of.

Thank you also to all of the other supervisors for asking me questions and pointing out new perspectives for during presentation sessions.

Finally, thank you so much to my fellow classmates. You have all been a fantastic group of people to bounce ideas off of and have provided much needed support when the work load has at times seemed overwhelming.

# **My Experience**

Choosing a topic for this dissertation, I wanted something that had meaning for me. As a 16 year old I found myself admitted to an intensive care unit following a traumatic accident. I experienced three long weeks in intensive care, feeling like with every step forward I took three backwards. I remember a significant amount from my experience. Although many of these memories are altered by confusion, delusions and hallucinations, they have shaped the way I will endeavour to practice nursing following my graduation. My experience as a critically ill patient was terrifying. Every time a machine alarmed, I thought my heart was stopping. Although the alarms may have been explained to me, I had no recollection of this. I also had no way of asking the nurse to explain what was happening. I remember desperately wanting reassurance from my nurse but not knowing how to get her attention. I remember pressing the button on my patient controlled analgesia pump over and over thinking that it was a call bell for the nurse caring for me. I had no idea that there was constantly a nurse at my bedside. Many times I thought that I had been left alone with no one to watch me when the nurse was actually only just out of my line of sight. It was these experiences that made me ask how can the patient's voice be improved in intensive care? How can we make it so that other patients don't have these feelings of terror every time a machine alarms? It is possible that had I been reassured and comforted I may have been able to relax, rest and maybe heal faster and move on sooner from intensive care.

# Table of Contents

<b>Acknowledgements .....</b>	<b>ii</b>
<b>My Experience.....</b>	<b>iii</b>
<b>Table of Contents .....</b>	<b>iv</b>
<b>Abstract.....</b>	<b>vi</b>
<b>1 Introduction .....</b>	<b>1</b>
1.1 Voice .....	1
1.2 The Intensive Care Experience .....	1
1.3 Aims .....	3
1.4 Literature Review Methodology .....	3
<b>2 The Therapeutic Nurse-Patient Relationship .....</b>	<b>5</b>
2.1 Knowing The Patient.....	5
<b>3 Communication.....</b>	<b>8</b>
3.1 Voicelessness – How Does a Patient Feel When Communication is Poor? ....	9
3.2 Barriers to Communication .....	11
3.2.1 Technology as a barrier. ....	11
3.2.2 Confusion as a barrier.....	14
3.3 Ways to Overcome Communication Barriers .....	15
3.3.1 Touch.....	16

3.3.2	Knowing the patient. ....	18
3.3.3	Verbal communication. ....	19
3.3.4	Patient empowerment .....	20
3.4	Successful Communication .....	21
<b>4</b>	<b>The Stages of the Therapeutic Relationship and Their Barriers .....</b>	<b>23</b>
4.1	The Pre-Interaction Phase .....	23
4.2	The Orientation Phase .....	24
4.3	The Working Phase .....	24
4.4	The Termination Phase.....	26
4.5	Successful Relationships .....	27
<b>5</b>	<b>Health Outcomes.....</b>	<b>30</b>
<b>6</b>	<b>Proposal for Future Research .....</b>	<b>34</b>
	<b>Conclusion .....</b>	<b>36</b>
	<b>References.....</b>	<b>37</b>

# **Abstract**

Providing nursing cares for a critically ill patient in an intensive care setting requires the registered nurse to use additional skills to overcome establish effective communication with the patient and allow for the establishment of an appropriate and effective therapeutic relationship. In reports on patient's experiences of being in intensive care, voicelessness has been described as an extremely unpleasant experience that can lead to feelings of fear, anger, vulnerability and loss of dignity (Almerud, Alapack, Fridlund, & Ekebergh, 2007; Granberg, Engberg, & Lundberg, 1998; Karlsson, Bergbom, & Forsberg, 2012; Karlsson, Lindahl, & Bergbom, 2012). In a review of the literature, the current dissertation aims to explore the cause of the experience of voicelessness and examine the potential impact on the patient's intensive care experience. This review also identifies some ways that registered nurses can assist the patient with finding their voice, with a focus on the therapeutic nurse-patient relationship. The impact that improving the patient's voice may have on particular health outcomes for that patient has also been discussed. Finally a brief proposal for future research has also been included.

# **1 Introduction**

## **1.1 Voice**

The Oxford dictionary has a variety of definitions for 'voice'. 'The sound produced by the larynx and uttered through the mouth as speech or song' is possibly the definition that is most commonly referred to (Oxford Dictionaries, 2015). There is only one way through which a critically ill patient can experience voice in this way, that is to remove the mechanical ventilation and/ or tracheostomy that is likely to be keeping them alive. The second definition that the Oxford dictionary provides for voice should however be achievable for critically ill patients. To have a voice is to 'express a particular opinion or attitude' (Oxford Dictionaries, 2015). To do this, a degree of communication is required, and to communicate effectively a level of relationship is also necessary. In intensive care, there are a number of barriers that can make communication and building a nurse-patient relationship difficult, however it should be possible that these are able to be overcome, allowing the patient's voice to be heard.

## **1.2 The Intensive Care Experience**

The intensive care environment is described as being extremely stressful for the majority of patients who are admitted (Hafsteindóttir, 1996). The frightening and sometimes painful medical and nursing interventions in conjunction with a critical, often life-threatening illness can be the most terrifying experience a person may have. Although in many instances patients do not remember their intensive care experience, a recent reduction in sedative use means that an increasing number of patients have recollections of their stay (Samuelson, Lundberg, & Fridlund, 2006). Sedation interruption programmes and low or no sedation have been shown to be associated with fewer mechanically ventilated days and fewer days spent in intensive care (Kress, Pohlman, O'Connor, & Hall, 2000; Strøm, Martinussen, & Toft, 2010;

Strøm, 2012) and as such many intensive care units (ICU) are turning to these protocols. A result of this; the patient experience of intensive care is now well documented. Baumgarten and Poulsen (2015) performed a qualitative metasynthesis of nine of these studies conducted between 1994 and 2012 in an attempt to describe the experience of being mechanically ventilated in intensive care. The main finding of this study was that patients feel dependent on health professionals but unable to communicate with them. This leads to feelings of anxiety, fear and loneliness for the patient (Baumgarten & Poulsen, 2015). These feelings as well as breathlessness, confusion, being helpless, feeling afraid and feeling out of control are commonly reported by patients when asked about their experience (Granberg, Engberg, & Lundberg, 1999; Russell, 1999; Karlsson & Forsberg, 2008; Karlsson, Bergbom, et al., 2012). Additionally, a patient in intensive care is typically mechanically ventilated and often sedated or confused making verbalisation impossible and non-verbal communication difficult. Patients have referred to this situation as being voiceless (Granberg et al., 1998; Karlsson, Forsberg, & Bergbom, 2012; Tembo et al., 2014). With reductions in sedative use, patients appear to be becoming increasingly aware of being a voiceless person during their ICU experience.

The demands of a critical illness mean that these patients are constantly exhausted, making it difficult for them to concentrate on alleviating these feelings (Hafsteindóttir, 1996; Karlsson, Lindahl, et al., 2012). Studies have also highlighted how a nurse can influence the experience of intensive care. During interviews with patients, Granberg et al. (1998) discovered that nursing care actions must be seen as vital factors in helping patients to overcome the routine medical interventions that can be terrifying when confused, delusional and fearful for one's life. This is supported by more recently by Karlsson and Forsberg (2008) who again interviewed patients and concluded that quality care requires a holistic approach which when achieved, results in an alleviation of suffering for the critically ill patient (Karlsson & Forsberg, 2008). Further evidence supporting these claims can be found throughout the literature



(Almerud et al., 2007; Wang, Zhang, Li, & Wang, 2008; Karlsson, Bergbom, et al., 2012; Karlsson, Lindahl, et al., 2012). It is important to note that the majority of studies investigating ICU experiences have been conducted in Scandinavia. Although not the same, the New Zealand healthcare system is comparable to Scandinavian healthcare systems, with services offered in the same way (The Commonwealth Fund, 2015). The ICUs provide the same type and level of care between each country, using comparable approaches for treating critical illness. As such, the findings of the Scandinavian studies are very likely to be applicable to New Zealand.

### **1.3 Aims**

The caring nurse-patient therapeutic relationship has the potential to reduce the psychological trauma associated with being a patient in intensive care. Many articles have examined the nurse's perspective of the therapeutic relationship however, it is important that the patient's view of this relationship and their experience of communication are also taken into account. The current dissertation aims to examine the cause and impact on the patient's experience of voicelessness in intensive care and explain some ways that registered nurses can assist the patient with finding their voice. It is possible that the strength of the therapeutic relationship and the patient's voice may alter the health outcomes for the patient and therefore this will also be investigated. Finally a brief proposal for future research has also been included.

### **1.4 Literature Review Methodology**

A review of the literature was performed as the basis for this dissertation. CINAHL, Medline and Google Scholar databases were searched using different combinations of the keywords: nurse-patient relations, therapeutic relationship, negotiated partnership, registered nursing, critical care nursing, critical care, intensive care, ICU, communication, patient attitudes, patient satisfaction, attitude to health and patient memories. Articles in languages other than English, conducted in paediatric settings and with a focus on communication with

the patient's family were excluded. Due to the small amount of research publications being available, no parameters were set regarding dates. It was possible to compare the older studies with the new literature and findings appeared similar. A total of 63 articles were found and included for further evaluation. This involved reading the abstracts of the articles and colour coding them for ease of reference based on the inclusion of four topics; patient perspective, communication, nurse-patient relationship, and health outcomes. Articles that included any one or any combination of these four topics were then analysed in full and included in the dissertation.

All 'nursing' that was referred to in the literature is the nursing undertaken by registered nurses. In New Zealand intensive care units, direct patient care is undertaken by registered nurses. As such, when referring to nursing care in the current dissertation, this will mean the care provided by registered nurses.

## **2 The Therapeutic Nurse-Patient Relationship**

Throughout their career, registered nurses must interact with, advocate for and care for many different people in a variety of different situations. A nurse must have the ability to develop a professional relationship with these individuals that allows him or her to fulfil this role. The relationship that a nurse develops with a patient is considered to be therapeutic when it is working towards specific health orientated outcomes for the patient (Treas & Wilkinson, 2013). The nature of a hospital environment can place a patient in a vulnerable position where they have the potential to be at risk of losing their privacy, autonomy and dignity. The ability of a nurse to align themselves alongside a patient and care for them in a way that maintains their privacy, autonomy and dignity is essential to providing quality, patient-centred care (Stein-Parbury, 2014). The development of a mutual partnership between a nurse and patient is necessary for the nurse to align themselves with the patient. Each party must contribute to the partnership to achieve the best outcomes for the patient. A nurse will contribute their knowledge of the system and medical interventions as well as the ability to assist the patient with their healthcare needs. The nurse can also be an advocate for the patient. Stein-Parbury (2014) refers to this as ‘being for’ the patient. She mentions the importance of a taking time to listen to and understand their experience, and then working alongside them to ensure that the patient receives care that respects their individual needs (Stein-Parbury, 2014). In turn the patient must be willing to let the nurse into their life and allow the nurse to ‘know’ them (Stein-Parbury, 2014).

### **2.1 Knowing the Patient**

Knowing the patient refers to the understanding of the patient’s needs, expectations and preferences. The nurse requires this information in order to provide that patient with safe, individualised and holistic care. Furthermore it assists the nurse to make safe clinical decisions

regarding the patients care (Bundgaard, Nielsen, Delmar, & Sørensen, 2012). Liaschenko and Fisher (1999) classified three components that are associated with knowing the patient; case knowledge, patient knowledge and person knowledge. These components were deduced by synthesising a number of studies conducted in a variety of nursing care settings to determine what nurses believed they required to know the patient (Liaschenko & Fisher, 1999). These components continue to be cited in recent literature that discusses this topic (see Stein-Parbury, 2014). The patient knowledge centres on how the patient is responding to their clinical situation. It requires the nurse to understand how the patient came to be known as a patient, how they are feeling about their treatment and how they are responding to their situation (Liaschenko & Fisher, 1999). The person knowledge requires the nurse to understand that the patient is a unique individual with their own personal and private life and as such their views may differ from that of the nurses. This may mean that they make sense of actions in a way that is foreign to the nurse (Liaschenko & Fisher, 1999). When combined with their case knowledge about the medical condition of the patient, a nurse can provide the patient with care that optimises the physical, psycho-social, emotional and spiritual outcomes for the patient, enhancing recovery times (Stein-Parbury, 2014).

In highly acute medical environments such as intensive care, a patient is usually critically unwell and often unconscious, sedated or confused. In these situations it is likely to be impossible for a patient to speak verbally or through gesture and thus gaining a proper understanding of their experience and getting to know them can be extremely challenging (Beeby, 2000; McGrath, 2008; Tunlind, Granström, & Engström, 2014). The vulnerable position of a critically ill patient makes developing a therapeutic relationship with them extremely important as it assists with reducing potential anxiety and maintaining dignity through communication. Getting to know a critically ill patient will be entirely dependent on their situation. When caring for a sedated or unconscious patient the nurse may be unable to

get to know the patient themselves and may instead rely on the family/ whanau to speak for the patient. O'Connell (2008) reflected on a situation where the patient she was caring for in an intensive care environment was unconscious. She was able to gain her 'patient knowledge' from the information reflected in the screens of the technology that was keeping him alive. Knowing the person was much harder. O'Connell instead formed a relationship with the patient's mother, a person who knew the patient well and was therefore able to speak for him. O'Connell concluded that the relationship she formed was therapeutic in nature as it was a "mutual and reciprocal alliance motivated by feeling of intense compassion and empathy" (O'Connell, 2008). This highlights a difficulty that a critical care nurse may face when coming to know the person however it also provides some strategies into how the barriers of sedation and unconsciousness may be overcome by the nurse. It is also possible that the patient may be conscious but ventilated and thus unable to communicate vocally. This provides the intensive care unit nurse with yet another challenge to overcome. This can be difficult as Magnus & Turkington (2006) mentioned that as you come to know a patient, communication gets easier (Magnus & Turkington, 2006) however getting to know a patient is extremely difficult without an established form of communication.

### 3 Communication

In New Zealand, for a nurse to become registered there are a number of competencies that they must meet that centre around the development of appropriate interpersonal relationships and communication skills [Nursing Council of New Zealand (NCNZ), 2012]. For a nurse to form an appropriate therapeutic relationship with a patient, they must be a competent communicator. According to the NCNZ competencies for registered nurses domain three, a competent communicator is one who is able to communicate effectively with health consumers and members of the health care team (NCNZ, 2012). To achieve this, they must meet several indicators that include how they communicate, the language they use and the techniques they develop to overcome barriers (NCNZ, 2012). For a nurse, not only do they have to effectively communicate with the patient during the relationship, but they must also have effective communication skills to interact with other members of the multidisciplinary team as an advocate for the patient. To communicate effectively, a nurse must be both responsive to what others are saying and assertive when it comes to stating their own point of view (Stein-Parbury, 2014). A balance of these interpersonal skills will enable a nurse to negotiate a caring relationship with their patient. Communication is the ability to convey thoughts, feelings and attitudes to another person. This can be via both verbal and non-verbal techniques (Stein-Parbury, 2014). It is crucial that a nurse is able to skilfully alter the way he or she communicates with different patients, their family/whanau and members of the multidisciplinary team, as different clinical contexts call for different communication techniques (Stein-Parbury, 2009). There are a number of different techniques a nurse may need to use to communicate with their patient and the patient's family/ whanau. The use of these techniques will vary depending on the context of the communication. Stein-Parbury (2009) highlighted both the verbal and non-verbal forms of communication that can either work together with the message to enhance it, or conflict with the message to confuse the receiver. It is important that a nurse is adept at

altering words, movements, voice inflection, facial expressions and use of space to ensure that the message and intent is clear for the patient (Stein-Parbury, 2009). The ability of a nurse to utilise these skills when working with a ventilated and/or sedated patient is important for the establishment of an effective communication strategy.

### **3.1 Voicelessness – How Does a Patient Feel When Communication is Poor?**

There have been a number of studies that have investigated how a patient feels when they are unable to communicate with their nurse (Hafsteindóttir, 1996; Granberg et al., 1998; Wojnicki-Johansson, 2001; Magnus & Turkington, 2006; Hofhuis et al., 2008; Tembo, Higgins, & Parker, 2014). Many of these have been conducted in the Scandinavian intensive care environment with small study numbers. Despite this, the Scandinavian health care systems are similar to a number of other Western health care systems, and the results from all of these studies are congruent, thus it is likely that the feelings associated with voicelessness that were highlighted in these studies, are typical representations of patient experiences.

A study by Granberg, Engberg and Lundberg (1999) identified communication difficulties as being the key facilitator of the stressful experiences that patients had during their stay in intensive care. The authors interviewed 19 patients at one week and eight weeks following discharge from an ICU in Sweden. They then performed a phenomenological-hermeneutic study to explore their experiences. This approach allows the researchers to understand the patient's experiences in both context and in a way that takes into account previous knowledge. It is important that, when performing a qualitative study, the researchers own opinions and understandings are taken into account, as they can compromise the openness and sensitivity that the researcher will have towards the study participants responses (Granberg et al., 1999). Acute confusion, disorientation, wakefulness, dreams and nightmares were

identified by the patients as stressful experiences (Granberg et al., 1999). It was discovered that these disturbing thought patterns resulted in the patients being unable to communicate appropriately, causing feelings of fear, anger, vulnerability and loneliness (Granberg et al., 1999). These findings have been supported more recently by Karlsson, Bergbom, and Fosberg (2012) and Tembo, Higgins and Parker (2014). Karlsson et al. (2012) identified voicelessness as being the worst experience for patients in an ICU. They interviewed 12 patients who had retained a level of consciousness during their period of mechanical ventilation. The interviews took place approximately one week after their discharge from a Swedish ICU. They also used a three step phenomenological-hermeneutic study to analyse the transcribed interviews and extract the core themes. They discovered that for the patient, the despair, irritation and anger at not being understood lead them feel they had lost their identity and were no longer being cared for as an individual (Karlsson et al., 2012). Tembo et al. (2014) used the phenomenological-hermeneutic approach with 16 patients. They interviewed the patients at both two weeks after discharge, and six to eleven months following discharge. They identified similar issues, in that the patient felt voiceless and this lead to a loss of control and power and well as a feeling of anxiety (Tembo et al., 2014). As a therapeutic relationship requires communication between the nurse and patient to form a partnership (McQueen, 2000), it is possible that the nurses caring for the patients in these studies had not successfully overcome the barriers to allow the patient to feel a part of their own care.

The experience of voicelessness is highly unpleasant for a critically ill patient. It is possible that the feelings that result from being unable to express an opinion and contribute to the planning of their care may lead to an increase in stress levels. High levels of stress reduce circulatory stability, requiring an increase in medication and poorer recovery times (Henricson, Ersson, Määttä, Segesten, & Berglund, 2008). Nurses working with critically ill patients have a responsibility to improve the patient's voice by overcoming the barriers to communication



and the therapeutic relationship with the aim of preventing the patient from experiencing the unpleasant feelings associated with being voiceless.

## **3.2 Barriers to Communication**

Stein-Parbury (2009) mentions a number of situations where communication can become challenging. These can include communicating with patients who are silent and/or withdrawn, through to those who are angry and demanding. Nurses will often come across patients who speak minimal English, which requires some ingenuity when it comes to developing a therapeutic relationship (Stein-Parbury, 2009). As mentioned earlier, the intensive care environment can make developing an effective therapeutic relationship between nurse and patient incredibly difficult due to the barriers created by technology, sedation and confusion. Although the nurse is still able to communicate verbally, the patient will generally be unable to speak and often, due to a confused state and limited memory, will struggle with comprehension (Magnus & Turkington, 2006). For a nurse to provide appropriate, patient-centred care for the critically ill person he or she is looking after, these barriers must be overcome and a relationship developed with the patient. The communication barriers that have been identified arise from particular factors that are unique to the ICU environment in particular, technology and confusion.

### **3.2.1 Technology as a barrier.**

Intensive care is an extremely technology dependent unit. Patients are generally ventilated and connected to a plethora of machines and monitors. Almerud, Alapack, Fridlund and Ekebergh (2007) performed a series of unstructured, open ended interviews with nine intensive care patients in the days following their discharge, to discover how this technology affected their experience of ICU. The results highlighted the way in which nurses in a technology rich environment such as an ICU, listen to what the machines say but not what the

patient says. The patients interviewed reported that they would cater to what the nurse required in the hope of being classed as a 'good patient'. They would let their caregivers make decisions and felt that they were not allowed to participate in their treatment decisions (Almerud et al., 2007). This appeared to be a crucial aspect of the origin of the negative feelings that patients experience during their intensive care admission. Almerud et al. (2007) concluded that the *"loud voice of technology silences the sick person and compromises the competence of the caregiver"* (Almerud et al., 2007). The results from this study are somewhat shocking. They heavily contradict what nursing students are taught throughout their training and undermine the majority of the Principles of the New Zealand Code of Conduct for Nurses (Nursing Council of New Zealand, 2012). Almerud et al. (2007) show that, from the patient's perspective, the nursing care is not patient centred but rather technology centred. It appears that the nurses have failed to negotiate a partnership with the patient and in doing so have removed any autonomy the patient may have been able to retain (Almerud et al., 2007). In their 2008 study, Almerud, Alapack, Fridlund and Ekebergh explain that the basic nursing skills of listening to a patient may be forgotten by the nurse as the technology takes precedence (Almerud, Alapack, Fridlund, & Ekebergh, 2008). They argue that there is a 'master-slave' relationship between the nurse and the technology with the technology driving the nurse's actions rather than basic needs of the patient (Almerud et al., 2008). These arguments have been supported with findings from Tunlind, Granstrom and Engstrom (2014) who conducted a number of qualitative personal interviews with eight intensive care nurses in Sweden. Despite recognising the technology as a necessary tool, it was also identified as an obstacle that prevents 'real' nursing work (Tunlind et al., 2014). They highlighted the way that medical devices lead to a reworking of nursing priorities as their bells and whistles led them to become the focus of attention, rather than the person who was connected to them (Tunlind et al., 2014). Conversely, a study by McGrath (2008) showed that nurses are able to embrace the technology and work

alongside it to provide a level of care that they believed was higher. This was however attributed to nursing experience. The nurses in this study were extremely attuned to the medical devices to the point where they did not need to focus their attention on them to know how they were operating. This enabled them to place the patient and family in the prioritised position (McGrath, 2008). These discrepancies between the findings of Tunlind et al. (2014) and McGrath (2008) are interesting as the ages and experience levels (minimum of two years in both studies) of the study participants were very similar. It is possible however, that the level of support given to unexperienced nurses varied between the intensive care units. The participants in McGrath's study highlighted the need to support novice nurses with one of the subthemes being 'sharing expertise' (McGrath, 2008). This was less evident in the study by Tunlind et al. (2014) although they did mention that the prioritisation of nursing cares became easier with experience.

Although not mentioned in these studies, there is the possibility that the nurses may also need to share their expertise with the patient. Personal experience and some studies (Russell, 1998; Magnus & Turkington, 2006; Almerud et al., 2007) have highlighted the need for patients to have a basic understanding about the technology that is keeping them alive. A small amount of information such as why the machine is alarming or that their tracheostomy is not permanent could assist with reducing anxiety and providing reassurance regarding their situation (Russell, 1998; Magnus & Turkington, 2006; Almerud et al., 2007). It appears that technology cannot only act as a barrier to communication and the development of a therapeutic relationship, but can also increase a patient's fear and anxiety. With experience it is possible that the nurse can overcome this barrier and focus their nursing cares on the patient rather than the technology

### **3.2.2 Confusion as a barrier.**

ICU syndrome is a term coined to describe the acute confusion, delirium, psychosis and clouding of consciousness that can occur in ICU patients (Granberg, Engberg, & Lundberg, 1998). Granberg et al. (1998) described the patient's experiences of ICU syndrome. They identified a state of chaos that a patient experiences upon waking from a sedated state, with the most intense feeling amongst this chaos being fear (Granberg et al., 1998). The real memories of patients upon awakening appear disjointed, with events being remembered in a fragmented manner. Yet the memories of confusion and unreal experiences remain intact and could be discussed with by the patient in great detail (Granberg et al., 1998). The patients in this study also identified their confusion as being a major barrier to communication with their nurse. Being unable to order thoughts and becoming disorientated would make it hard to focus on their needs. If the nurse found a way to break through the technology communication barrier, then it was likely that the patient would remain unable to express themselves due to confusion and disorientation (Granberg et al., 1998). This study also provided information on how the patient perceived the nurse caring for them during their time of confusion. The patients reported that they classified nurses as good or bad, kind or evil. The nurses who prioritised the medical equipment over the patient were labelled a 'bad' nurse and those nurses who took the time to talk to the patient, orientate them and fully understand what the patient was feeling were the 'good' nurses (Granberg et al., 1998). This highlights the importance of maintaining basic communication skills when nursing in a technology heavy environment. This highly confused state that a patient may experience in an ICU has also been identified by Stein-Parbury and McKinley (2000). In a review of the published literature from 1980 to 1997, the authors concluded that the highly confused state that a patient experiences in an ICU is often what is best remembered by that patient (Stein-Parbury & McKinley, 2000). This is further supported by a study by Storli, Lindseth and Asplund (2008) who, using a hermeneutic-

phenomenological approach, interviewed ten ICU patients ten years post discharge. They discovered that these patients were still affected by the memories they have of their experience with flash backs of panic and anxiety sometimes occurring. They remembered being in a state of confusion and attempting to give meaning to their chaotic thoughts and unreal experiences (Storli et al., 2008). Storli et al. (2008) highlighted the importance of the nurse to be by their side during that time, to help them find a meaning in their confusion and thus hopefully help to reduce the long term impact of an often terrifying experience.

### **3.3 Ways to Overcome Communication Barriers**

There have been a number of studies that have investigated communication between an intensive care nurse and patient from the nurse's perspective. Beeby (2000) performed a phenomenological study with nine ICU registered nurses in London. The findings of this study showed that 'being there' and 'being close' to a patient were central to the care that the nurses provided. These perceptions of the nurses match what Stein-Parbury (2014) identifies as 'being for' the patient. To 'be there' or 'be close', a level of communication was required between the nurse and the patient. It was crucial that the patient could understand them and that they in turn could obtain feedback from the patient (Beeby, 2000). In this study the nurses have identified the need to communicate with the patient when 'being there' and 'being close' to a patient and believe that they are able to achieve this in the intensive care environment (Beeby, 2000). Barriers to communication were however, identified as one of the major frustrations of the nurses, as they could significantly hinder care (Beeby, 2000). In stating this, the nurses have highlighted the importance of finding a way to overcome communication barriers to provide the patient with proper nursing care.

Many of the studies that have described the ICU experience from the patient's perspective have also highlighted the importance of the nurse overcoming the communication

barriers and forming a relationship with the patient (Wojnicki-Johansson, 2001; Carroll, 2007; Karlsson, Forsberg, et al., 2012). The participants in the study by Carroll (2007) mentioned the nurses that made the effort to lip-read and spent time trying to understand them, made them feel empowered and much more positive about their rehabilitation progress (Carroll, 2007). In intensive care units the use of facial expressions and gestures are often the easiest form of communication for the patient however these can also be the hardest forms for a nurse, physician and family/whanau to interpret. Karlsson et al. (2012) attributed this to mechanically ventilated patients having their faces obscured by tape and tubes often rendering the patients expressionless. Another form of communication can be via the use of aids such as a pen and paper or communication board. Although patients report these methods effective and efficient, they also find them extremely exhausting to use and are often too tired to complete their message. Furthermore, patients are often unable to write because of injuries to their hands (Karlsson et al., 2012).

### **3.3.1 Touch.**

The use of touch for communicating with patients who are confused, sedated or unconscious has also been recommended by a number of authors. A 2009 study by Hertenstein, Holmes and McCullough showed that the use of touch can be a powerful conveyer of emotions between people. Participants in the study were given an emotion to display via touch to another participant. No other form of communication was used and the participant receiving the touch information was blind to the participant giving it. It was discovered that emotions such as anger, fear, happiness, sadness, love and sympathy could be decoded by the receiving participant through different forms of touch (Hertenstein, Holmes, McCullough, & Keltner, 2009). The use of touch as a method of communication was mentioned by Stein-Parbury (2009). She warns that nurses must be aware of a patient's personal space. The act of caring for a patient frequently requires the nurse to move into the personal space of a person. Stein-Parbury (2009) mentions

the zones of touch through which a nurse may move. Zones such as the face, front of body and genitalia require much more sensitivity than the likes of the hands, arms, shoulders and back (Stein-Parbury, 2009). It would be crucial that a nurse is aware of this prior to communicating with a patient via touch. Three forms of touch that are frequently used in nursing were described by Verity (1996). Comforting touch is used by nurses to assist the patient with coping with stressors related to their illness. Task touch is used when performing nursing tasks; this has been identified as the most frequent use of touch in an intensive care environment. Finally affectionate touch can be used by nurses to transmit and receive signals of recognition, acceptance, protection and caring concern. This form of touch has been identified as extremely important for sedated and unconscious patients with an increased need of reassurance and security (Verity, 1996).

Interviews with patients who have spent time in an intensive care unit have shown that in many cases patients remember very little. Interestingly however often they will remember times when a caregiver or family member used touch to communicate with the patient and noted that it made them feel comforted and reassured (Russell, 1999). This aligns with findings from a 2009 study where patients cared for in two ICUs in Sweden were exposed to tactile touch therapy and compared with those who were not. The patients who received touch therapy reported that it provided them with moment of pleasure during their critical illness and gave them hope for the future (Henricson, Segesten, Berglund, & Määttä, 2009). Most importantly it allowed the patients to experience the “here and now”; they returned to reality for the duration of the tactile touch therapy. This has the potential to greatly reduce the incidence of the subsequent post-traumatic stress disorder that has been correlated with ICU admission (Henricson et al., 2009). This is supported by a study by Wojnicki-Johansson (2001) who interviewed 22 patients and their respective nurses about the effectiveness of communication in ICU. This included their preferred communication methods. Fifty-four percent of the

patients preferred the method of body language and touch and although the nurses reported using a mixture of methods, they also found the body language and touch was the most effective way of communicating with their patients (Wojnicki-Johansson, 2001). For a nurse caring for an unconscious or sedated patient, the use of touch is a powerful way to overcome barriers that prevent therapeutic communication to the patient. It allows for reassurance and a feeling of safety to be conveyed to the patient.

### **3.3.2 Knowing the patient.**

In 2012 Karlsson, Lindahl and Bergbom released findings from a study in which they video recorded and then analysed how patients communicated during mechanical ventilation. This study delved into how patients felt while receiving mechanical ventilation and asked them about their preferred communication methods. This study is relatively unique in that the patients were still in intensive care and receiving mechanical ventilation while the interview took place. One of the key findings of this study was that, due to the face of the patient being obscured by tubes and tape, the nurses could not read the facial expressions of the patient. This would mean that often the nurses would often not engage with the patient as they perceived that patient as not wanting to be disturbed. The patients felt that the nurses were unaware of their needs because the nurses interpreted their minimal use of facial expression as not wanting to be disturbed (Karlsson et al., 2012). This study also investigated the modes of communication used by the patients. Head nods, writing and lip-reading were the easiest forms of communication for the patients. It was noted that writing was very tiring for patients and they often didn't successfully communicate their needs before they were exhausted (Karlsson et al., 2012). This is supported by the findings of Carroll (2007) who also investigated communication in non-vocal patients. Although not in an intensive care unit, the participants in Carroll's study experienced mechanical ventilation and were unable to vocalise for at least two hours a day during the time of the interview. The participants in this study highlighted the



need to keep communication as close to speaking as possible. They all preferred to mouth words and communicating with a competent lip-reader that knew the patient allowed them to almost feel they were communicating “naturally” (Carroll, 2007). These studies support a conclusion made by Magnus and Turkington (2006) following a series of semi-structured interviews with patients who had recently been transferred to a ward following their intensive care admission. It was discovered that knowing the patient and their preferred communication methods can greatly assist the registered nurse and the patient with developing rapport and a relationship (Magnus & Turkington, 2006). These studies highlight the importance of continuity of care in an intensive care environment as a way to overcome certain barriers to communication.

### **3.3.3 Verbal communication.**

Although a patient may be unable to communicate verbally, the nurse still has this ability and it is vital that it is used. Studies have shown that in unconscious patients often hearing is one of the only remaining senses. There are also a significant number of reports of sedated patients remembering the noises that surround them. Some reports from patients have detailed the distress they felt at hearing the nurses discuss their personal lives whilst providing the patient with intimate cares. This made them feel very impersonalised and as though they were non-existent (Russell, 1999; Jenabzadeh & Chlan, 2011). Verbal communication remains the most efficient form of communication when caring for a patient in intensive care. Patients that were interviewed in a study by Samuelson (2007) reported the sounds of voices around them as being calm and relaxing. Hearing people talking in a relaxed manner assisted the patients with feeling safe and comforted (Samuelson, 2011). A number of studies have explained the importance of talking to patients and giving them adequate and accurate information about their situation, treatment and prognosis. In her reflection on her own experience as a critically ill patient, Jenabzadeh (2011) felt reassured and comforted when the

nurses would talk to her directly and explain the care that was being provided. Alternatively when a nurse was caring for her and did not acknowledge her she would feel anxious and frustrated (Jenabzadeh & Chlan, 2011). The frustration that patients feel at a lack of information was also reported by Wojnicki-Johansson (2001) and Magnus and Turkington (2005). Magnus and Turkington also mentioned that it is possible that the nurse may have given the patient the information they desire however the patient can easily forget this. As such it is important that the nurse is constantly checking in with the patient to ensure that they have remembered all of the necessary information (Magnus & Turkington, 2006). It is important that nurses continue to speak directly to their patients during care not only to reassure the patient but also as a respect for the dignity of that patient during a time when they are particularly vulnerable.

### **3.3.4 Patient empowerment**

One aspect of a critically ill patient's intensive care unit experience is a feeling of a loss of control and having to rely on technology and other people to survive (Granberg et al., 1998; Granberg et al., 1999; Hofhuis et al., 2008; Karlsson, Bergbom, et al., 2012). It is possible that these feelings can contribute to the acute confusion and delirium that is associated with ICU syndrome. Almerud et al. (2007) reported that when working in the technologically advanced environments, caregivers tended to set the tone and give directions regarding treatment. Patients were not allowed to participate in or decide their course of treatment (Almerud et al., 2007). This contradicts the way nurses are taught to care for a patient; in a negotiated partnership that is built on mutual agreement and trust. Wåhlin, Ek and Idvall (2006) investigated how patient empowerment can help to reduce these feelings of being out of control, assisting patients with remaining in the moment thus reducing acute confusion. Patient empowerment involves the patient's participation in healthcare decisions. This can be as simple as arranging a pillow in a way that is most comfortable for a patient or informing a patient of

test results and what they mean. It was discovered that patient empowerment occurred naturally when the environment surrounding the patient was positive and safe. It was important that patients were provided with the full details of any information as when the overheard snippets they could easily become confused and distressed (Wåhlin et al., 2006). It was discovered that patient empowerment in intensive care can increase the patient's joy in life and enhance their will to survive (Wåhlin et al., 2006)

### **3.4 Successful Communication**

When evaluating the success of communicating with a critically unwell patient, it is important that a nurse considers how their own perceptions of the patient's experience and how the patient's perceptions of that experience may differ. A study by Wojnicki- Johansson (2001) provided some interesting insight in to how the nurse's perceptions can differ from those of the patients. The author used a series of structured questionnaires to understand how both the patients and the nurses caring for them communicated. Twenty two patients and each of their respective nurses participated in the study. It was discovered that nineteen of the nurses believed that they were successfully communicating with their patient and were both taking into account and meeting their needs. Interestingly however, only thirteen of the patients reported that the nurses understood their wishes (Wojnicki-Johansson, 2001). Although taking into account the patient's preferences for communicating is very important, at times another barrier may present in the nurses skill level. As mentioned earlier, patients interviewed by Carroll (2007) identified the need to try to communicate as naturally as possible. Their preferred method of communication was through lip-reading. It is likely that not all nurses are able to successfully lip read and this could lead to another frustration for the patient. The implications of these studies are that, although a nurse may believe that he or she is forming or has formed a negotiated partnership with their patient, the patient doesn't perceive this. This is very important when considering communication and the establishment of a therapeutic

relationship. If a patient doesn't believe that they are being looked after in a caring manner then no matter what the opinions of the nurse, they are right.

## **4 The Stages of the Therapeutic Relationship and Their Barriers**

Communication is a vital component for autonomy during the recovery process but effective communication becomes particularly beneficial during the establishment of a professional therapeutic relationship. A well established and appropriate therapeutic relationship is very important as it enables trust and connectedness to develop between the nurse and patient. This is something that people in vulnerable positions, such as a patient in hospital, can find solace in during a difficult time in their lives (Stein-Parbury, 2014). The therapeutic relationship consists of a number of components that make it unique. Empathy, respect, genuineness, correctness and confrontation are all required to make a relationship therapeutic (Treas & Wilkinson, 2013) however for these components to be present the relationship must progress through a number of phases to a level where each party can display these characteristics. Although there is minimal literature directly related to the therapeutic nurse-patient relationship in an intensive care unit, studies that have investigated the patient's perspective of their experiences can provide some insight. It appears that there are many barriers that can exist which make it much harder to progress through the phases of the relationship.

### **4.1 The Pre-Interaction Phase**

The pre-interaction phase that occurs initially is likely to be the only stage during which a nurse is able to confidently carry out. This involves the gathering of data and information about the person he or she will be caring for (Treas & Wilkinson, 2013). When referring to Liaschenko and Fisher's (1999) components to knowing a patient, this stage will involve the

gathering of case knowledge and some patient knowledge. This stage should not be affected by the acuity of the patient.

## **4.2 The Orientation Phase**

The second stage through which a therapeutic relationship should progress is the orientation phase. This involves meeting the patient for the first time, performing introductions and allowing the patient to explain their reason for the visit (Treas & Wilkinson, 2013). In a developing therapeutic relationship between nurse and patient in intensive care, this is where a number of barriers may arise. An unconscious, sedated or confused patient is likely to be unable to introduce themselves to a nurse, and explaining the reason for the visit is likely to be near impossible. Furthermore, a critically ill patient will typically be ventilated requiring either an endotracheal tube or a tracheostomy, both of which render the patient unable to speak. It is likely that these barriers to this phase will mean that it is either very brief or completely omitted (Treas & Wilkinson, 2013). A study by Almerud et al. (2007) interviewed nine intensive care patients about the experience of being a patient in a highly technological area. They found that upon commencement of their treatment/ admission to the unit, the patients gave themselves over to the healthcare system unquestioningly. They did not expect and nor did they receive any form of orientation and introduction to the unit and their health care team (Almerud et al., 2007) thus supporting the comment by Treas & Wilkinson (2013) regarding the omission of this stage.

## **4.3 The Working Phase**

The working phase of the relationship is often thought of as the active phase. This occurs following the establishment of rapport and often contains the bulk of the therapeutic communication (Treas & Wilkinson, 2013). It is during this stage that the components of the therapeutic relationship will be most prominent. The nurse will be providing the patient with

care and in return the patient expresses their thoughts and feelings. The relationship reaches this level through negotiation and mutual respect between the nurse and patient (Treas & Wilkinson, 2013). In an intensive care unit it is possible that it is during this stage that the nurses actions will be noticed by the patient and the patient may begin to contribute to the relationship. Studies that have investigated the patient's perspective of their intensive care experience have provided some insight into the working stage of the therapeutic relationship. They have highlighted medical interventions such as suctioning, or the removal of secretions from the airway, as particularly traumatic (Granberg et al., 1998; Hofhuis et al., 2008; Jenabzadeh & Chlan, 2011; Samuelson, 2011; Karlsson et al., 2012; Karlsson et al., 2012; Baumgarten & Poulsen, 2015). Furthermore, patients were more likely to remember these moderately to extremely traumatic events (Rotondi et al., 2002). A registered nurse providing patient centred care in an appropriate therapeutic relationship should be able to assist the patient through these experiences by providing explanations about the process and what to expect and being a source of comfort and reassurance during the experience.

In a reflective piece on her own experience of mechanical ventilation, Jenabzadeh (Jenabzadeh & Chlan, 2011) described the discomforts associated with mechanical ventilation and mentions the nurse's ability to make these traumatic experiences far worse or much better. The endotracheal tube was very irritating to her throat and her mouth was always dry. She would feel like she was "drowning in secretions" and the only way to fix this was to be suctioned. This would make her body convulse as she felt as though her insides were being "pulled out" She states that "they [the nurses] made the difference between my being in agony and my feeling comfortable and safe" (Jenabzadeh & Chlan, 2011). Jenabzadeh also mentioned the frustration of hearing conversations between nurses and their colleagues about their personal life; she believes that nurses often assume that because a patient is sedated they are no longer aware of what is occurring around them. This has been supported by a number of

other studies including one by Russell (1998) who interviewed patients on their ICU experience. A number of patient's in this study remember having intimate procedures such as a bed wash performed whilst staff joked about their social lives (Russell, 1999). The nurses in these studies are not actively engaging in the working phase of the therapeutic relationship, they are instead making assumptions about their patients level of consciousness. These accounts demonstrate how a patient can easily lose their dignity and become increasingly vulnerable during this phase of the therapeutic relationship. It is important that a critical care nurse recognises this. Karlsson et al. (2012) highlighted this importance in a study in which they interviewed 12 patients who had been conscious during mechanical ventilation in an intensive care unit. They concluded that nurses must be constantly present and willing to cooperate and interact with the patient to understand their dependence and vulnerability (Karlsson et al., 2012). Although these findings were from a study in which conscious patients were interviewed, it is clear that sedated patients continue to be aware of what is occurring around them. It has been mentioned that sedated patients may require the nurse's presence even more as they are often confused and thus unable to make sense of what is occurring (Granberg et al., 1999; Stein-Parbury & McKinley, 2000; Storli, Lindseth, & Asplund, 2008). Nurses in intensive care need to have a heightened awareness of developing a therapeutic relationship with their patients even if communication can only occur one way.

#### **4.4 The Termination Phase**

The final stage of the therapeutic relationship as described by Treas & Wilkinson (2013) is the termination phase which occurs as the patient is moving on from under the care of the nurse. This may be at the conclusion of a shift or as the patient is leaving the ward, facility or service (Treas & Wilkinson, 2013). It is important that the nurse and patient leave the relationship in a state that means they are prepared for future interactions but not expecting anything more. In intensive care there is the possibility that this stage of the relationship can



proceed as normal. A patient will usually leave intensive care following extubation and a reduction in their sedative drugs. As a result the communication will be much easier. However, relationships that must end at the conclusion of a shift can again face similar barriers. As a result this is a stage in the relationship where communication between colleagues can assist the patient with feeling secure and safe. By sharing observations and communication methods, nurses and other members of the multidisciplinary team can ensure that the patient continues to remain involved in their care and retain as much autonomy and dignity as possible (Treas & Wilkinson, 2013).

## **4.5 Successful Relationships**

A report by Foster and Hawkins (2005) brought in to question the fate of the therapeutic relationship in technology dependent areas. They identified how, even on a standard ward, the presence of technology can prevent a therapeutic relationship from developing. A nurse can walk into a room, check that a pump is doing its job and then leave. This requires no engagement with the patient (Foster & Hawkins, 2005). A patient in an ICU bed will be connected to an array of different machines that will tell the nurse exactly how the patient is physiologically coping. This removes the need for the nurse to form a relationship with the patient to determine how they are responding to their treatment (Foster & Hawkins, 2005). It is important that registered nurses in highly technological areas are aware of this so that they can do their best to encourage a therapeutic relationship between themselves and their patients. There are numerous barriers that can prevent the natural development of a nurse-patient therapeutic relationship in intensive care but it is important that registered nurses find ways to overcome these barriers and work alongside the patient to provide them with quality, person-centred care.

There have been a number of reflective articles that discuss how a nurse forms a therapeutic relationship in intensive care. In a reflection on his practice, Johns (2005) mentioned the difficulty he has in developing a therapeutic relationship with his patients. In an ICU environment it is very easy for a nurse to increase the sedation of an agitated patient rather than attempt to communicate with them to discover the source of their agitation (Johns, 2005). As mentioned in an earlier section, O'Connell (2008) has also reflected on her practice as a critical care nurse in an Irish hospital. She believed that she had developed a therapeutic relationship as she had come to know the patient both physically, through the machines and as an individual, through his family (O'Connell, 2008). Although technically the nurse wasn't in a negotiated partnership with the patient, she was still able to negotiate his care through interactions with his family. O'Connell also gave a reason as to why nurses may be hesitant about forming relationships with their extremely unwell patients. An engaging relationship exposes the nurse to emotional pain as the chances of their patient not surviving is much higher than if they were in a different nursing environment. O'Connell was advised by a more experienced nurse to avoid relationships such as the one she developed with her patient if she "*wanted to survive this place*" (O'Connell, 2008). This has been supported by Verity (1996) who, in a review of the literature, concluded that nurses themselves can create barriers to communication and thus the development of a therapeutic relationship. This occurs as the nurses do not want to develop a closeness to the patient that will place them in a vulnerable position (Verity, 1996). Furthermore, Verity stated that nurses find it most difficult to communicate with those who perhaps need the most communication. That is those patients who may be bereaved, distressed or dying. Verity (1996), Foster and Hawkins (2005), Johns (2005) and O'Connell (2008) all make it evident that for a nurse working in intensive care, the development of a therapeutic relationship is very difficult as barriers present not only in the form of technology, but also in the emotional requirements of the registered nurse.

The success of the therapeutic relationship in intensive care from the patient's perspective appears to have received minimal discussion in the literature. The study by Granberg et al. (1999) addressed the patient's memories of the nursing staff. The patients reported on the sensitivity they felt towards the nursing staff. Although they did not specifically identify their experiences with their nurses as being good or bad and they did not comment on the exact nature of the relationship, they noted that the behaviour of the nurse would impact how they felt about their situation. For example a nurse who took the time to overcome the communication barriers and talk to the patient in a relaxed manner would make the patient feel human again (Granberg et al., 1999). It appears that in this situation some nurses were very good at this and others not so. It is possible that this was related to the nurse's experience with handling the technology (Granberg et al., 1999). It is evident that more research in this area is required give a better description of how a critically ill patient perceives the nurse-patient relationship.

## 5 Health Outcomes

With the cost per day of an intensive care unit stay steadily increasing, it is unsurprising that hospitals around the world are looking for ways to reduce the number of days that a patient may stay in ICU. The factors that can influence the length of stay in an intensive care unit are numerous and it would be impossible to list them all. They can include number of physicians employed in the unit, specific medical interventions used by a unit, the type and severity of patient illness and whether or not a patient has an advanced directive in place (Gruenberg et al., 2006). There are also a number of social and psychological factors that Gruenberg et al. (2006) believed could be improved by an increase in communication between health professionals, patient and the patient's family. Despite stating this, Gruenberg et al. (2006) went on to only review an increase in communication between health professionals and patient's families. In the literature surrounding communication levels and health outcomes, this is a well-researched topic. Many articles provide statistics on how increasing communication with the family members of a patient can help to reduce the number of ventilated days and the number of days in ICU (Ahrens, Yancey, & Kollef, 2003; Gruenberg et al., 2006; Curtis et al., 2015). There is very minimal literature around how increasing communication with the patient may assist with reducing their stay.

A study by Henricson et al. (2008) provided some interesting insight into how tactile touch can reduce stress. A randomised controlled trial was performed in two ICUs in Sweden, some patients received tactile touch therapy during a one hour rest period, and others did not receive any touch therapy. It was discovered that in those patients who received tactile touch therapy, anxiety levels (as measured by the Faces Anxiety Scale developed by McKinley et al. (McKinley, Stein-Parbury, Chehelabi, & Lovas, 2004)) were significantly reduced during the phasing out of sedatives (Henricson et al., 2008). Furthermore, patients required

significantly lower doses of noradrenaline to achieve circulatory stability following tactile touch therapy, again suggesting a reduction in stress levels. Although these findings are not directly linked to communication and the therapeutic relationship between nurse and patient, the use of touch is a tool that a nurse can easily employ to assist him/her in communicating not only with an unconscious or sedated patient but also a conscious patient who is unable to vocalise. As mentioned earlier, the use of therapeutic touch is able to convey feelings of love, sympathy and reassurance with patients reporting touch between them and a caregiver or family member provided them with moments of pleasure and feelings of safety (Russell, 1999; Henricson et al., 2009).

Another outcome that has also been considered in studies is the psychological effect of an intensive care admission. Post-traumatic stress disorder (PTSD) can be experienced by critically ill patients following their recovery (Cuthbertson, Hull, Strachan, & Scott, 2004; Davydow, Gifford, Desai, Needham, & Bienvenu, 2008; Jones et al., 2007). In a study by Jones et al. (2007) 238 patients were interviewed one week, two months and three months post-discharge from an intensive care unit about their memories of intensive care. They also investigated the rate of PTSD among the patients. The patients included in this study had no previous PTSD diagnosis and were not at risk for developing PTSD for anything other than their ICU admission. The memories of the experience were predominantly of treatments and procedures that the patients found extremely traumatic. Due to their confused and delirious states, patients would often perceive routine nursing procedures such as an injection as an attempt on their life by the nurse (Jones et al., 2007). They reported that they never felt safe or cared for. The patients with these memories also had the highest rates of PTSD symptoms. The authors concluded that the nature of the ICU care dictated the chance of a patient experiencing PTSD symptoms. This is supported by Samuelson (2011) who investigated the memories that patients retained of their ICU stay post discharge. Out of the 250 participants, 81% remembered

their stay with 71% of those who remembered describing unpleasant memories (Samuelson, 2011). These unpleasant memories included physical, emotional, perceptual and environmental distress and being unable to express this. The patients in this study described the attitudes of some nurses as disrespectful, non-caring and lacking in attention and these traits often resulted in an unpleasant and stressful experience for the patient. Conversely, when a patient reported a nurse with a caring attitude and “nice” personality they also reported feeling relief from their distress. According to the author, some of the patients came to the conclusion themselves that the professionalism of the staff could counterbalance stressful experiences. The majority of the memories that these patients retained were stressful with poor nursing care being noted as running alongside the stressful experiences. It was also mentioned however that a skilful and caring nurse could reduce the trauma associated with some experiences (Samuelson, 2011). These studies highlight the importance of maintaining a form of communication with a patient in intensive care to help them understand their experience and remind them that they are safe. It is possible that the patients who reported being fearful of the nurse in the study by Jones et al. (2007) had had the procedures explained to them and had forgotten. The patients in a study by Magnus & Turkington (2005) explained that often they could not remember having procedures explained to them or may not have properly understood the explanations despite the nurse having reported giving the explanation.

Currently there appears to be very minimal evidence regarding the health outcomes for intensive care patients and if these outcomes are influenced by the care they receive from their nurse. The above studies indicate that the presence of a caring nurse could potentially minimise unpleasant memories for the patient and that nurses that overcome communication barriers and develop a trusting relationship with their patient are likely to improve that patient’s recollection of their stay. There is also evidence to show that improving communication through the nurse of touch with a patient can assist in reducing stress levels requiring less medication to keep

them physiologically stable. It is possible that the length of stay for these patients may have been reduced by this intervention.

## 6 Proposal for Future Research

From the above literature review, it is evident that there remains a gap in the current research. A proposal for a future study could therefore be to investigate if improving the critically ill patient's voice through the therapeutic nurse-patient relationships can improve the health outcomes for that patient. Health outcomes could include the number of days the patient is ventilated and the number of days they spend in the intensive care unit and other hospital wards. This could be achieved through the use of action research. Action research involves implementing a change in an environment and then measuring how the change influences the area of interest (O'Reilly & Kiyimba, 2015). Action research is a useful tool as it involves not only researchers in the research process but also those working in the practice-based environment. Furthermore, it enables the researcher to position themselves alongside a world-view that is consistent with their own beliefs (O'Reilly & Kiyimba, 2015). In this situation, a potential methodology could involve recruiting two intensive care units. One would continue to care for patients as they had been with no change in their practice. In the other unit nurses could be provided with additional information and assistance to ensure that all patients are properly communicated with and that appropriate, high quality therapeutic relationships are established. Following this, both the patients and their respective nurses could be interviewed about their experience, and the health outcomes for the patient measured.

Although this method could answer the question and fill a gap in the literature, there are a number of variables that would need to be controlled for and there would also be a number of factors that would need to be considered to ensure that the project would be ethical. It would not be possible to compare the results from the two intensive care units unless the patients were very similar. As such, it is likely that it would take a long time to gather data and there would be the possibility that it would be extremely difficult to get congruency between the patients.



Ethically there could also be some issues with obtaining consent from the patients. As the majority of patients enter intensive care either unconscious or heavily sedated gaining informed consent would be extremely difficult. There is the possibility that this could be avoided by only including those patients for whom admission is planned such as cardiac surgery patients however this would make the results much less generalisable to the intensive care patient population as a whole. It is likely that this methodology will prove difficult to carry out however the results that could be gained from such a study will be important as they will possibly provide some insight into how health outcomes for a critically ill patient could be improved.

## Conclusion

The experience of being a critically ill patient in an ICU has been described as scary and at times traumatic. In confused and delirious states, patients can perceive routine medical interventions and nursing cares as harmful as they do not understand what is happening and why it is happening. This is further compounded by being 'voiceless'. The patients feel they are unable to express themselves and communicate their feelings to those in charge of their care. This can lead to an ineffective nurse-patient relationship whereby the nursing cares are not being provided as part of a negotiated partnership, but rather as what the nurse perceives as necessary. A registered nurse has a responsibility and the ability to assist the patient with finding their voice during their ICU stay. By getting to know the patient and using varying forms of communication, it is possible that the patient can become involved in their treatment. Although there is currently limited information surrounding this topic, it is likely that, as a patient finds their voice and consistently gets their mental and emotional needs met, their health outcomes may improve. As such, future research into this area could include assessing if improving critically ill patient's voices through the establishment of a therapeutic nurse-patient relationship can improve the health outcomes for those patients.

## References

- Ahrens, T., Yancey, V., & Kollef, M. (2003). Improving family communications at the end of life: implications for length of stay in the intensive care unit and resource use. *American Journal of Critical Care, 12*(4), 317-324.
- Almerud, S., Alapack, R. J., Fridlund, B., & Ekebergh, M. (2007). Of vigilance and invisibility—being a patient in technologically intense environments. *Nursing in Critical Care, 12*(3), 151-158.
- Almerud, S., Alapack, R. J., Fridlund, B., & Ekebergh, M. (2008). Beleaguered by technology: care in technologically intense environments. *Nursing Philosophy, 9*(1), 55-61.
- Baumgarten, M., & Poulsen, I. (2015). Patients' experiences of being mechanically ventilated in an ICU: a qualitative metasynthesis. *Scandinavian Journal of Caring Sciences, 29*(2), 205-214.
- Beeby, J. P. (2000). Intensive care nurses' experiences of caring part 2: research findings. *Intensive and Critical Care Nursing, 16*(3), 151-163.
- Bundgaard, K., Nielsen, K. B., Delmar, C., & Sørensen, E. E. (2012). What to know and how to get to know? A fieldwork study outlining the understanding of knowing the patient in facilities for short-term stay. *Journal of Advanced Nursing, 68*(10), 2280-2288.
- Carroll, S. M. (2007). Silent, slow lifeworld: the communication experience of nonvocal ventilated patients. *Qualitative Health Research, 17*(9), 1165-1177.
- Curtis, J. R., Treece, P. D., Nielsen, E. L., Gold, J., Ciechanowski, P. S., Shannon, S. E., Engelberg, R. A. (2015). Randomized trial of communication facilitators to reduce family distress and intensity of end-of-life care. *American Journal of Respiratory and Critical Care Medicine*(ja).
- Cuthbertson, B. H., Hull, A., Strachan, M., & Scott, J. (2004). Post-traumatic stress disorder after critical illness requiring general intensive care. *Intensive Care Medicine, 30*(3), 450-455.
- Davydow, D. S., Gifford, J. M., Desai, S. V., Needham, D. M., & Bienvenu, O. J. (2008). Posttraumatic stress disorder in general intensive care unit survivors: a systematic review. *General Hospital Psychiatry, 30*(5), 421-434.

- Foster, T., & Hawkins, J. (2005). The therapeutic relationship: dead or merely impeded by technology? *British Journal of Nursing*, 14(13), 698-702.
- Granberg, A., Engberg, I. B., & Lundberg, D. (1998). Patients' experience of being critically ill or severely injured and cared for in an intensive care unit in relation to the ICU syndrome. Part I. *Intensive and Critical Care Nursing*, 14(6), 294-307.
- Granberg, A., Engberg, I. B., & Lundberg, D. (1999). Acute confusion and unreal experiences in intensive care patients in relation to the ICU syndrome. Part II. *Intensive and Critical Care Nursing*, 15(1), 19-33.
- Gruenberg, D. A., Shelton, W., Rose, S. L., Rutter, A. E., Socaris, S., & McGee, G. (2006). Factors influencing length of stay in the intensive care unit. *American Journal of Critical Care*, 15(5), 502-509.
- Hafsteindóttir, T. B. (1996). Patient's experiences of communication during the respirator treatment period. *Intensive and Critical Care Nursing*, 12(5), 261-271.
- Henricson, M., Ersson, A., Määttä, S., Segesten, K., & Berglund, A.L. (2008). The outcome of tactile touch on stress parameters in intensive care: a randomized controlled trial. *Complementary Therapies in Clinical Practice*, 14(4), 244-254.
- Henricson, M., Segesten, K., Berglund, A., & Määttä, S. (2009). Enjoying tactile touch and gaining hope when being cared for in intensive care-a phenomenological hermeneutical study. *Intensive & Critical Care Nursing*, 25(6), 323-331. doi: 10.1016/j.iccn.2009.07.001
- Hertenstein, M. J., Holmes, R., McCullough, M., & Keltner, D. (2009). The communication of emotion via touch. *Emotion*, 9(4), 566.
- Hofhuis, J. G. M., Spronk, P. E., van Stel, H. F., Schrijvers, A. J. P., Rommes, J. H., & Bakker, J. (2008). Experiences of critically ill patients in the ICU. *Intensive & Critical Care Nursing*, 24(5), 300-313.
- Jenabzadeh, N., & Chlan, L. (2011). A nurse's experience being intubated and receiving mechanical ventilation. *Critical Care Nurse*, 31(6), 51-54.
- Johns, C. (2005). Reflection on the relationship between technology and caring. *Nursing in Critical Care*, 10(3), 150-155.
- Jones, C., Bäckman, C., Capuzzo, M., Flaatten, H., Rylander, C., & Griffiths, R. (2007). Precipitants of post-traumatic stress disorder following intensive care: a hypothesis generating study of diversity in care. *Intensive Care Medicine*, 33(6), 978-985.

- Karlsson, V., & Forsberg, A. (2008). Health is yearning—experiences of being conscious during ventilator treatment in a critical care unit. *Intensive and Critical Care Nursing*, 24(1), 41-50.
- Karlsson, V., Bergbom, I., & Forsberg, A. (2012). The lived experiences of adult intensive care patients who were conscious during mechanical ventilation: a phenomenological-hermeneutic study. *Intensive and Critical Care Nursing*, 28(1), 6-15.
- Karlsson, V., Forsberg, A., & Bergbom, I. (2012). Communication when patients are conscious during respirator treatment—A hermeneutic observation study. *Intensive and Critical Care Nursing*, 28(4), 197-207.
- Karlsson, V., Lindahl, B., & Bergbom, I. (2012). Patients' statements and experiences concerning receiving mechanical ventilation: a prospective video-recorded study. *Nursing inquiry*, 19(3), 247-258.
- Kress, J. P., Pohlman, A. S., O'Connor, M. F., & Hall, J. B. (2000). Daily interruption of sedative infusions in critically ill patients undergoing mechanical ventilation. *New England Journal of Medicine*, 342(20), 1471-1477.
- Liaschenko, J., & Fisher, A. (1999). Theorizing the knowledge that nurses use in the conduct of their work. *Research and Theory for Nursing Practice*, 13(1), 29-41.
- Magnus, V. S., & Turkington, L. (2006). Communication interaction in ICU-Patient and staff experiences and perceptions. *Intensive & Critical Care Nursing*, 22(3), 167-180.
- McGrath, M. (2008). The challenges of caring in a technological environment: critical care nurses' experiences. *Journal of Clinical Nursing*, 17(8), 1096-1104.
- McKinley, S., Stein-Parbury, J., Chehel Nabi, A., & Lovas, J. (2004). Assessment of anxiety in intensive care patients by using the Faces Anxiety Scale. *American Journal of Critical Care*, 13(2), 146-152.
- McQueen, A. (2000). Nurse–patient relationships and partnership in hospital care. *Journal of Clinical Nursing*, 9(5), 723-731.
- Nursing Council of New Zealand. (2012). *Code of conduct for nurses*. Retrieved from <http://www.nursingcouncil.org.nz/Nurses/Code-of-Conduct>
- Nursing Council of New Zealand. (2012). *Competencies for registered nurses*. Retrieved from <http://www.nursingcouncil.org.nz/Nurses/Scopes-of-practice/Registered-nurse>
- O'Connell, E. (2008). Therapeutic relationships in critical care nursing: a reflection on practice. *Nursing in Critical Care*, 13(3), 138-143.

- O'Reilly, M., & Kiyimba, N. (2015). *Advanced qualitative research: A guide to using research theory*. London, UK: SAGE Publications.
- Rotondi, A. J., Chelluri, L., Sirio, C., Mendelsohn, A., Schulz, R., Belle, S., Pinsky, M. R. (2002). Patients' recollections of stressful experiences while receiving prolonged mechanical ventilation in an intensive care unit. *Critical Care Medicine*, 30(4), 746-752.
- Russell, S. (1999). An exploratory study of patients' perceptions, memories and experiences of an intensive care unit. *Journal of Advanced Nursing*, 29(4), 783-791. doi: 10.1046/j.1365-2648.1999.00953.x
- Samuelson, K. A. (2011). Unpleasant and pleasant memories of intensive care in adult mechanically ventilated patients—Findings from 250 interviews. *Intensive and Critical Care Nursing*, 27(2), 76-84.
- Samuelson, K., Lundberg, D., & Fridlund, B. (2006). Memory in relation to depth of sedation in adult mechanically ventilated intensive care patients. *Intensive Care Medicine*, 32(5), 660-667.
- Stein-Parbury, J. (2009). Communication. In J. Crisp & C. Taylor (Eds.), *Potter & Perry's fundamentals of nursing* (pp. 369-390). Australia: Elsevier.
- Stein-Parbury, J. (2014). *Patient & person: interpersonal skills in nursing*. Australia: Elsevier.
- Stein-Parbury, J., & McKinley, S. (2000). Patients' experiences of being in an intensive care unit: a select literature review. *American Journal of Critical Care*, 9(1), 20-27.
- Storli, S. L., Lindseth, A., & Asplund, K. (2008). A journey in quest of meaning: a hermeneutic-phenomenological study on living with memories from intensive care. *Nursing in Critical Care*, 13(2), 86-96.
- Strøm, T. (2012). Sedation in the ICU. *Dan Med J*, 59(59), B4458.
- Strøm, T., Martinussen, T., & Toft, P. (2010). A protocol of no sedation for critically ill patients receiving mechanical ventilation: a randomised trial. *Lancet*, 375(9713), 475.
- Tembo, A. C., Higgins, I., & Parker, V. (2014). The experience of communication difficulties in critically ill patients in and beyond intensive care: Findings from a larger phenomenological study. *Intensive and Critical Care Nursing*(0). doi: 10.1016/j.iccn.2014.10.004

- The Commonwealth Fund. (2015). International profiles of healthcare systems. Retrieved from [http://www.commonwealthfund.org/~media/files/publications/fund-report/2015/jan/1802\\_mossialos\\_intl\\_profiles\\_2014\\_v7.pdf](http://www.commonwealthfund.org/~media/files/publications/fund-report/2015/jan/1802_mossialos_intl_profiles_2014_v7.pdf)
- Treas, L., & Wilkinson, J. (2013). *Basic nursing: concepts, skills & reasoning*: F. A. Davis Company.
- Tunlind, A., Granström, J., & Engström, Å. (2014). Nursing care in a high-technological environment: Experiences of critical care nurses. *Intensive and Critical Care Nursing*(0). doi: 10.1016/j.iccn.2014.07.005
- 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.
- Voice [Def 1 & 2]. (2015). Oxford Dictionaries Online. Retrieved from <http://www.oxforddictionaries.com/definition/english/voice>
- Wåhlin, I., Ek, A.-C., & Idvall, E. (2006). Patient empowerment in intensive care—an interview study. *Intensive and Critical Care Nursing*, 22(6), 370-377.
- Wang, K., Zhang, B., Li, C., & Wang, C. (2008). Qualitative analysis of patients' intensive care experience during mechanical ventilation. *Journal of Clinical Nursing*, 18, 183-190.
- Wojnicki-Johansson, G. (2001). Communication between nurse and patient during ventilator treatment: patient reports and RN evaluations. *Intensive and Critical Care Nursing*, 17(1), 29-39.