Critical care nurses' experiences of communication-vulnerable patients in the intensive care unit and the influence on rendering compassionate care

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Background. Interventions administered to critically ill patients, including mechanical ventilation, sedation or other treatments may hinder communication between patients and nurses. These communication challenges may affect critical care nurses' ability to provide compassionate, person-centred care.
Objective. To identify nurses' experiences with patients who are communication-vulnerable in the intensive care unit and how they affect nurses' ability to offer compassionate care.
Method. This qualitative explorative descriptive study involved nurses who worked in intensive care units from four private hospitals in Gauteng, South Africa. Focus groups were conducted with 30 critical care nurses in groups of two to six participants each. Thematic analysis was used to identify themes.
Results. Five main themes were identified based on nurses' reports of their experiences with critically ill patients who experience communication difficulties and their impact on rendering compassionate care. Themes were deductively identified based on the social purposes of communication categories. Participants indicated that communication-vulnerable patients influence their ability to provide compassionate care. Generally, the physical, emotional, social and communication difficulties of assisting communication-vulnerable patients caused nurses to feel frustrated and negative towards their work environment, which added to their work stress and sometimes resulted in compassion fatigue.
Conclusion. The study shows that various factors could impact the nurses' ability to provide compassionate care and that they require support to provide person-centred care. These factors can include the physical environment, the patient's alertness and awareness and institutional barriers. To support nurses in providing compassionate care, communication partner training may be warranted.

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Contribution of the study
This study aims to increase awareness of the aspects that may contribute to compassion fatigue for nurses.
By identifying these aspects greater support can be provided by facilities where nurses work.

Compassion refers to the experience of being deeply connected with others' distress, knowledge of the distress and moral responses to comfort the other person.[1,2] This concept is central to compassionate care in nursing, which can be defined as establishing a relationship with patients to improve patients' health outcomes, safety and dignity.[1,2] It also allows patients to play an active role in their care process.[3] Critical care nurses provide care to persons in distress on a daily basis and therefore the concept of compassionate care should be reflected in their nursing practice.[2,4]

Establishing a relationship with patients involves meeting the social purposes of communication, specifically communicating wants and needs, transferring information, establishing social closeness, applying social etiquette and having an internal dialogue with the self. [5] In the intensive care unit (ICU), establishing such a relationship may be difficult, as patients often experience communication challenges due to endotracheal intubation or other intensive care-related interventions (sedation).[6] Patient communication challenges may affect the nurses' ability to actively listen to the patient, consider the patient's narratives and identify resources, expectations and barriers.[7] This may cause frustration for nurses, prompting them to communicate minimally with communication-vulnerable patients and to reduce the duration of communication.[6,8] Apart from medical interventions that may result in communication vulnerability, patients with a different first language or culture than nurses, are also regarded as communication-vulnerable,[9] which may add to nurse-patient communication challenges and subsequent decline in compassionate care.

Compassionate care occurs within a specific context and therefore the physical environment in which nursing care occurs should also be discussed.[3] The environment in the ICU may be affected by staff shortages, policies that require the nurses to be task orientated and additional responsibilities that could limit nurses' contact time with patients.[10] Most nurses desire to have a compassionate and

empathetic relationship with patients. Nevertheless, in the ICU they often feel overwhelmed by their responsibilities and workload.[11] This may influence their ability to render compassionate care in the ICU.

Personal factors, such as the nurses' own psychological and physical health can also influence their experiences of patients with communication challenges. They may suffer burnout due to work stress, which may in turn lead to depersonalisation, compassion fatigue and emotional exhaustion.[12] Compassion fatigue may be further aggravated by the nurses' feeling of powerlessness within their occupational environment, the continuous experience of trauma and the often complex relationship with families, patients and other healthcare practitioners.[3] This can greatly impact nurses' ability to provide compassionate care and will affect both their person-centred care, job satisfaction and their relationship with the patient.

When critically ill patients also present with communication challenges, it may create even more stress for nurses who do not have the knowledge, skills or time to assist the patient optimally.[13] This problem should be addressed by offering continuing professional development to support the nurses' accomplishments and improve their level of compassionate care.[4,14] Training nurses to address the communication challenges of patients may greatly reduce these nurses' negative experiences and result in improved person-centred care and reduced negative feelings.[15]

The ability of critical care nurses to provide compassionate care is influenced by the interplay of relational components (communication with patients), the physical environment and personal factors affecting the nurse.[3,4] Supporting the nurse in these areas may result in improved person-centred care, contributing to improved patient goal-setting, patient perception of their integrity and an enhanced sense of self.[3] This study aimed to identify nurses' experiences of patients who are communication-vulnerable and the effect on their ability to offer compassionate care.

Methods

Study design

The study followed a qualitative explorative descriptive design. The qualitative design allowed the researchers to obtain descriptive data resulting in a better understanding of the participants' experiences. Four private hospitals from a specific hospital group in Gauteng, South Africa (SA), were involved in this research. The four identified hospitals comprised two or more ICUs including medical, surgical and trauma-related ICUs. Most patients in the ICU were mechanically ventilated due to medical-related complications such as respiratory distress.

Sample

Nurses were registered with the South African Nursing Council (SANC) and were identified by gatekeepers including ICU managers. Purposive sampling was used to identify nurse participants meeting the following criteria: 1) registered nurses and 2) possessing a minimum of 1 year of experience working in ICU settings. Initially, 33 participants were identified by the gatekeepers, however three of the participants were excluded as they did not meet the inclusion criteria. A total of 30 participants were selected and included in six focus groups.

Data collection

Prior to data collection, a focus group script was developed based on the research by Kuyler and Johnson[16] and a pilot study. This script included discussing the ethical considerations for participants and the open-ended questions to obtain the information relevant to addressing the aim. Focus groups were conducted over three months prior to the COVID-19 pandemic at the four hospitals that provided written permission to participate. A group of two to six nurses were purposely selected by the managers of the ICU at the participating hospitals to improve cohesiveness and compatibility among group members. Two groups consisted of two participants each and four groups consisted of six participants each. The group size was determined by the number of available staff at the respective hospitals. The primary researcher diligently monitored the interpersonal dynamics within the focus group to ensure that each participant had an equal opportunity to contribute, as recommended by Steward and Shamdasani.[17] Nurses were given the option to participate in one of the six focus groups. The focus group discussions were arranged according to the specific hospital's visiting hours or allocated times for in-service training at the institution. All focus group meetings were scheduled to avoid conflicting with nurses' duties and were held in either an empty kitchen or staff room. The interview script and procedural checklist were used to ensure that procedures were conducted consistently across all focus groups. The nurses were asked to write down one word that describes patient-nurse communication. They also had to comment on their experiences of working with patients with communication challenges. The remaining details of the focus groups that examined the requirements and layout of a communication board for use in the ICU are reported in Kuyler and Johnson.[16] As part of member checking, nurses' responses were reviewed during the sessions, allowing them to add any information. This process was repeated with all the questions to confirm the correctness of the data.[18] By adding member checking of the answers to the focus group procedures, additional time was not required after the session for this purpose. Audio recordings were used to capture the focus group discussions, assisting in comprehensive data analysis and supplying additional information. Additionally, field notes were recorded during the data collection procedures.[19] Participants provided written consent for audio recordings and were reminded of their rights and ethical considerations at the beginning of the focus group session. None of the participants withdrew from the sessions.

Data analysis

Verbatim transcriptions of the focus group sessions were made by a research assistant and the first author reviewed the transcriptions while listening to the audio transcriptions to ensure transcription accuracy. Data saturation was obtained after focus groups were conducted with 30 participants. Transcriptions were further analysed using thematic analysis, which allows for the inclusion of the subjective perspectives of participants.[20] The six phases for thematic analysis as suggested by Clarke and Braun[20] were adopted. The authors started by reviewing the data to familiarise themselves with its content. Subsequently, they coded the data by identifying and labelling important features and eliminating irrelevant information.[21] Themes were deductively identified based on the social purposes of communication categories as specified by Beukelman and Light[5] that include communication of needs and wants, information transfer and social closeness, and sub-themes, such as *alertness* and *intervention*. Lastly, data extracts were added to the themes and sub-themes.[20]

Academic rigour

This research study was qualitative and therefore attempted to adhere to the four principles of trustworthiness including, credibility, dependability, confirmability and transferability. To ensure that the

participants' experiences were portrayed accurately and the results were credible, member checking was performed during the focus groups. This was because member checking was not feasible after the session due to the staff's busy work schedules. The following process was followed during the focus groups:

1. The primary researcher questioned the participants.
2. The participants were expected to write down their responses on a sticky note.
3. The primary researcher then asked each member to state their response, which was then transcribed onto an A3 size paper, visible to all participants.
4. All focus group participants then discussed their written answers and were allowed to add or remove any text.
5. The primary researcher then collected the sticky notes.

Member checking is a process validating participants' experiences through reviewing their personal reports.[18,21-23] This process of member checking improves the credibility of information and allows for a true understanding of a phenomenon through reports of lived experiences.[18]

Data saturation was obtained after six focus groups with 30 participants, which increased both the dependability and transferability of the findings. The verbatim transcriptions were conducted by an independent research assistant and the primary researchers checked the transcriptions for accuracy. All researchers convened for an online meeting to discuss the identified themes. Only those themes that achieved a 100% inter-rater agreement were ultimately included. This increased the confirmability of the results. During data collection, the primary researcher made field notes of considerations for conducting focus groups as well as notes on potential biases. These were discussed with the last author to increase the reflexivity of findings.

Ethical considerations

The relevant authorities provided ethics approval (GW20171135HS) and written permission was obtained from the hospital managers and research boards of the four participating hospitals. Data collection only commenced once informed consent was obtained from participants, which allowed voluntary participation and the right to withdraw from the study without any negative impact on the participants. During the focus group meetings, participants were given numbers to facilitate the confidentiality of participants and the de-identification of personal information during data storage ensured the confidentiality of findings. Owing to the face-to-face nature of the focus group discussions, anonymity could not be ensured. An interview script and procedural checklist were developed to assist in maintaining the beneficence of the participants. Non-maleficence was maintained as none of the procedures caused harm to the participants.

Results

Demographic information

Table 1 presents a summary of the participants' characteristics. Most participants (97%; *n*=29) were female, with only one male nurse (3%). Participants represented all four ethnic groups in SA. Their ages ranged from 28 - 57 (mean 42.4) years. The majority (37%) fell in the second-oldest group ranging from 40 - 49 years old. The years of nursing experience of participants ranged from 1 - 30 (mean 9.03) years. The majority (63%) had between 1 and 9 years of experience as a critical care nurse. The three dominant African first languages spoken by participants were isiZulu (10%), Tshivenda (10%) and Setswana (10%), with 30% of participants indicating Afrikaans and 17% English as their first language. All participants (*N*=30) spoke at least one other language apart from their first language. All participants (*N*=30) were qualified nurses with either a diploma (80%), Bachelor's degree (10%) or master's degree (10%) in nursing. In total, 53% of the participants had received additional training in critical care. Of these, 43% had completed an additional diploma in critical care, 25% had a 6-month training certificate obtained from the hospital at which they were employed, 19% had a postgraduate degree with a specialisation in critical care and 13% did not specify their critical care qualification.

Table 1. Summary of nurse participant characteristics (*N*=30)

Demographic characteristic	*N* (%)
Age (years)	
20 - 29	5 (17%)
30 - 39	7 (23%)
40 - 49	11 (37%)
50 - 59	7 (23%)
Years' experience (years)	
0 - 9	19 (63%)
10 - 19	5 (17%)
20 - 29	5 (17%)
30 - 39	1 (3%)
Ethnic group	
Black	19 (63%)
Coloured	1 (3%)
Indian	2 (7%)
White	11 (27%)
First languages	
African language	24 (80%)
English	3 (10%)
Afrikaans	3 (10%)
Qualification	
Diploma	24 (80%)
Bachelor's degree	3 (10%)
Masters' degree	3 (10%)
Current job title	
Registered nurse	20 (66%)
Trained clinical nurse	5 (17%)
Enrolled nurse	5 (17%)

Nurses' experiences

The main themes included the five social purposes of communication proposed by Beukelman and Light[5]: 1) communication of wants and needs; 2) information transfer; 3) social closeness; 4) social etiquette and 5) internal dialogue. Additionally, participants put forward nine sub-themes to describe their experiences with patients who have communication challenges. Table 2 summarises the findings of the study and lists the examples of quotes by participants.

Communication of wants and needs

In this study, the first theme, *communication of wants and needs*, refers to components that participants cited as important prerequisites for patients to communicate their basic wants and needs. By communicating needs and wants, critically ill patients are often able to control the communication partners' behaviour (e.g., the nurse's behaviour) in an attempt to fulfil their needs and wants.[3] This theme included two sub-themes, namely i) alertness and ii) medical interventions that affected communication of basic wants and needs. Participants mentioned that their communication with patients was affected by the patient's

Table 2. Description of results

Theme	Definition	*N*	Sub-theme	Quotes by nurses	Mentioned by participants
1. Communication of needs and wants	Components nurses mentioned are important prerequisites for patients to communicate their basic wants and needs.	1	Alertness	'It is important to see if the person is responsive" (P1) 'I think the Glasgow Coma Scale is very important as it allows you to see whether person is alert and can communicate' (P16)	P1, P2, P12, P15, P16, P30
		3		'Orientation to person, place and time allows you to understand if the person is awake' (P7)	P1, P5 - P8, P12
		4	Intervention	'Sometimes it appears as if the participants are deaf because you don't know if they can hear you' (P13)	P13
		5		'Most of the patients in the critical care unit are intubated and have difficulty to ask for help' (P9)	P9, P10
				'Most of the participants are ventilated and therefore experiences difficulties communicating' (P5)	P3 - P5
		6		'The majority of patient in the critical care unit have various medical complications and therefore cannot talk about their needs, family or wants' (P11).	P11, P12
2. Information transfer	Components nurses mentioned that affected information transfer to patients in the CCU.	7	Comprehension of information	'It is important for me to know that the patient understands what I am saying to them' (P12) 'It was difficult for me to communicate with the patient as he did not understand me' (P13)	P1 - P3, P6, P8, P9, P12 - P16, P20
		8		'When the person is ventilated, you do not know what their cognitive level is' (P11)	P11
		9		'I could only communicate with the patient if they were verbal' (P21)	P21 - P26, P29
		10		'We had lots of patients from other African countries and we could not speak their language' (P30). 'South Africa is a culturally and linguistically diverse population and sometimes I would get an Afrikaans lady and I could not speak her language' (P28).	P17, P18, P28 - P30
		11		'Age is also important as different people are at different stages in their life and have different topics to converse about' (P26) 'Old people would sometimes not listen to me as they would think I am too young and inexperienced' (P7)	P7, P26
		12	Communication	'I used to write down what I wanted to communicate for example are you hungry or do you want to see your family' (P18) 'Sometimes writing messages would be difficult as the patient may not be literate and this also made it hard to communicate with them' (P5)	P5, P10, P18, P19, P27, P28
		13		'Talking with patients should be bilateral and one-on-one' (P23). 'Sometimes it would feel as though I am talking to myself as the patient won't respond' (P24)	P23 - P25
		14		'Communication should be comprehensive and include all the topics that the person wants to discuss' (P5)	P5
		15	Environment	'The environment in which you work is very important' (P9)	P9
		16		'I was very busy and had a lot to do and therefore making time to talk to the patient was difficult' (P10)	P10

(continued)

Table 2. (continued) Description of results

Theme	Definition	*N*	Sub-theme	Quotes by nurses	Mentioned by participants
3. Social closeness	This theme describes components that nurses mentioned affected their ability to establish social closeness with patients.	17	Negative affect	'It was very difficult to talk to the patient, I did not know what to do' (P7) 'I struggled a lot to understand the patient' (P6)	P6 - P9, P15 - P17, P21, P22, P23, P26
		18		'I got very frustrated because we are trying to communicate with each other but couldn't understand each other' (P1)	P1 - P5
		19		'I stressed a lot thinking that I had to communicate with a patient that was ventilated' (P11)	P11, P12
		20		'I got angry at the patient as I had so much to do and it was taking to long to try an understand what they wanted' (P13)	P13
		21		'I just avoided trying to talk to the patient and just performed my routine' (P14)	P14
		22		'I felt so confused as I thought the patient was saying one thing but they kept on indicating something else' (P20) 'Talking to ventilated patients just made me feel so lost'	P20, P25
		23		'It was very demotivating to talk to a patient with communication challenges' (P15)	P15
		24		'I felt talking to the patient was ineffective and very effortful' (P26)	P13, P26
		25		'Communicating with patients with communication challenges was a complete mess and caused lots of problems' (P9)	P9, P12
		26	Positive affect	'It was so important to establish a relationship with the patient and just having that person contact with another human being' (P2)	P2, P29
		27		'You need to have a lot of patience when you talk to a patient who has communication difficulties' (P27)	P23
		28		'The most important thing is having respect for the patient and treating them with human dignity' (P23)	P12, P13, P28, P29
4. Social etiquette	Related to using socially appropriate vocabulary.	29	Introduction	'I think one of the most important things in communicating with patients is to introduce yourself and to greet them' (P12)	P17
5. Internal dialogue	Refers to keywords that relate to internal conversations that nurses have with themselves.	30	Spiritual	'Before I even start the day I just pray for strength because I know I will need extra strength for the ventilated patients who can't talk' (P17)	

alertness, specifically the patient's responsiveness and orientation to person, place and time. Nurses reported that they had an increased difficulty in understanding the needs and wants of patients who were communication-vulnerable. Furthermore, participants highlighted interventions necessitated by medical diagnosis, such as intubation, mechanical ventilation and sedation, which hindered patients' ability to communicate with nurses. Table 2 includes the participant quotes.

Information transfer

The second theme, *information transfer*, refers to patient communication challenges that resulted in information transfer difficulties between nurses and patients in the ICU. This includes nurse-patient communication of necessary biographical and personal information and the means of communicating this information. This theme comprises three sub-themes, specifically i) nurse's comprehension of information, ii) nurse-patient communication and iii) the communication environment. Participants mentioned that they experienced difficulty understanding information communicated by communication-vulnerable patients during nurse-patient communication. Several specific variables contributed to the nurses' poor comprehension of information. These included difficulty in understanding patients owing to communication barriers secondary to mechanical ventilation, confusion or sedation. Additionally, language barriers were noted when nurses could not speak the patient's language and they demonstrated limited awareness of alternative forms of communication, for instance, they were aware of using pen and paper to write but not communication boards when the person could not communicate verbally. Participant quotes are included in Table 2.

Social closeness

The third theme participants mentioned was the difficulty in establishing *social closeness* with patients in the ICU. Social closeness refers to

applying social etiquette and having an internal dialogue with the self. Participants particularly mentioned that they experienced negative emotions towards caring for patients due to the patient's communication challenges which increased nurses' occupational stress. Most participants had negative emotions towards communicating with communication-vulnerable patients describing communication as difficult, frustrating, effortful and ineffective. Few participants experienced positive emotions when caring for patients with communication challenges and stated that 'you need to have patience' and emphasized the importance of establishing a relationship through human contact, regardless of the communication challenges experienced in the ICU. Direct quotes are presented in Table 2.

Social etiquette

The fourth theme, *social etiquette*, refers to the use of socially appropriate vocabulary and practice of social etiquette.[3] The findings alluding to social etiquette are included in Table 2. Participants mentioned that even though limited responses are obtained from patients with communication challenges, the nurses should still introduce themselves and greet the patient.

Internal dialogue

The last theme, *internal dialogue*, includes aspects relating to communicating with oneself or conducting a dialogue with oneself.[3] Within this theme, participants mentioned one sub-theme: spirituality. Participants regarded patients with communication challenges as stressful, which required strength through prayer. Quotes are included in Table 2.

Discussion

This study aimed to identify nurses' experiences of patients who are communication-vulnerable and the effect on their ability to offer compassionate care. The findings will further be discussed according to the social purposes of communication by Beukelman and Lights.[5] Since communication and meeting the social purpose of interaction are central to establishing a mutually beneficial relationship between nurses and critically ill patients, it has a tremendous impact on person-centred care.[24,25] Nurses' attempts to establish a mutually beneficial relationship with patients emphasise the humanistic components of providing compassionate care. These humanistic components specifically encompass being there for oneself and others, respecting human vulnerability, reducing personal prejudice towards others, giving a voice to the voiceless and accepting that compassion is a gift from others.[26,27]

Communication of wants and needs

When patients experience communication challenges, this may hamper effective nurse-patient communication, which could lead to nurses not being there for their patients and not giving a voice to the voiceless.[25,28,29] The communication challenges experienced by patients may make it hard for them to discuss their unique needs, join in conversations with nurses and participate in building nurse-patient relationships.[17,30,31] Although nurses may respect the patients' vulnerability, communication challenges may lead them to harbour prejudices against these patients, mistakenly believing that they do not need communication.[17,29,32] This may be the reason why nurses tend to prioritise the communication of basic needs and wants. In the ICU, they may focus specifically on a patient's responsiveness, alertness and awareness, as these are indicators that the patient's level of consciousness is returning and that the patient is on the journey to recovery.[33-35] Owing to limited staff numbers and insufficient beds in the ICU, coupled with medical aid funding restrictions and organisational restructuring, nurses may experience pressure to expedite each patient's recovery process.[3] Nurses in this study confirmed this statement as various organizational barriers impeded their ability to provide person-centred care. Organizational barriers included policy barriers and support from hospital management.

Information transfer

During this study, the nurses mentioned that reciprocal comprehension in patient-nurse interaction was a central component of their ability to provide compassionate care. They further described patients' communication and linguistic challenges as the greatest component affecting successful information transfer.[36] Furthermore, nurses were aware that the language and culture of the patients in their care constituted a means for patients to perceive and construct their natural and social worlds.[25] In the current study, nurses expressed frustration due to the multilingual and multicultural nature of the ICU, feeling they lacked adequate competence to overcome these linguistic and cultural barriers. They perceived these language challenges as potentially detrimental to nurse-patient communication. Nurses mentioned the limited availability of translators fluent in the patient's first language, especially those unfamiliar to the nurses themselves. While they attempted to use pen and paper for communication, some patients were either too ill to write or did not understand the instructions. As a result, nurses often felt helpless to alleviate the suffering of those in their care, and they felt alienated from establishing a personal relationship with patients, which undermines the nurses' ability to provide compassionate care.[26]

Social closeness

Besides the linguistic and cultural barriers, communication barriers may also impede some nurses from establishing social closeness with patients.[25] In the current study, nurses described their communication experiences with critically ill patients as negative. For example, some nurses felt that it was a challenge to communicate with patients with communication challenges, partly because the patients were mechanically ventilated and/or they could not understand each other. This finding is further supported by other researchers, who argue that nurses prefer to communicate with patients only when family members or translators are present and when nurses can act as communication initiators.[6,25] These problems with communication make it difficult for nurses to experience compassion as a gift from others during humanistic care (e.g., critically ill patients) and may lead to prejudice against communication-vulnerable patients.[26,37] Therefore, the need for communication partner training for nurses working in the ICU is proposed to address nurse-patient communication challenges and to promote the levels of compassionate care.

Social etiquette

Some nurses felt that despite all the difficulties experienced in the ICU, establishing a relationship of mutual respect with patients was important.[26] They felt that social etiquette principles allowed them to emphasise the humanistic side of caring and allowed them to provide compassionate care to the patient.[26,38] According to Walivaara,[39] introducing oneself and greeting another individual are the first steps in establishing social closeness and setting the precedent for a caring relationship. This caring relationship includes the whole person and enables personal growth, a sense of being understood, alleviation of suffering and a promise of togetherness and personal contact—all of which improve compassionate care. Nurses in this study supported

this sentiment as they acknowledged that the whole person requires compassionate care and the focus of care should not only include addressing medical needs.

Internal dialogue

A caring relationship allows both the nurse and patient to strike a balance between vulnerability and dignity.[40] However, in practice, greater emphasis is placed on the patient's vulnerability, while the fact that nurses also experience vulnerability due to unfamiliar relationships and environments is often ignored.[40] The vulnerability of nurses in this study was reflected in their descriptions of their internal dialogue, which impacted their perception of their competence and practice. Wiklund and Wagner[26] suggest that the nurses' perceived vulnerability should be addressed by teaching them to first ensure their wellbeing, before focusing on the patient.

This self-compassion and support may increase nurses' feelings of competence and enhance their experience of communication-vulnerable patients.[26,37] Supporting critical care nurses through professional development and creating a positive occupational environment may increase their psychological and physiological wellbeing.[40] Professional development should include the training of nurses to implement communication strategies for critically ill patients. In this way, they will provide a voice to the voiceless, improve their experience with patients and enhance their ability to provide compassionate care.[15,41] Nurses in this study acknowledged these aspects but mentioned that time constraints may impact their ability to attend all professional development opportunities provided by their institutions.

Limitations

This study had a few limitations. Since the study was conducted at four private hospitals from the same hospital group in a single province in SA, its findings have specific limitations. Although the nurse participants were a culturally diverse sample, no participants from public hospitals were included. A recommendation for future research may thus be to replicate the study in the public hospital setting in SA.

Conclusion

This study confirms that nurses' experiences of patients' communication challenges often influence their ability to provide compassionate care. Interacting with communication-vulnerable patients generally makes nurses feel frustrated and negative towards their work environment, which adds to their work stress and can cause compassion fatigue. Some nurses do however see the communication challenges of patients as an opportunity to establish a compassionate relationship with them. Various factors affect the critical care nurses' ability to provide compassionate care and they also require support to improve their person-centred care. It is recommended that nurses receive communication partner training to address nurse-patient communication challenges and promote the levels of compassionate care offered in the ICU.

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1. Henderson, A., Jones, J. Developing and maintaining compassionate care in nursing. Nurs Standard 2017;32(4):60-69. https://doi.org/10.7748/ns.2017.e10895
2. Zamanzadeh V, Valizadeh L, Rahmani A, van der Cingel M, Ghafourifard M. Factors facilitating nurses to deliver compassionate care: A qualitative study. Scand J Caring Sci 2018;32(1):92-97. https://doi.org/10.1111/scs.12434
3. Muntlin Athlin Å, Brovall M, Wengström Y, Conroy T, Kitson AL. Descriptions of fundamental care needs in cancer care: An exploratory study. J Clin Nurs 2018;27(11-12):2322-2332. https://doi.org/10.1111/jocn.14251
4. Jones J, Winch S, Strube P, Mitchell M, Henderson A. Delivering compassionate care in intensive care units: nurses' perceptions of enablers and barriers. J Adv Nurs 2016;72(12):3137-3146. https://doi.org/10.1111/jan.13064
5. Beukelman DR, Light J. Augmentative and alternative communication-Supporting children and adults with complex communication needs. 5th ed. Baltimore: Brookes Publishing; 2020.
6. Bayog KMS, Bello DMC, Benabaye JMP, et al. A conjoint analysis of the communication preferences of registered nurses towards mechanically ventilated patients. Int J Nurs Pract 2019;e12809:1-12. https://doi.org/10.1111/ijn.12809
7. Boström E, Ali L, Fors A, Ekman I, Andersson AE. Registered nurses' experiences of communication with patients when practising person-centred care over the phone: A qualitative interview study. BMC Nurs 2020;19(1):1-9. https://doi.org/10.1186/s12912-020-00448-4
8. Dithole KS, Sibanda S, Moleki MM, Thupayagale-Tshweneagae G. Nurses' communication with patients who are mechanically ventilated in intensive care: The Botswana experience. Int Nurs Rev 2016;63:415-421. https://doi.org/10.1111/inr.12262
9. Blackstone SW. Issues and challenges in advancing effective patient-provider communication. In: Blackstone SW, Beukelman DR, M. YK, editors. Patient-provider communication: Roles for speech=language pathologists and other healthcare professionals. San Diego: Plural Publishing; 2015.
10. Brooke J, Ojo O. Elements of a sustainable, competent, and empathetic workforce to support patients with dementia during an acute hospital stay: A comprehensive literature review. Int J Health Plann Manage 2018;33(1):e10-25. https://doi.org/10.1002/hpm.2448
11. Andersen E, Havaei F. Measuring relational care in nursing homes: Psychometric evaluation of the relational care scale. J Nurs Meas 2015;23(1):82-95. https://doi.org/10.1891/1061-3749.23.1.82
12. Buckley L, Berta W, Cleverley K, Medeiros C, Widger K. What is known about paediatric nurse burnout: A scoping review. Hum Resour Health 2020;18(1):1-23. https://doi.org/10.1186/s12960-020-0451-8
13. Romagnoli KM, Handler SM, Ligons FM, Hochheiser H. Home-care nurses' perceptions of unmet information needs and communication difficulties of geriatric patients in the immediate post-hospital discharge period. BMJ Qual Satefy 2014;22(4):324-332. https://doi.org/10.1136/bmjqs-2012-001207
14. Dewar B, Mackay R. Appreciating and developing compassionate care in an acute hospital setting caring for older people. Int J Older People Nurs 2010;5(4): 299-308. https://doi.org/10.1111/j.1748-3743.2010.00251.x
15. Gropp M, Johnson E, Bornman J, Koul R. Nurses' perspectives about communication with patients in an intensive care setting using a communication board: A pilot study. Heal SA Gesondheid 2019;24:1-9. https://doi.org/10.4102/hsag.v24i0.1162
16. Kuyler A, Johnson E. Patient and nurse content preferences for a communication board in the intensive care unit. Intensive Crit Care Nurs 2021 Apr 1;63:103005. https://doi.org/10.1016/j.iccn.2020.103005
17. Stewart DW, Shamdasani PN. Focus groups: Theory & Practice. 3rd ed. LA: SAGE Publications Inc.; 2014.
18. Harper M, Cole P. Member checking: Can benefits be gained similar to group therapy? Qual Rep 2012;17(2):1-8.
19. Jewitt C. An introduction using video research. 2012.
20. Clarke V, Braun V. Teaching thematic analysis: Overcoming challenges and developing strategies to effective learning 2012. http://eprints.uwe.ac.uk/21155/3/Teaching thematic analysis Research Repository version.pdf. (accessed 1 January 2023).
21. Nowell LS, Norris JM, White DE, Moules NJ. Thematic Analysis: Striving to Meet the Trustworthiness Criteria. Int J Qual Methods 2017;16(1):1-13. https://doi.org/10.1177/1609406917733847
22. Birt L, Scott S, Cavers D, Campbell C, Walter F. Member Checking: A Tool to Enhance Trustworthiness or Merely a Nod to Validation? Qual Health Res 2016;26(13):1802-1811. https://doi.org/10.1177/1049732316654870
23. Candela AG. Exploring the Function of Member Checking. 2019;24(3):619-628 https://doi.org/10.46743/2160-3715/2019.3726
24. Zimmermann E, Alfes CM. Simulating the role of the parent-Promoting family-centered nursing care. Nurs Educ Perspect 2019;14(2):121-122. https://doi.org/10.1097/01.NEP.0000000000000339
25. Kwame A, Petrucka PM. Communication in nurse-patient interaction in healthcare settings in sub-Saharan Africa: A scoping review. Int J Africa Nurs Sci 2020;12:100198. https://doi.org/10.1016/j.ijans.2020.100198
26. Wiklund G. L, Wagner L. The butterfly effect of caring - clinical nursing teachers' understanding of self-compassion as a source to compassionate care. Scand J Caring Sci 2013;27(1):175-183. https://doi.org/10.1111/j.1471-6712.2012.01033.x
27. Cossette S, Cote JK, Pepin J, Ricard N, D'Aoust LX. A dimensional structure of nurse-patient interactions from a caring perspective: Refinement of the caring nurse-patient interaction scale (CNPI-Short Scale). J Adv Nurs 2006;55(2):198-214.
28. Fleischer S, Berg A, Zimmermann M, Wüste K, Behrens J. Nurse-patient interaction and communication: A systematic literature review. J Public Health (Bangkok) 2009;17(5):339-353.
29. Karlsen MMW, Ølnes MA, Heyn LG. Communication with patients in intensive care units: A scoping review. Nurs Crit Care 2019;24(3):115-131. https://doi.org/10.1111/nicc.12377
30. Leung CCH, Pun J, Lock G, et al. Exploring the scope of communication content of mechanically ventilated patients. J Crit Care 2018;44(2018):136-141. https://doi.org/10.1016/j.jcrc.2017.10.044
31. Mobasheri MH. Communication aid requirements for ICU patients with transient speech loss. Augment Altern Commun 2016;32(4):261-271. https://doi.org/10.1080/07434618.2016.1235610
32. Falk AC, Schandl A, Frank C. Barriers in achieving patient participation in the intensive care unit. Intensive Crit Care Nurs 2019;51:15-19. https://doi.org/10.1016/j.iccn.2018.11.008
33. Giacino JT, Katz DI, Schiff ND, et al. Practice guideline update recommendations summary: Disorders of consciousness: Report of the guideline development, dissemination, and implementation subcommittee of the American Academy of Neurology; the American Congress of Rehabilitation Medicine; and Neurology. 2018;91(10):450-460. https://doi.org/10.1212/WNL.0000000000005926

34. Pundole A, Crawford S. The assessment of language and the emergence from disorders of consciousness. Neuropsychol Rehabil 2018;28(8):1285-1294. https://doi.org/10.1080/09602011.2017.1307766
35. Tomaiuolo F, Cecchetti L, Gibson RM, et al. Progression from vegetative to minimally conscious state is associated with changes in brain neural response to passive tasks: A longitudinal single-case functional MRI study. J Int Neuropsychol Soc 2016;22(6):620-630. https://doi.org/10.1017/S1355617716000485
36. Holm A, Dreyer P. Nurse-patient communication within the context of non-sedated mechanical ventilation: A hermeneutic-phenomenological study. Nurs Crit Care 2018;23(2):88-94. https://doi.org/10.1111/nicc.12297
37. Létourneau D, Goudreau J, Cara C. Humanistic caring, a nursing competency: modelling a metamorphosis from students to accomplished nurses. Scand J Caring Sci 2021 Mar;35(1):196-207. https://doi.org/10.1111/scs.12834
38. Aupia A, Lee TT, Liu CY, Wu SFV, Mills ME. Caring behavior perceived by nurses, patients and nursing students in Indonesia. J Prof Nurs 2018;34(4):314-319. https://doi.org/10.1016/j.profnurs.2017.11.013
39. Walivaara B-M. Caring relationships in home-based nursing care: Registered nurses' experiences. Open Nurs J 2013;7:57-63. https://doi.org/10.2174/1874434620130516003
40. Garon M. Speaking up, being heard-Registered nurses' perceptions of workplace communication. J Nurs Manag 2011;20:361-371. https://doi.org/10.1111/j.1365-2834.2011.01296.x
41. Radtke JV, Tate JA, Happ MB. Nurses' perceptions of communication training in the ICU. Intensive Crit Care Nurs 2012;28(1):16-25. https://doi.org/10.1016/j.iccn.2011.11.005

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