

11-20-1998

Factors associated with critical care nurses' communication with non-communicative patients in the ICU

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DOI: 10.25148/etd.FI14051155

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FLORIDA INTERNATIONAL UNIVERSITY

Miami, Florida

FACTORS ASSOCIATED WITH CRITICAL CARE NURSES'
COMMUNICATION
WITH NON-COMMUNICATIVE PATIENTS IN THE ICU

A thesis submitted in partial fulfillment of the

requirements for the degree of

MASTER OF SCIENCE

in

NURSING

by

Michelle Binns

1998

To: Dean DeLois P. Weekes
College of Health Sciences

This thesis, written by Michelle Binns, and entitled FACTORS ASSOCIATED WITH CRITICAL CARE NURSES' COMMUNICATION WITH NON-COMMUNICATIVE PATIENTS IN THE ICU, having been approved in respect to style and intellectual content, is referred to you for judgement.

We have read this thesis and recommend that it be approved.

Sue Kopel, Ed.D.

Tomas Madayag, Ed.D.

Divina Grossman, Ph.D.
Major Professor

Date of Defense: November 20, 1998

The thesis of Michelle Binns is approved.

Dean DeLois P. Weekes
College of Health Sciences

Dean Richard L. Campbell
Division of Graduate Studies

Florida International University, 1998

DEDICATION

I dedicate this thesis to my son, Chazz, whose outstanding friendship, love, patience and support was a major factor in the completion of this thesis, and to my parents Angela and Eddie, my sister Nichole, my brother Demion, my nephews Ragielle and Avery and my friends. With their love and prayers all this was possible.

ACKNOWLEDGMENTS

I wish to thank the members of my committee for their support and guidance. A special thanks to Dr. Sue Kopel for her skill and expertise in statistical analysis and for always being there for me. I would also like to thank the nursing staff and management of the CCU at Florida Hospital Medical Center, Orlando Florida, Mary and Ina for their unending support of my endeavors. Thanks also to Florence for keeping me on the right track.

ABSTRACT OF THE THESIS
FACTORS ASSOCIATED WITH CRITICAL CARE NURSES'
COMMUNICATION WITH NON-COMMUNICATIVE PATIENTS IN THE ICU

by

Michelle Binns

Florida International University, 1998

Miami, Florida

Professor Divina Grossman, Major Professor

Hospitalized individuals are isolated from their familiar environment at the onset of illness. Those individuals who are non-communicative are detached from the world and from life, as they previously knew it. Although nurses have long since recognized the importance of communication, patients still report the lack of it. This study was done to identify factors influencing critical care nurses to communicate with their non-communicative patients.

The overall results of the study indicate that nurses are aware of the importance of verbal communication with patients who may be intubated, paralyzed, unconscious, comatose or neurologically impaired and are not deterred by them. Despite these results, some significant observations emerged identified. CCRN certified nurses and nurses with more years of experience were less likely to have verbal communication with non-communicative patients. Nurses with children, spouses and those working full-time were more likely to communicate with non-communicative patients.

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Chapter 1

INTRODUCTION

Mosby's Medical Dictionary (1989), states that communication is basic to all nursing and contributes to the development of all therapeutic relationships.

Communication fosters relationship, and without it, feelings of detachment and isolation may occur. According to one critical care nurse after his recovery from Guillain-Barre, a disease which left him non-communicative in a critical care unit for several weeks, the one thing that kept his mind intact was when individuals would talk to him and communicate with him (Villaire, 1995).

It is not difficult to imagine a person's feelings of loneliness or isolation when we ourselves can relate to feeling more alone in a crowded room than if we were alone on a deserted island. Hospitalized individuals are isolated from their familiar environment at the onset of illness. Those individuals who are non-communicative are detached, not only from their family, but also from the world and from life, as they previously knew it.

One patient, recently cared for in the ICU, returned to the hospital to thank the nurses for caring for him. He tells the events of his illness as he recalls (C.S., personal communication, June 1995). He remembers being put to sleep for a prostate biopsy. He remembers opening his eyes, in what seemed like hours later, in heaven. There were a lot of angels, but none of them were talking to him. He tried to talk to them but he only gagged and coughed. There seemed to be something tied to his mouth. He tried to wave at one as she walked by, but his hands were heavy, he could not move them. Then he looked towards his hands and realized they were tied to the bed. To his horror he realized he was not dead, but now he thought he had been captured from his native island of

Cayman and taken into a hostile territory where he was being held prisoner in a hospital, bound and gagged to a bed. This made him angry and he started to fight. Nurses and attendants came to his bedside. No one talked to him. There was only shouting over him, his blood pressure was up, his heart rate was climbing and his respiration was rapid. One nurse with a familiar accent, like his, came to his side. She touched his hand, stroked his forehead and reoriented him to person, place and time. He then became aware of his body and his mind. He once again felt in touch with himself and his surroundings and he fell asleep.

The hours that he thought had passed between the time he was put to sleep and the time he was awakened were actually several weeks, during which time he had experienced cardio-pulmonary arrest four times and returned to the O.R. twice. Each time there was talk at his bedside about “the end” and “no chance for survival”, which he remembers. This was his reason for thinking he was dead. When communication was established with him he was brought back to reality with a sense of survival.

Nurses are faced with the task of establishing a therapeutic relationship every working day. Most often, this relationship is with someone they have never met before. Some nurses have good social skills while others do not. In some cultures, minimal conversation is noted as a sign of showing great respect, and a nurse of this culture may wish to treat the patient with such respect. Problems arise in such a situation when the nurse and the patient do not share the same culture. Common misinterpretations of cultural differences are blamed on racism, social segregation, and lack of respect or dislike for the patient or the job to be performed.

Non-communicative patients are isolated. They are alone with themselves, unless communication takes place with them. A client who does not understand what is happening or who feels misunderstood may appear angry, non-compliant or withdrawn. Without the ability to communicate, care will be inadequate... the physical healing process may be impaired (Gieger and Davidhizar, 1995).

Connolly and Shekleton (1991), in an article on communicating with ventilator dependent patients, stated that the American Association of Critical Care Nurses ranked this topic as ninth on a list of 74 areas needing research. There is a need for more research on finding effective nursing interventions for patients with impaired communication.

Purpose

The purpose of the study is to examine what differences exist between those critical care nurses who communicate with their non-communicative patients and those who do not.

Problem Statement

General Problem

What factors influence critical care nurses' communication with non-communicative patients?

Specific Problems

1. How are nurses' communicating with non-communicative patients influenced by:
 - a. their communication preferences and beliefs
 - b. nursing tasks
 - c. emotional implications

d. treatment implications

2. Is there a significant difference in factors affecting communication, in the mean scores on the Binns Survey for nurses with more years of experience and for those with less?
3. Is there a significant difference between scores on the Binns Survey for nurses that have been or that have had family members who have been non-communicative in an ICU?
4. What personal attributes are associated with nurses' communication with non-communicative patients in the ICU?

Study Variables

Dependent Variable

Communication with non-communicative patients.

Independent Variable

Factors influencing critical care nurses.

Definition of Terms

1. Critical Care Nurses (CCNs) -Refers to licensed registered nurses, who provide skilled nursing care for patients in an intensive care unit setting.
2. Communication -Any process, whether gesture, action, sound, written word or visual image containing information which may be transferred from one person to another.
3. Non-communicative patients (NCP) – Any hospitalized person, conscious or unconscious, who is not able to communicate for reasons of paralysis, intubation, sedation or current disease process.
4. Intensive Care Unit (ICU) – A hospital unit in which patients requiring close monitoring and intensive care are housed. It contains highly technical and sophisticated

monitoring devices and equipment and is staffed with nurses educated to give critical care as needed (Mosby, 1989).

Assumptions

1. Similarities exist among Critical Care Nurses who communicate with non-communicative patients.
2. Differences in the factors that motivate communication are rooted in common personal attributes and abilities.

Significance of the study

This study sought to ascertain information that will explain whether or not there are common factors that influence CCNs communication with the non-communicative patients. The state of coma, paralysis, or intubation is as much a barrier to communication as a different language. The benefit of being able to speak or vocalize is that an interpreter may be available for a different language.

For a patient who is unable to speak, communication reestablishes a sense of self and body boundaries, maintains psychological integrity and keeps a person in touch with his or her own well being and progression of care. Feelings of helplessness and despair can change to a positive outlook, which enables recovery.

Patients perceived level of awareness and receptive ability might also be a hindrance to anyone who may want to initiate communication. Baker & Melby (1996) reported in their study on communication in the ICU, that the nurses felt some ambiguity about the patients' awareness due to the patients' level of consciousness. Even though they knew that communication is still very important at this point, this was a major deterrent to communication in their study.

This study examined differences in communication motivators that exist among critical care nurses (CCNs). The researcher wished to ascertain whether there is a similarity in a group of nurses who talk to patients who are non-communicative (NCPs) for reasons of unconsciousness, encephalopathy, intubation, coma or paralysis.

In this cultural melting pot, South Florida, culture care diversity is always an issue. Knowing and understanding how health and death experiences affect people of different cultures and knowing certain health and death practices or rituals will not only improve patient care but make care giving experiences more rewarding (Peterson, Whitman & Smith, 1997). The study searched for demographic similarities among those nurses who include communication in the nursing process when caring for a non-communicative patient.

Regardless of their culture of origin, nurses, as advocates and liaisons for their patients, are expected to represent their patients. In the case where a patient is non-communicative, nurses are often expected to be their patient's voice. Family members of intubated patients will often ask the nurse, "what does his facial expression mean?" or "what is he trying to tell me?"

CCNs, caring for non-communicative patients of different cultures, have the particularly difficult task of interpreting a language that is not vocal. Cultural differences are not always easily accepted, but must always be respected. CCNs must accept and respect cultural differences of these patients whom they have met for the first time and who are non-communicative. By one means or another, communication remains a vital part of an effective, therapeutic nurse-patient relationship.

Nurses have long since recognized the importance of communication in the healing process (Giger & Davidhizar, 1995). Yet barriers still exist, particularly when different cultures are involved. Although communication is the core of most nursing curricula (Giger & Davidhizar, 1995), barriers still exist and need to be identified and bridged in order to promote health care.

Conceptual Framework

This study was based upon the conceptual framework of Ida Jean Orlando. She asserts that communication is a necessary component of the nursing process. Orlando (1961) sees the nursing process as being the interaction between patients behavior, nurses reaction and nurses action taken as a result of patients' behavior. She maintains that the process could not take place without communication.

She postulated that the patient's need for help is arrived at through the interactive, communicative process in the nurse-patient relationship. Without communication between the nurse and the patient, needs cannot be recognized or acted upon.

Orlando believes that the nurse should not assume that any aspect of nurses' reaction to the patient is correct, helpful or appropriate until the validity is checked through exploration with the patient in the interactive, communicative process.

Although her earliest works were in mental health, Orlando was able to apply her research findings to many specialty areas, the focus of which was interaction. In one of the earliest studies by Orlando (1970) on dynamic nurse-patient relationship, she reported that research resulted in identification that a nurse's statement of her perceptions, thoughts or feelings about the patient's behavior differentiated between effective and ineffective communication.

The basis of her concept is that through effective nurse-patient communication, the nurse will be able to identify the patient's needs and deliberately act upon that need for resolution or improvement.

According to Orlando, unless deliberative actions are carried out, professional nursing functions are not fulfilled. Deliberative action as defined by Orlando is that which has been arrived at and agreed upon through nurse-patient communication and interaction with resolution of patients' needs. Resolution of needs is indicated by improved patient condition.

If the nurses' action is not deliberative, then it is automatic. Automatic action does not take into consideration patients' needs, but rather, carries out doctors orders or routine patient care without communication (George, 1995).

This concept by Orlando is seen as a continuous interactive process between the nurse and the patient, that will foster a relationship for communication, which enables correct identification of the individuals needs, to be acted upon by the nurse for therapeutic resolution.

Hypothesis

The following hypothesis was tested:
There is significant difference in the attributes of CCNs who communicate with non-communicative patients and those who do not.

Chapter 2

Literature Review

What Patients Say

Villaire (1995) conducted an interview with a patient 2 years after she had been discharged from a critical care unit. The patient spent 2 ½ months on that unit intubated and non-communicative. Villaire reported that the patient's biggest fear was not being able to communicate. It was a major source of her frustration. The most important thing for her was human contact, communication. "Acknowledge me," she said, "even though I can't communicate with you, treat me like a human being. Just say anything". She told the interviewer that it bothered her when the nurses would pay greater attention to their report and monitors and machines than to her. Some of the nurses, even though they took care of her, were very cold. One nurse on the night shift seemed very impatient with her. She seldom came into her room and when she did she insisted she go to sleep. It seemed to her the nurse was trying to shut her out. She even closed the curtain. The patient told this interviewer that there was no communication. She felt that the nurse could not hear her because she was not communicating with her.

Although the disease was self-limiting, and she had a complete recovery, she remembers that the most important thing to her during that time was communication- to her, with her, or around her. The disease she had was Guillain Barre'.

Ropper (1994) examined general problems associated with the disease and the acute care in the critical care unit. He identified the patients as virtually "locked-out" Physicians who had experienced the disease gave accounts themselves. They emphasized

the importance of early establishment of a code system and maintenance and preservation of communication.

Eloise Monger (1995) conducted a study with patients who also had the experience of being non-communicative in a critical care unit. They too, felt communication was the most valuable factor in helping them return to reality. In a comparison study between two hospitals, Monger (1995) studied strategies for caring for intubated patients in critical care units. The purpose of that study was to identify means of caring for intubated patients that were less expensive, with fewer side effects to the body than sedation. They found that if communication was initiated at the time of admission to the critical care unit and maintained throughout hospitalization, less sedation and analgesia was needed. Patients reported that when coming out of anesthesia it was difficult to differentiate between reality and hallucination, but that the nurses' presence and constant reassurance and communication appeared to have been influential in finding reality.

Hallenberg, Bergbom-Engberg and Haljamae (1989,1990) have done extensive research on the communication process with ventilator patients in the ICU. Patients' recall of the ventilator period of their hospitalization was very clear 2-4 years after their stay in the ICU. The patients most often reported that the isolation due to communication difficulties was a greater problem than direct airway-related nursing care activities.

The findings in the study also indicated communication problems, inadequate information and lack of trust in the nursing staff mainly caused feelings of insecurity.

Communication As A Priority

The literature supports the notion that nurses are aware that communication with non-communicative patients is essential not only in maintaining psychological integrity but also to the rehabilitation process. Still it appears to be a low priority for some. Hagland (1995) reports the results of research into nurse-patient communication in five critical care units done by Ashworth (1980). That study showed that nurses often forgot some of the most fundamental aspects of communication, such as introducing themselves.

A small-scale qualitative study by Turnock (1989) reported that communication is nurse-centered, relating mostly to tasks and procedures. The researcher suggests that due to the condition of these patients in the critical care unit, nurses feel that physiological needs take priority over psychological needs. Turnock also suggests from the results of the study, that establishing physical priorities serve as a coping mechanism for the nurses. In Turnock's study nurses felt that high levels of anxiety are evoked from working in the critical care unit and they are aware that communication is as difficult as it is vital.

What the Nurses Say

Nurses are often put in the position of discussing aspects of patients' condition, treatment, and prognosis with the patient. These topics may be difficult for some nurses on a personal level. Therefore rather than face emotional turmoil they avoid establishing a communicative relationship and communication barriers are raised (Ashworth, 1980).

Taylor (1971) believes that critical care nurses develop a defense mechanism in caring for patients who are at great risk of dying by deliberately not forming a close relationship with them. It protects them from emotional turmoil in the event of death.

Turnock (1991) explored other reasons for poor nurse-patient communication in critical care units and suggests that this might be largely due to insecurities felt by nurses. They experience insecurities about their environment, level of education, orientation to critical care nursing, intensive care monitors, equipment, critical disease states and also insecurities about their own feelings towards the patients' knowledge and attitude toward their condition.

The article also suggests that when new nurses in the critical care unit have to learn from nurses who have technical experience and longevity on the job, but have poor communication skills, the vicious cycle on the continuum of poor nurse-patient communication continue.

Turnock (1991) discussed another factor influencing nurse-patient communication in interviews with nurses about their perceptions of psychological needs of the patient in which they identified barriers to communication. The nurses reported that they experienced feelings of self-consciousness when talking to patients who were ventilated or sedated.

According to that article, the research study of Ashworth (1980) suggested critical care nurses feel that communication is a two-way process and becomes very difficult when conducted in a one-way mode. Patients' response or the lack thereof was a deterrent for further communication. Critical care nurses remain aware of the need to communicate, even though the one-way nature of this process may limit the length of the interaction (Turnock, 1991)

Leathart (1994) conducted an exploratory study designed to determine the state of communication between conscious intubated and oriented patients and nurses in a critical

care unit. The purpose of the study was to determine what factors influence communication. Using participant observation, the researcher adopted a passive role with no direct social interaction in the setting.

The study consisted of eight elements. For two consecutive hours each, the researcher sat in a corner of the patients' room and observed and recorded data on nurse-patient interactions. Each interaction was termed a bit. A bit was defined in the study as a sentence that represents a unit of communication. The researcher then conducted structured interviews on the nurses' experience and qualifications.

The results of the study revealed that the number of nurse bits ranged from 52-205 in the two-hour period. The number of patient bits ranged from 15-61. According to the study there seemed to be a high positive correlation (Pearson $r = 0.918$) between the number of nurse and patient bits, suggesting that if nurses communicate with patients, patients will communicate with nurses. Nurse-initiated interactions ranged from 74-85%, whereas patient-initiated interactions ranged from 11-29% of the time. On an average 56% of communication consisted of short term, less than 30 seconds, task related information, commands or questions.

Nurses reported that their greatest difficulty with communication was lack of feedback, the patients' psychological state and the lack of communication skills training. There was also a preoccupation with being busy in 50% of the cases. Being busy is often at the expense of communicating with the patient. The idea here is that a patient would not interrupt a nurse who is busy.

Although the Hawthorne effect was established with the researcher openly watching the study participants, the conclusion was sound. CCNs are fully aware that

they should communicate with the patients as much as possible. In reality they learn that keeping communication to a minimum minimizes their own anxiety. This was found to be a defense mechanism adopted by nurses to protect themselves from anxiety.

In their effort to investigate the attitudes and practices of critical care nurses towards communication with unconscious patients, Baker and Melby (1996) conducted a research study designed as non-experimental and descriptive-exploratory. A sample of five critical care nurses was observed for four (4) hourly periods, then structured interviews were conducted.

Qualitative and quantitative analysis indicated that critical care nurses spend on an average 5% of their time verbally communicating with unconscious patients. Most of this communication involves informing the patient of immediate procedural matters or providing reassuring statements. The study demonstrated that most CCNs claim that verbal communication with unconscious patients is very important, and that some ambiguity is apparent as to the unconscious patients' level of awareness.

Major factors influencing communication in the study are the patients' level of consciousness, the amount of physical care being given, and the presence of relatives.

Culture Care- a Factor?

Culture is defined by Madeleine Leininger (1991) as the values, beliefs, norms, and practices of a particular group that are learned and shared and that guide thinking, decisions, and actions in a patterned way. It is believed that demography is destiny, demographic change is reality, and demographic sensitivity is imperative (Giger and Davidhizar, 1995).

With the steady immigration of people from other countries into the United States, health care workers have been asked to assess and respond to the needs of a more diverse community (Peterson, Whitman and Smith, 1997). In our multicultural society, cross-cultural encounters are becoming increasingly common in the health care setting (Jecker, 1995). By the year 2000, one in every three Americans will be a member of a non-white group.

Foreign nurse recruitment remains a fairly common practice among hospitals and nursing homes (Grossman, 1995). This has allowed us growth and development and a multicultural strength that enables us to draw from various bodies of nursing. This strength has also created barriers to communication and lack of understanding between the nurse and patient and alteration in the nursing process.

An Interdisciplinary Multicultural Patient Care Team (IMPACT) at the University of Wisconsin Hospital and Clinics (UWHC) and the University of Wisconsin Children's Hospital, conducted a study using a survey design to identify multicultural awareness, deficits and needs among hospital and clinic employees (Peterson, Whitman and Smith, 1997).

The literature review conducted for the study revealed that there were no studies conducted that examined the levels of cultural awareness, sensitivities, or education needs among employees. However, IMPACT did determine a need for multicultural awareness based on the increase in the number of multicultural residents. The information from the surveys indicated that better care could be provided for patients if the staff was educated on multicultural differences. The study suggested education programs on how to communicate better in a culturally diverse setting could meet their

needs.

The study showed that although other resources were available for problem solving, i.e. nursing communications specialist, chaplain, social workers, and the multicultural patient care team, the staff nurse was most frequently called upon when a need existed based on a cultural difference. Whether or not the nurse is culturally competent, she is expected to represent, and advocate for the patients' needs.

Anthony pillai (1993) conducted a study using surveys to determine whether or not communication needs were met between patients and nurses of differing cultures in an intensive care environment. A secondary aim of the study was to investigate nurses' opinions on cross-cultural communication. Recently there has been an increase in the number of people who migrate to the United States for their specialist surgeries from countries where it is less possible.

Questionnaires were used as a means of collecting data. Of the nurse respondents, 87% said they found it difficult to communicate due to language and cultural barriers. These nurses described difficulty in communicating as a frustrating and dissatisfying experience. The experience was described as stressful by 31% of the nurses. The opinion that the delivery of care was affected was expressed by 75% of the nurses. Nurses responded that they perceived negative emotions, fright, isolation, anxiety, agitation, insecurity and discomfort from the patients.

The study showed that although patients of the same culture as their nurses felt that they were well prepared for their critical care stay, those patients who were not of the same culture or language as their nurses felt that they may have missed a vital part of their preparation. This may have been the element that created problems during their stay

in the critical care unit.

In conclusion the study suggested a communication aid in the form of a booklet, that may be used cross-culturally to enhance understanding and recognition of needs. This may help to guide nurses in developing their role as interpreter, thereby being more supportive in bridging the gap in cross-cultural communication.

The critical care unit has been described by patients and nurses as an area that generates high anxieties. Misunderstandings and ineffective communication of needs often bring on this anxiety. Not understanding patients' needs based on cultural differences leads to inappropriate or lack of care.

Kelley and Frisch (1990) conducted a study on the differences in the use of nursing diagnoses between Mexican and American nurses to determine the level of agreement between nurses of differing cultures. Of the six scenarios given, they disagreed on all but one. The researcher pointed out that differences in interpretation of the scenarios are the result of differences in cultural perspectives.

Rothenberger (1990) discussed another barrier to communication. He states that people of the Western world are educated to believe that Western medicine is know all, cure all. When this school of thought meets resistance irrational behavior ensues. This results with lack of confidence in Western medicine by people of other cultures.

The article continues with ethnic beliefs and customs as another barrier to communication. One example given is that in some cultures illness is accepted as God's will, resulting in patients' suffering in silence. In some cultures the patient would rather spare the nurses feelings than convey that inadequate instructions were given.

The author presents some strategies for overcoming some barriers in the

following suggestions: develop the awareness that every person perceives things through several sets of variables; notice when the patient nods yes to every question or statement; learn to ask the right questions.

The article concludes that acceptance and therapeutic behavior toward cultural differences begin with examining our own attitudes toward other ethnic groups. Progress will begin once we assimilate the routines and rituals for standardization created in Western medicine with learned cultural variations in illness and healthcare.

Culture Competent Communication

Critical care nurses are faced with issues of health, illness and death on a daily basis. Communication is the only way to understand the expectations of the patient who must deal with these issues. Although the nurse may have dealt with a patient in a similar situation on another occasion, the patient does not usually have many opportunities to be non-communicative and deal with life or end-of-life issues.

Ineffective communication due to cultural insensitivity or awareness may be devastating at this time (Wright, Cohen, and Caroselli, 1997). It is without question that nurses have realized that physiologic needs are a critical issue, but providing for the patients' psychological needs is also critical (Ashworth 1980). Culturally competent care is required when addressing patients' needs holistically (Wright, Cohen, Caroselli, 1997).

Wright and colleagues (1997) described culturally competent care as not only required when addressing patients' needs holistically, but also as an opportunity to enrich and deepen the critical care nurse-patient-family relationship, advocate for the patient and broaden the opportunities for communicating among staff. They suggested that critical

care nurses and organizations do more to address the alienation encountered when their culture is different from the predominant culture of the unit.

This study further investigated other potential barriers to communication with non-communicative patients in the critical care unit as perceived by critical care nurses. It examined what personal factors, as a nurse would see it, affect the ability of that nurse to establish and maintain a therapeutic communicative relationship with the non-communicative patient.

Conceptual Framework

This study was based upon the conceptual framework of Ida Jean Orlando. Orlando asserts that communication is a necessary component of the nursing process. Orlando (1961) sees the nursing process as being the interaction between patients' behavior, nurses' reaction and nurses' action taken as a result of patients' behavior. She maintains that the process could not take place without communication.

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Chapter 3

Methodology

Design

A non-experimental quantitative, correlation research was conducted. The study attempted to show whether CCNs who communicate with NCPs share common attributes. A survey, along with a questionnaire for demographic information was distributed.

Sample

The study aimed for a sample of 100 respondents. The population was comprised of nurses currently working in a critical care environment. Sampling criteria were critical care nurses currently living and working in Florida. Nurses who were not currently involved directly in bedside care, e.g. nurse managers, assistant nurse managers, unit educators and clinical nurse specialists, were excluded from the sample.

Non-probability convenience sampling was used to acquire voluntary participants from any and all cultural groups. Each participant currently lived in the United States and was fluent in reading and writing the English language.

Consent

A packet, which included a cover letter, demographic information questionnaire, the research survey and an informed consent, was distributed to potential participants. The cover letter indicated that return of the questionnaire and survey implies consent to participate in the study. The packet provided information regarding the purpose of the study as well as the researcher's name, address and telephone number for potential questions from participants.

Protection of Human Rights

To ensure anonymity, protect confidentiality and encourage reliable and truthful participation, names were not requested. Each subject was given a code number and an unmarked envelope was provided for the return of the questionnaire and research survey. Raw data collected were entered into the computer using these code numbers for identification. The cover letter included in the packet stated that the participant had the right to refuse or withdraw from the study at any time without providing reason or fear of penalty.

Measurement Tools

Previous research conducted on the topic was qualitative by design, in which the researchers used semi-structured interviews with the subjects for data collection. They readily identified limitations to their study based on this design.

Turnock (1989) reported that he used hand written notes as well as tape recorders during the interviews to ensure that vital data were not lost. He reported that this seemed to frighten some people as they expressed their reluctance to participate due to the dislikes of having themselves recorded. Clark (1981) reported that nurses become inhibited by the knowledge that their conversations are being recorded.

Turnock (1989) also reported that the lengthy interview process and the availability of the nurses on a busy ICU were a big factor in recruiting participants (personal conversation, April 1998). Honesty and reliability of the information gathered was also a factor in his study due to the perceived intimidation by the nursing supervisor. Her reluctance to cooperate with the study at times was also a barrier to interaction with the nurses.

Ashworth (personal communication, July 8th 1998) reported that conducting semi-structured interviews for her research on the problems of communication between patients and nurses in intensive therapy units (1980) was a very lengthy and difficult process. Because of this she had a very small sample size. Leathart (1994) encountered the same problems (n<12).

Due to these limitations the primary investigator for this study developed a pen and paper survey. Using the semi-structured interviews of Pat Ashworth (1980), Chris Turnock (1989), Bergbom-Engberg & Haljamae(1989), Allison Leathert (1994) and the information outlined in the literature review, the Binns Survey was formulated.

The Binns Survey addresses the general ideas expressed by nurses in these interviews and allowed the nurses in the study to score them, on a Likert scale, on the extent to which they agreed with the item. The Likert scale presented choices one thru five. Choice number one corresponded with strongly agrees, two with agree, three with not sure, four with disagree and five with strongly disagree.

In order to deter the participant from intentionally scoring a false high or a false low, the numbers on the questionnaire were replaced by letters A, B, C, D, E respectively. After the subject had completed the survey, the letters were then transcribed back to numbers to enable quantitative statistical analyses.

Validity and reliability testing was completed on the survey since it was developed for the study. Content validity was obtained from a panel of 5 expert nurses in the field of critical care. They were given a sample survey (appendix F) and a cover letter (appendix E) in which they were asked to rate each question on a four point Likert scale. The choices were 1= not relevant, 2= somewhat relevant, 3= quite relevant and 4= very

relevant. The scores obtained on all questions were either 3 or 4 for an average of 94%. No item received a score of less than 3. Therefore no adjustments were made and content validity was established.

Using the internal consistency method, reliability was established for the tool. With a sample of sixteen questionnaires Cronbach's coefficient alpha was calculated at $r = 0.89$ on all the questions. With the exception of item number 1 all the questions were asked negatively. Number 1 was a general information question and therefore neutral. If it is not included, a coefficient of .90 is calculated. These scores indicated that the instrument is reliable and no adjustments were necessary.

Data Collection

The questionnaire packet, which included cover letter (appendix A), informed consent (appendix B), request for demographic data (appendix C) and The Binns Survey (appendix D) were distributed to conveniently chosen subjects from various critical care units in Florida. They were approached and the packets were administered outside their work area to avoid environmental pressures and or influences. Completion time was estimated at 10-15 minutes and participants were asked to return the completed packet in the blank envelope provided, sealed, to the researcher at that time. Participants were informed in the cover letter that results of the study are available to them upon request.

Data Analysis

The purpose of the study was to identify what common factors, if any, influence CCNs' communication with NCPs in the ICU. The study was conducted to answer the specific problems outlined in Chapter 1 under the heading of Problem Statement.

The survey used in the study was comprised of 26 items which asked questions concerning some of the problems encountered by CCNs in their care of NCPs. The survey contained 4 subscales. Each subscale had a different number of items, therefore participants' total scores and average scores for each subscale were used to directly compare subscale scores.

One participant did not answer item number 2 on the Binns Survey. So as not to lose the data, a response to that item was calculated by averaging the participant's total score.

The range of possible total scores on the survey was a minimum of 26 to a maximum of 130. Questions included in each subscale with range of score are shown in Table 11. High scores indicate that the nurse feels that communication preferences and beliefs, nursing tasks, emotional implications and treatment implications are not deterrents for communicating with NCPs in the ICU.

Demographic information are presented as means, frequencies, percentages, standard deviations, minimums and maximums. Data for item number 1 are shown in frequency distributions and analysis of variance for the four categories on all the questions. Median split and t-test for independent sampling were used for items number 2 and 3 for analysis of means. For item number 4, data are presented using a series of chi-square analyses to look for associations between demographic variables and participants' scores on the questionnaires.

Chapter 4

Results

This study was done to identify common factors among CCNs who communicate with NCPs in the ICU. The findings generated from the research will be reported in this chapter. Demographic information as well as data pertaining to the research problems are summarized and outlined in tables. Four important but not significant personal attributes associated with CCNs communicating with NCPs were identified and will also be presented here.

Sociodemographic Profile of Participants

Of the 100 surveys distributed, 99 (99%) usable responses were received. Table 1 presents respondents' demographic data on 12 variables using frequency distribution and percentages. As expected the majority of the respondents were females (85.9%). More than half the population was married (52%). An annual income of \$41,000.00 or more was earned by 64.6% of the respondents and 92.9% worked full time, primarily dayshift (84.8%). There were seven participants that worked part-time, with an average 87.42 hours worked each month.

Among the participants, 50% were born in the United States, 47.5% were white non-Hispanic, 30% Black non-Hispanic, 13.1% were Hispanic, 8.1% were Asian or Pacific Islander. The primary language in 77.8% was English. There were 34 Catholics, 32 Protestants, 3 of the Jewish religion and 30 participants categorized their religion as other. Other consisted of atheists, agnostics, Druse and Moslems.

Most of the respondents (64.6%) indicated that neither themselves nor a family member had ever been non-communicative in an ICU.

More than two thirds (67%) of the participants were not CCRN certified, 43.4% had a BSN degree, 36.4% were associate degree nurses, 15.2% were diploma nurses, and 5.1% had an MSN degree in nursing.

Table 2 summarizes participants' responses to questions on 5 categories of emotional support systems that were available to them. Spousal support was identified most often (61.6%).

Approximately two thirds (66.7%) of the participants did have children. A mean of 1.44 children were indicated (SD 1.88).

Less than one half of the study population (48.5%) were not born in the United States but have lived here for an average of 18.33 years (SD 10.32).

The mean age of the subjects was 38.5 years (SD 7.94). Years working as a registered nurse was 14.26 (SD 7.44), and as a critical care nurse was 10.24 years (SD 6.90).

Research Question #1

How are nurses communicating with NCPs influenced by: (a) their communication preferences and beliefs, (b) nursing tasks, (c) emotional implications, (d) treatment implications?

In order to answer this question, full descriptive statistics are presented on the Binns Survey. Table 3 summarizes the statistics.

Those who had a high score on this survey indicated disagreement with the items in general, which would indicate that communication with NCPs is not affected by the

above. A low score indicates agreement with the items and that communication with NCPs is affected by the above.

The items with the lowest scores on the survey were item numbers 2, 3, and 17. Item number 2 had a mean score of 2.85 (SD 1.18), indicating that participants agreed that a patient's response motivates them to communicate. Item number 3 had a mean score of 2.79 (SD 1.28) indicating that the respondents preferred to take care of patients who can tell them how they feel and what they need. Item number 17 had a mean score of 2.88 (SD 1.17). Here respondents agreed that sedation is the best treatment for anxiety in a patient who is intubated, paralyzed, unconscious or neurologically impaired.

Items with a mean score equal to or greater than 4 were item numbers 4, 5, 10, 11, 12, 13, 14, 16, 19, 21, 22, 23, and 24. These scores indicate that the respondents were not deterred from communicating with NCPs for the reasons stated in these items. Of these items, number 21 had the highest mean score, 4.71 (SD 1.03). Respondents were in agreement that introduction to patients who are intubated and conscious is necessary.

Item #1 on the survey was the only neutral question. Agreement with this item would yield a low score. It asked whether or not the nurses thought they had good communication skills in general. Among the respondents 91.9% agreed (47.5%) or strongly agreed (44.4%) that they had good communication skills. Therefore item #1 was not factored in the tabulations.

Each item from the Binns Survey (appendix D) was categorized and placed into subscales for the topics outlined in research question #1. The items were assigned as follows: subscale for (a) included items #2, #3, #4, #21, #22, #23, #24, #25, #26, (b)

included items #10, #11, #12, #13, (c) included items # 5, #6, #7, #8, #9, # 19 and (d) included items #14, #15, #16, #17, #18, #20.

Total scores for the Binns Survey were obtained for each person for questions 2-26. Total subscale scores for each subscale were also obtained by totaling participants' scores on each subscale. In addition, average subscale scores were computed for each to compare scores between subscale.

Table 4 shows means and standard deviations for the total scores and subscale scores, as well as the average subscale scores. As presented in the table, the mean total score is 96.04 - note that possible scores range from 26-130.

Total subscale scores are not commented on since each subscale is based on a different number of items. Means and averages are presented and will indicate approximate scores.

The highest mean average subscale score was obtained for nursing tasks subscale (M=4.25). The lowest was obtained for treatment implications (M=3.67). There was little difference between the communication subscale (3.81) and the emotional subscale (3.78). It is noteworthy that all the average subscale scores were greater than 3, the neutral point, therefore, there was overall agreement on all items.

Question #2

Is there a significant difference in the factors affecting communication, in the mean scores on the Binns Survey for those nurses with more years of experience and for those with less?

A series of t-tests for independent samples were performed between nurses with 10 or more years of nursing experience and those with less than 10 years of experience.

Ten was calculated as the median for years of experience. T-tests were also performed for each of the four subscales and for total scores for participants on the Binns Survey.

As can be seen from table 5, none of the T-tests reached a significance level. This indicates that there is no significant difference between subscale scores and total scores for the nurses with more or less than 10 years of nursing experience.

It must be noted, however, that there was an important difference on the emotional subscales scores ($p=.09$) which some pilot studies consider as a significant value.

Question #3

Is there a significant difference between scores on the Binns Survey for nurses that have been or that have had family members who have been non-communicative in an ICU?

A series of t-tests for independent samples were performed between nurses who have been or who have had family members who have been non-communicative in an ICU and those who have not. T-tests were performed for each of the four subscales and for total scores for participants on the Binns Survey.

As illustrated in Table 6, there were no significant differences in scores for any of the scores.

Question 4

What personal attributes are associated with nurses' communication with NCPs in the ICU?

In order to explore associations between personal attributes and total scores on the

Binns Survey, respondents were categorized into high scorers and low scorers based on a median score $M=98.00$. A score of 98.00 or less was categorized as a low scorer, and a score greater than 98.00 was categorized as a high scorer.

A series of cross tabulations were then constructed and chi-square analyses were performed to examine significant associations. Four significant findings emerged. The first significant finding was made between the 2 categories of CCRN, those who were certified and those who were not with scoring status- high or low. Table 7 shows that there were more low scorers in nurses who were CCRN certified than was expected by chance ($X^2 = 5.87$, $df = 1$, $p = .01$).

The second significant finding resulting from chi-square analysis was between nurses working full-time and those working part-time. There were more high scorers working full-time than was expected by chance ($X^2 = 5.55$, $df = 1$, $p = .02$) as shown in Table 8.

The third significant association was between those nurses with children and those without and their total scores on the Binns Survey. There were more high scorers among nurses with children and conversely more low scorers among nurses without children than was expected by chance ($X^2 = 6.69$, $df = 1$, $p = .01$). These results are illustrated in table 9.

Table 10 shows the fourth significant finding. This was made between those nurses who reported that they had emotional support from their spouses and those who did not, with their total scores on the Binns Survey. There were more high scorers among those nurses who indicated they had emotional support from their spouses than was expected by chance ($X^2 = 4.58$, $df = 1.00$, $p = .03$).

There were no other chi-square values resulting from cross tabulations and other demographic information that were of significance.

Table 1

Frequency Distribution of 12 Demographic Characteristics of Respondents (n=99)

Variable	Frequency	Percent (%)
Gender		
Male	14	14.1
Female	85	85.9
Marital status		
Single	32	32.3
Married	52	52.5
Divorced	14	14.1
Separated	1	1.0
Current Annual Income		
20,000 or less	2	2.0
21,000-30,000	5	5.1
31,000-40,000	26	26.3
41,000 or more	64	64.6
Ethnic Background		
White non-Hispanic	47	47.5
Black non-Hispanic	30	30.3
Hispanic	13	13.1
Asian/Pacific/Others	8	8.2
Born in the U.S.A		
Yes	50	50.5
No	48	48.5
Missing answer	1	1.0
Primary Language		
English	77	77.8
Spanish	8	8.1
Creole	1	1.0
French	3	3.0
Other	10	10.1
Religion		
Catholic	34	34.3
Protestant	32	32.3
Jewish	3	3.0
Other	30	30.3

Table 1 contd.

Frequency Distribution of 12 Demographic Characteristics of Respondents (N=99)

Variable	Frequency	Percent %
Ever been NCP in ICU		
Yes	35	35.4
No	64	64.6
Do you work		
Full-time	92	92.9
Part-time	7	7.1
Shift worked primarily		
Day	84	84.8
Night	15	15.2
CCRN certification		
Yes	32	32.3
No	67	67.7
Highest degree as R.N.		
Diploma	15	15.2
Associate	36	36.4
BSN	43	43.4
MSN	5	5.1
Ph.D.	0	0

Table 2

Frequency Distribution of Emotional Support Systems Available to the Nurses (n-99)

Variable	Frequency	Percentage
Spousal Support		
Yes	61	61.6
No	38	38.4
Sibling Support		
Yes	42	42.4
No	57	57.6
Parental Support		
Yes	44	44.4
No	55	55.6
Other Support Systems		
Yes	46	46.5
No	53	53.5
No Support Systems		
Yes	7	7.1
No	92	92.9

Table 3

Means and Std. Deviations on the Binns Survey for 99 Respondents

Item #	Mean	Std. Deviation
Q1- good communication skills in general	1.69	.80
Q2- patient's response motivates communication	2.85	1.18
Q3- prefer patients who are communicative	2.79	1.28
Q4- prefer patients who don't talk	4.00	.94
Q5- taking care of NCPs is anxiety producing	4.20	.82
Q6- frustrating when NCPs try to communicate	3.50	1.14
Q7- communication devices are frustrating for nurses	3.64	1.17
Q8- communication devices are frustrating for patients	3.40	1.15
Q9- relationships may be painfully ended	3.70	1.05
Q10- communication a low priority	4.04	1.08
Q11- better at nursing tasks without communication	4.22	.85
Q12- unnecessary part of the nursing process	4.36	.73
Q13- focus on high tech equipment	4.37	.66
Q14- no time for frequent interaction in the ICU	4.27	.83
Q15- NCPs need decreased environmental stimuli	3.18	1.28
Q16- NCPs need little communication	4.07	.87
Q17- NCPs need sedation for anxiety	2.88	1.17
Q18- sedation to prevent ICU psychosis	3.91	.82
Q19- orientation to place time is useless information	4.23	.87
Q20- discouraging to know how sick they are	3.71	.94

Table 3 contd.

Means and Std. Deviations on the Binns Survey for 99 Respondents

Q21- introduction not necessary conscious NCPs	4.71	1.03
Q22- introduction not necessary unconscious pts.	4.17	1.03
Q23- unnecessary if patient cannot acknowledge me	4.29	.87
Q24- NCPs unaware of surroundings	4.30	.81
Q25- communication not likely if response not likely	3.59	1.25
Q26- communication not likely without pt. perception	3.56	1.22

Table 4

Means & Std. Deviations of Binns Survey Scores (n=99)

Subscale	Mean Score	Std Deviation	Range of Scores
Communication preferences	34.29	6.76	9 -45
Emotional implications	22.69	3.52	4 -20
Nursing Tasks	17.00	2.73	6 -30
Treatment implications	22.05	3.61	6 -30
Total Binns Survey Scores	96.04	12.86	26 -130

Averages of Binns Survey Scores (n=99)

Subscale	Mean	Std. Deviation
Communication preferences	3.81	.75
Emotional implications	3.78	.58
Nursing tasks	4.25	.68
Treatment implications	3.67	.60

Table 5

T-tests for Subscale and Total Binns Survey Scores for Research Question 2

Is there a significant difference in the factors affecting communication, in the mean scores on the Binns Survey for those nurses with more years of experience and for those with less?

Subscale	t	df	p
Communication subscale	-1.57	97	.11
Emotional subscale	-1.67	97	.09
Nursing Tasks Subscale	-1.19	97	.23
Treatment subscale	-.16	97	.87
Total Binns Score	-1.58	97	.11

Table 6

T-tests for Subscale and total Binns Survey Scores for Question 3

Is there a significant difference between scores on the Binns Survey for nurses that have been or that have had family members who have been non-communicative in an ICU?

Subscale	T	df	p
Communication preferences	-1.07	97	.28
Emotional implications	.21	97	.83
Nursing Tasks	.23	97	.81
Treatment implications	-.97	97	.33
Total Binns survey Scores	-.72	97	.46

Chi-square Analyses and Cross Tabulations for Research Question 4

What personal attributes are associated with nurses' communication with NCPs in the ICU?

Table 7

CCRN certification	Yes	No	Total
Low score	24	33	57
High score	8	34	42
Total	32	67	99

Chi-square = 5.87, df = 1, p = .01

Table 8

Working full-time/part-time	Full-time	Part-time	Total
Low score	50	7	57
High score	42	0	42
Total	92	7	99

Chi-square = 5.55, df = 1, p = .02

Table 9

Do you have children	Yes	No	Total
Low score	32	25	57
High score	34	8	42
Total	66	33	99

Chi-square = 6.69, df = 1, p = .01

Table 10

Spousal support	Yes	No	Total
Low score	30	27	57
High score	31	11	42
Total	61	38	99

Chi-square = 4.58, df = 1, p = .03

Table 11

Subscale item numbers with range of scores

Subscale Topic	Items included	Range of scores
Communication preferences and beliefs	#2, #3, #4, #21, #22, #23, #24, #25, #26	Minimum 9 Maximum 45
Nursing tasks	#10, #11, #12, #13	Minimum 4 Maximum 20
Emotional implications	#5, #6, #7, #8, #9, #19	Minimum 6 Maximum 30
Treatment implications	#14, #15, #16, #17, #18, #20	Minimum 6 Maximum 30

Chapter 5

Discussion

The purpose of the study was to examine what common factors, if any, exist among CCNs who communicate with their NCPs. The results generated from the study will be discussed in this chapter along with limitations of the study, recommendations for further study and nursing implications.

Conceptual Framework

The conceptual framework utilized for this study was that of Ida Jean Orlando. She conceptualized the function of professional nursing as finding out and meeting patients' needs through interaction and communication.

Orlando (1961) asserts that patients experience distress more as a reaction to the hospital setting than to their illness and as a result are not able to communicate their needs. If the nurse establishes an interactive, communicative relationship with the patient, some of the distress may be alleviated. The channels of communication are opened and the patients' needs can be identified and appropriately addressed.

The results of the study indicate that nurses fully recognize the importance and the need for communicating with patients who are non-communicative, whether they are conscious or unconscious. The findings also indicate that nurses are aware that the nursing process is not completed without nurse-patient communication to verify that those needs have been met after deliberative nursing action has taken place.

Summary of Findings

The subjects in the study provided their perceptions, through survey questionnaire, of whether or not specific issues influenced them to initiate and maintain verbal communication with NCPs.

The specific issues targeted in the questionnaire are outlined in the problem statement in chapter 1. They include the nurses' communication preferences and beliefs, nursing tasks, emotional implications and treatment implications.

These issues of subcategories were developed from the findings of earlier studies by Leathart (1994), Ashworth (1980), Turnock (1989) and Bergbom-Engberg and Haljamae (1992). Their studies revealed that nurses most often identified these issues as influential in their deterrence or motivation for communication with NCPs.

The results of this study indicated that there was a high degree of agreement among the nurses that these were all influential reasons to communicate verbally with NCPs and that none of these issues were a significant deterrent.

Although there were no significant differences found, there was, however, one important difference noted in the results. Nurses with fewer years of experience scored higher on the emotional subscale. This would indicate that emotional issues are more of a deterrent to communication with NCPs for nurses with more years of critical care nursing experience than for nurses with less years of critical care nursing experience.

These findings are consistent with those of Turnock (1989), who reported from his study that more experienced nurses had less verbal communication with their patients to avoid building an emotional attachment. Less experienced nurses were still influenced

by their academic curriculum. Leathart (1994) reported from her study that nurses protect themselves from anxiety by restricting communication with their patients.

In contrast, in Sweden, Bergbom-Engberg and Haljamae (1993) reported from their study that less experienced nurses were more likely to report stress, resulting from establishing and maintaining a relationship and communication with the patients and the nurses' personal worries. They did report, however, that if the nurse developed a relationship with the patient, there was more verbal communication from an emotional caring viewpoint. It seemed that if nurses felt for the patient emotionally, they communicated more.

There were 35 study participants (35.4%) who were or who had family members who were NCPs in an ICU. Surprisingly, there were no significant differences in their attitudes on communicating with NCPs in the ICU, from the rest of the study population.

There were four significant findings on personal attributes associated with nurses' communication with NCPs in the ICU. The first finding was among nurses who were CCRN certified. These nurses seem to communicate less often than those who were not certified ($p=.01$).

Although the CCRN certification recognizes critical care nurses for their expertise, communication with NCPs does not seem to be a topic of much attention. These results may indicate that as CCNs become more recognized for their expertise in this highly technical and critical area of health care, they become less likely to include communication in the nursing process.

The second significant finding was with nurses working full-time. There were more high scorers for the Binns Survey who worked full-time than was expected by

chance ($p=.02$). This could indicate that full-time workers have become more accustomed to communicating with these kinds of patients, simply due to the fact that they spend more time with them.

The study also resulted more high scorers on the Binns Survey for those CCNs who had children than was expected by chance ($p=.01$). This demographic information was not available on previous studies for comparison. Not many individuals would disagree that parenting a child is associated with much verbal communication. It may be that the experiences provided in this nurturing, caring parenting role is carried over into their role as CCNs. This would be one lesson taught by nature that should be included in the nursing curriculum.

The final significant finding was among nurses who reported they had emotional support from their spouses. There were more high scorers among these nurses than was expected by chance ($p=.03$). This demographic information was also not available on previous studies for comparison. CCNs with spouses may well understand, through the relationship with their spouses, the importance of having someone to communicate their feelings with. This may make them more sensitive to a patient who is isolated by being non-communicative.

The results say, in other words, that if a nurse who works in the ICU has children and or the emotional support of a spouse he or she is more likely to initiate and maintain communication with their NCPs. The possible explanations are endless. These nurses with children have become accustomed to talking to people who do not listen. The nurses with spouses have become accustomed to talking to people who ignore them, or who do

not talk back. Fortunately or unfortunately such conjecture would entail a separate research study.

The study participants were very similar to those of previous studies. It was mainly comprised of female nurses, working day shift, with as little as one year and as much as 36 years of experience with some source of emotional support outside the work place, family or friends.

The major difference in the populations studied is the country where the studies have taken place. The subjects in this study have lived in the United States for a mean of 18.33 years (SD 10.32). The earlier studies took place among Europeans living there. This topic has not been studied in the United States before now and may be a reason for the disparity on the research findings.

Limitations of the Study

1. The primary investigator created the measurement tool used in the study, since there were no others in existence. A coefficient alpha of $r = .89$ was obtained. Since the earlier studies on the topic were qualitative by design the instrument had not been tested in other studies.
2. Selection of subjects was through convenience sampling due to time constraints for collecting the data. The population was primarily from a select area in Florida and therefore cannot be generalized to other nursing populations.
3. The subjects were limited in their expression of factors influential to them in communicating with NCPs in the ICU by the specific questions asked in the survey.
4. The study was limited by under representation of nurses who worked part-time evening shift or night shift.

5. Subjects were asked to answer and return the surveys within 15 minutes of distributing them. If they could have been given 24 hours to answer the items more thoughtfully, perhaps their answers would reflect more on how they really practice as opposed to what they know to be appropriate for critical care nursing.

Recommendations for Further Study

1. The instrument would be strengthened if the study could be replicated with a more generalized population of nurses working all shifts.
2. Replication of the study using the instrument developed along with observation of the nurses to compare how they actually communicate, with their answers on the survey, in a qualitative type study as has been done in the earlier research.
3. Replication of the study using an open ended questionnaire to give the subjects the opportunity to express their personal attitudes and concerns on communicating with NCPs in the ICU.
4. According to the results of this study, nurses have indicated that they do communicate with NCPs in the ICU. Further study into how patients perceive communication with their nurses may give more information on the problems of communication with NCPs in the ICU.

Implications for Nursing Practice

The nurses in this study have indicated that they realize the importance of communicating with NCPs. The results of the study also indicate that despite demographic variables most nurses do communicate with their NCPs.

It is now old news that nurses know the importance of communicating with patients who are isolated by their critical condition of coma, intubation or paralysis.

Communication in the ICU still remains an issue for nurses and patients. Patients are still reporting that there was little or no verbal communication with them. Issues of communication are still on the minds of the patients after their stay in the ICU.

The study found no demographic differences among nurses who communicate with NCPs, but those nurses seem to lose some communicative motivation once they have earned CCRN certification.

Another finding is that motivation for communicating with NCPs lessened with years of experience. More experienced CCNs may benefit from regular motivational classes, which show the benefits of communicating with NCPs in the ICU. Continuing education classes may re-enlighten these more seasoned professionals.

Nurses who work full-time reported more communication with NCPs than did nurses working part-time. Spending more time in the environment with these types of patients may be the best method for becoming used to communicating with them. This would enable the nurse to establish a comfort level with NCPs.

The relationship with or the presence of family (children and spouse) in the lives of CCNs has shown to be an asset in the nurses' motivation for verbal communication with their NCPs. All nurses are not endowed with the presence of family in their lives, but they can certainly learn from those who do. We all learn from each other, in the dynamic processes we exchange with each other, everyday. We can learn from each other and teach each other from our life experiences. The bottom line would be an improved nursing process and better patient outcome.

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Appendix A

Cover Letter

Mickey Binns

Florida International University

Graduate School Of Nursing

Dear Potential Participant:

I am a graduate student at Florida International University School of Nursing, currently collecting data for the completion of my thesis requirement. The purpose of the study is to examine what differences exist between those critical care nurses who communicate with their non-communicative patients and those who do not.

To complete this study, I am requesting your voluntary participation. The entire packet, which includes demographic data and research questionnaire should take 10-15 minutes to complete, at which time I will gladly secure your answers in the envelope enclosed and forward them for analysis.

Included here also, is an informed consent, which will provide some insight into the purpose of the study. Should you be interested, research findings will be available to you upon request. Please contact me at (954) 704-8276 or Dr. Divina Grossman at Florida International University, College of Health Sciences if you need further information about this study.

Thank you for participating.

Yours Sincerely

Mickey Binns

Appendix B

Informed Consent

PURPOSE

The purpose of the study is to investigate what common factors influence Critical Care Nurses to communicate with their non-communicative patients.

PROCEDURE

You are asked to answer questions pertaining to demographic information as well as a research questionnaire. Both should take 10-15 minutes to complete. If at any time you want to discontinue the questionnaire, please do so. Upon completion please place the questionnaires in the envelope provided and return them to me, sealed, for your privacy.

RISKS

There are no known, expected or anticipated risks to you or anyone else. Participation is voluntary and you may choose to discontinue the questionnaire at any time. There is no monetary reward. The benefits will be to the body of nursing knowledge.

CONFIDENTIALITY

No names will be asked or will appear on the questionnaires. Results will be based on group statistics rather than individual information. The primary investigator, the research committee, and the statistician only will handle the raw data. Please be reminded that participation is voluntary and may be abandoned at any time. Return of the questionnaire implies informed consent to participate.

Appendix C

Demographic Questionnaire

1. Male _____ Female _____
2. Your age _____
3. Marital Status: Single ____ Married ____ Divorced ____ Separated ____ Widowed ____
4. Do you have children ____ how many ____?
5. What is your current annual income?
\$20,000 or less ____ \$21,000- \$30,000 ____ \$31,000- \$40,000 ____ \$41,000 or more ____
6. Racial/ Ethnic background
White non-Hispanic ____ Black non-Hispanic ____ Hispanic ____ Asian/Pacific Islander ____
Other (specify) _____
7. Were you born in the U.S.A.? _____ If not, how long have you lived here? _____
8. What is your primary language? _____
9. Religion _____
10. What are your sources of emotional support? (Mark all that apply)
Spouse ____ Parents ____ Siblings ____ Other (specify) _____ None ____
11. Have you or any family member ever been comatose, intubated or by any other means, non-communicative in an ICU? _____
12. Do you work full- time? ____ Part-time? ____ If part time, how many hours each month _____
13. What shift do you work primarily? _____
14. How many years have you practiced as a registered nurse? _____
15. How many years have you practiced as a critical care nurse? _____

16. Are you currently, or have you ever been CCRN certified? Yes ____ No ____

17. What is your highest degree earned as a registered nurse?

Diploma ____ Associate ____ BSN ____ MSN ____ Ph.D. ____

18. List any specialty classes on communication you have attended

THE BINNS SURVEY

NURSES' COMMUNICATION WITH NON-COMMUNICATIVE PATIENTS

From the choices below, please write in the letter that corresponds to your answer.

A=STRONGLY AGREE, B=AGREE, C=NOT SURE, D=DISAGREE,

E=STRONGLY DISAGREE

1. I have good communication skills in general. _____
2. It is a patient's response that motivates me to communicate. _____
3. I prefer to take care of patients who can tell me how they feel and
what they need. _____
4. I prefer to take care of patients who don't talk because I don't have
to talk to them. _____
5. I get very anxious when I have to take care of a non-communicative
patient _____
6. I get very frustrated when an intubated patient tries to communicate
with me. _____
7. I find that communication devices such as picture boards and pen and
paper are a source of frustration for nurses. _____
8. I find that communication devices such as picture boards and pen and
paper are a source of frustration for patients. _____
9. If I encourage communication with my ICU patient I could foster a
relationship which may be painfully ended at discharge or death _____

A=STRONGLY AGREE, B=AGREE, C=NOT SURE, D= DISAGREE,

E= STRONGLY DISAGREE

10. Communication is low on my priority list when the patient is very sick. _____
11. I can perform nursing tasks more efficiently if I don't communicate
with my patients. _____
12. I feel that verbal communication is an unnecessary part of the nursing process
when caring for a non-communicative patient. _____
13. I keep communication with my ICU patients to a minimum so
that I can focus on the high tech equipment, monitors and machines
without distractions. _____
14. If I establish a communicative relationship with my non-
communicative patients they may want to interact frequently and
there is no time for that in the ICU. _____
15. Decreased environmental stimuli is the best treatment for anxiety
in a patient who is intubated, paralyzed, unconscious, or
neurologically impaired _____
16. Little communication is the best treatment for anxiety in a patient
who is intubated, paralyzed, unconscious, or neurologically impaired. _____
17. Sedation is the best treatment for anxiety in a patient who is intubated
paralyzed, unconscious or neurologically impaired. _____
18. I keep my ICU patients sedated to prevent ICU psychosis. _____
19. When a patient is non-communicative, orientation to place, time
and events is useless information for him or her to have to deal with. _____

A= STRONGLY AGREE, B= AGREE, C= NOT SURE, D= DISAGREE,
E= STRONGLY DISAGREE

20. ICU patients become discouraged, and do poorly, when they are
aware of how sick they are. _____
21. It is not necessary for me to introduce myself to patients who are
intubated and conscious. _____
- 22 It is not necessary for me to introduce myself to patients who are
unconscious. _____
23. If the patient cannot acknowledge understanding, there is no reason
for me to explain procedures before performing them. _____
24. It seems likely, that if a patient cannot verbally respond, he or she
is unaware of the surroundings and communication is pointless. _____
25. I am less likely to initiate communication with a patient whom I
don't think will respond. _____
26. I am less likely to initiate communication with a patient whom I
don't perceive understands me. _____

Appendix E

Letter to Experts for Content Validity Testing

Dear _____,

You have been selected to assist with validity testing for a research questionnaire based on your expertise in critical care nursing or research. Enclosed is a copy of the questionnaire to be used for the study. The title of the research is Factors Associated with Critical Care Nurses' Communication with Non-communicative Patients in the ICU. The purpose of the study is to examine what differences exist between those critical care nurses who communicate with their non-communicative patients and those who do not.

An evaluation tool is also included on the questionnaire. This for you to rate each item's relevance to the purpose of the study. On a scale of one thru four, from not relevant to very relevant, please indicate your thoughts on this item by writing in your answer. I am asking that you take a moment to give an explanation or suggestion for any item you give a score of less than three.

Please feel free to add any questions you think may be important to this topic. For any questions please contact me at (954) 704-8276. Thank you for participating.

Yours Sincerely

Mickee Binns

Appendix F

NURSES' COMMUNICATION WITH NON-COMMUNICATIVE PATIENTS

QUESTIONNAIRE

Please remember that you are examining the questions for content validity then rate each question on a scale, 1= Not Relevant, 2= Somewhat Relevant, 3= Quite Relevant, and 4= Very Relevant.

1. I have good communication skills in general. _____
2. It is a patient's response that motivates me to communicate. _____
3. I prefer to take care of patients who can tell me how they feel and
what they need. _____
4. I prefer to take care of patients who don't talk because I don't have
to talk to them. _____
5. I get very anxious when I have to take care of a non-communicative
patient _____
6. I get very frustrated when an intubated patient tries to communicate
with me. _____
7. I find that communication devices such as picture boards and pen and
paper are a source of frustration for nurses and patients. _____
8. If I encourage communication with my ICU patient I could foster a
relationship which may be painfully ended at discharge or death _____
9. Communication is low on my priority list when the patient is very sick. _____
10. I can perform nursing tasks more efficiently if I don't communicate
with my patients. _____

11. I feel that communication is an unnecessary part of the nursing process
when caring for a non-communicative patient. _____
12. I keep communication with my ICU patients to a minimum so
that I can focus on the high tech equipment, monitors and machines
without distractions. _____
13. If I establish a communicative relationship with my non-
communicative patient, they may want to interact frequently and
there is no time for that in the ICU. _____
14. Decreased environmental stimuli, little communication and sedation
is the best treatment for anxiety in an intubated patient. _____
15. I keep my ICU patients sedated to prevent ICU psychosis. _____
16. When a patient is non-communicative, orientation to place and time
and to events is useless information for them to have to deal with. _____
17. ICU patients become discouraged, and do poorly, when they are
aware of how sick they are. _____
18. It is not necessary for me to introduce myself to a patient who is
intubated, unconscious, or comatose. _____
19. If the patient cannot acknowledge understanding, there is no reason
for me to explain procedures before performing them. _____
20. It seems likely, that if a patient cannot verbally respond, he or she
is unaware of the surroundings and communication is pointless. _____

Please complete the questionnaire by answering the following questions:

How comprehensive is the questionnaire for examining reasons that ICU nurses may or may not communicate with non-communicative patients? (Please circle your answer)

1=NOT COMPREHENSIVE, 2=SOMEWHAT COMPREHENSIVE,

3= QUITE COMPREHENSIVE, 4= VERY COMPREHENSIVE

If you feel that any pertinent items were omitted that need to be included please state them in the space provided below. For the questions you rated not relevant or somewhat relevant please also explain the reasons for you ratings here.

Thank you for your assistance.



Date: October 27, 1998

From: Douglas A. Coffin, PhD, ARNP
SON URC Representative

To: Michelle Binns, BSN, RN

Subj: Your Application for Approval of Research Involving Human Subjects.

Cc: Dr. Divina Grossman, PhD, RN, Chairperson, Thesis/Research Report for Michelle Binns.

Your request for application for approval of research involving human subjects has been approved for "Factors Associated with Critical Care Nurses' Communication with non-Communicative Patients in the ICU," once you have included the survey instrument and/or questionnaire so that it can be included in the application packet.

Approval has been granted for Expedited Review: Category # 9.

Please understand that any additions or changes in the procedure that has been approved involving human subjects can only be made after approval of the URC or its representatives. One copy of the application will be returned to you, one copy will go to the URC and one copy will be maintained within the School of Nursing.

School of Nursing
North Campus, North Miami, Florida 33181
(305) 919-5915 • TDD, via FRS 1-800-955-8771 • FAX (305) 919-5395

Equal Opportunity/Equal Access Employer and Institution

FLORIDA INTERNATIONAL UNIVERSITY
UNIVERSITY RESEARCH COUNCIL (URC)

APPLICATION FOR APPROVAL OF RESEARCH INVOLVING HUMAN SUBJECTS

1. PROJECT TITLE: FACTORS ASSOCIATED WITH CRITICAL CARE NURSES' COMMUNICATION
WITH NON-COMMUNICATIVE PATIENTS IN THE ICU
2. PRINCIPAL INVESTIGATOR: MICHELLE BINNS SS#: 263-93-0843
Address: 10842 NW 8th St Pembroke Pines, FL 33026 Phone #: (954) 704-8276
Position: ☐ Faculty ☒ Graduate Student ☐ Undergraduate Student ☐ Other (Specify) _____
3. FACULTY SUPERVISOR (if PI is a student): Dr. Divina Grossman, PH.D. RN
4. STATUS OF PROJECT REVIEW:
☐ New project ☐ Revision of previously approved project ☐ Continuation of approved project
5. BRIEF DESCRIPTION OF SUBJECTS
Number of subjects: 100
Check all of the following categories that describe your research subjects:
☒ Males
☒ Females
☐ Minors (under 18 years old)
☐ Students (Please Specify): _____
☐ Persons With Physical Disabilities (Please Specify): _____
☐ Persons With Mental/Psychological Disabilities (Please Specify): _____
☐ Persons With Physical or Mental Health Problems (Please Specify): _____
☐ Persons With No Known Disabilities and No Known Health Problems
☐ Prisoners
☐ Pregnant women, fetuses, fetal material or placenta (Please Specify): _____
☐ Persons In Some Type of Program (Please Specify): _____
☒ Other Pertinent Information (Please Specify): Critical Care RNs Currently Practicing in Florida
6. TYPE OF REVIEW REQUESTED (See pages 6 & 7 of the Information for Experimenters booklet):
☐ Exempt; Category #(s): _____
☒ Expedited Review; Category #(s): 9
☐ Full URC Review (Can be neither Exempted nor Expedited)

If this is a new project, please attach information about the following. If this is a revision of a previously approved project, please complete any items that involve changes. If this is a continuation of a previously approved project without change, there is no need to provide the following information.

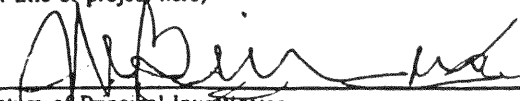
Please be brief and to the point when providing the requested information. Do not simply attach your thesis or grant proposal. However, if the information requested below is provided in short sections of your thesis or grant proposal, feel free to integrate those sections into this application.

7. **RESEARCH OBJECTIVES:** Concisely describe the theoretical and empirical goals of this research project.
8. **SUBJECT RECRUITMENT:** Describe the sources of potential subjects, where and how their names will be obtained, and the selection criteria. Selection of subjects on the basis of sex, age or minority status must be justified. Describe where and how you will contact potential subjects, and what information you will give them about the experiment (up to the point of obtaining informed consent).
9. **BENEFITS:** (a) Describe any benefits, such as money or credit in a university course, that the subjects will receive. If course credit is given, describe alternatives available for students who do not wish to participate to obtain equivalent course credit. If extrinsic benefits are provided, specify what action will be taken if the subject discontinues participation before the experiment is completed.
(b) Describe the anticipated benefits to society of this research.
10. **INFORMED CONSENT:** Describe the manner in which informed consent will be obtained. Attach a copy of the written informed consent form. A sample form is provided in the Information for Experimenters handout. The informed consent form must be written at a level that the subjects will understand; avoid jargon and use simple language. If your subjects do not comprehend English you must have an informed consent form in their language. If you will not obtain written consent (a signature on an informed consent form) from the subjects, justify this lack. Provide any other relevant information. Please be aware that you are legally required to retain all signed informed consent forms for at least three years after the project terminates.
11. **CONFIDENTIALITY OF DATA:** Explain how data will be secured to safeguard confidentiality. Note that confidentiality is critical if information will be obtained about sensitive or illegal behavior.
12. **METHOD AND PROCEDURES:** Explain the methods and procedures of your experiment, with an emphasis on implications for subjects' experiences.
13. **STIMULUS MATERIALS:** Attach copies of all questionnaires and other stimulus materials.
14. **RISKS TO SUBJECTS:** Describe in detail any immediate or long range risks to subjects that may arise from the procedures used in the study. Indicate whether these risks are greater than those faced in normal life. Detail the precautions you have taken to minimize these risks. Justify the scientific necessity of the experimental aspects that lead to these risks. (Risks may be physical, psychological, social, economic, or legal.)

15. AFFIRMATION OF COMPLIANCE AND ACCEPTANCE OF RESPONSIBILITY

I agree to follow the procedures outlined in this summary description and any attachments. I understand that no contact may be initiated with subjects until I have received approval of these procedures from the URC and have complied with any modifications required in connection with that approval. I understand that additions to or changes in the procedures involving human subjects can only be made after approval of the URC. I understand that I must promptly report to the URC any problems with the rights or welfare of the human subjects. I understand and will follow Florida International University's policies concerning research with human subjects. I will do everything in my power to protect the rights and welfare of human subjects in my research project.

FACTORS ASSOCIATED WITH CRITICAL CARE NURSES' COMMUNICATION WITH NON-COMMUNICATIVE
(print title of project here) PATIENTS IN THE ICU



Signature of Principal Investigator

10-12-98


Date

MICHELLE BINNS

Printed name of Principal Investigator

If the PI is a student, the faculty supervisor must sign below.

I have read this application and assume responsibility for its accuracy and for supervision of the proposed research project.



Signature of Faculty Supervisor

10-12-98

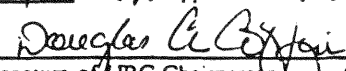
Date

Divina Grossman

Printed name of Faculty Supervisor

ACTION RECOMMENDED BY URC **For URC use only**

Date: 10/27/98 ☒ Approved ☐ Changes/Clarifications Requested ☐ Require Full Board Review



Signature of URC Chairperson *Ex Officio URC-SOS Representative*

DOUGLAS A COFFIN

Printed name of URC Chairperson

Date: _____ ☐ Approved ☐ Changes/Clarifications Requested ☐ Require Full Board Review

Signature of URC Chairperson

Date: _____ ☐ Approved ☐ Changes/Clarifications Requested ☐ Require Full Board Review

Signature of URC Chairperson

FLORIDA INTERNATIONAL UNIVERSITY
UNIVERSITY RESEARCH COUNCIL (URC)

INFORMATION FOR EXPERIMENTERS

Research by FIU faculty and students that involves human subjects must receive prior approval by the University Research Council (URC). Federal regulations define "research" as "a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge." Thus research performed for pedagogical purposes (not designed to develop or contribute to generalizable knowledge), is excluded from these regulations *if it involves no more than minimal risk and does not involve any protected classes of subjects*. "Minimal risk" means that the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests. Thus, for example, research projects employed in undergraduate classes to teach students how to do research are excluded. In this case the instructor is responsible for ensuring that the research involves no more than minimal risk, and for assuring ethical conduct on the part of everyone involved in the research project. Research performed at other locations by FIU faculty and students must receive approval from FIU *even if previously approved by other organizations*.

The requirement for prior approval, as well as the information and instructions that follow, are based on the FEDERAL POLICY FOR THE PROTECTION OF HUMAN SUBJECTS; NOTICES AND RULES, published in the Federal Register, Vol. 56, No. 117, June 18, 1991, as Department of Health and Human Services 45 CFR 46 and other agencies under separate sections of CFR, as noted. All researchers should have copies of these regulations; they can be obtained from the Division of Sponsored Research and Training or from Psychology Department secretaries. The purpose of this handout is to abstract the most frequently needed information from the Federal regulations, but it must be understood that the Federal regulations govern in case of real or apparent discrepancies between those regulations and this handout.

Before approving any research the URC must determine that all of the following requirements are satisfied: (1) Risks to subjects are minimized. (2) Risks to subjects are reasonable in relation to anticipated benefits to subjects and the importance of the knowledge that may reasonably be expected to result. (3) Selection of subjects is equitable. (4) Informed consent will be sought from each prospective subject or the subject's legally authorized representative. [More detail about informed consent is given below.] (5) Informed consent will be appropriately documented. (6) Where appropriate, the research plan makes adequate provision for monitoring the data collected to insure the safety of subjects. (7) Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.

To apply for approval please turn in to the URC chairperson several copies of each application (application form plus all required materials). Turn in 3 copies of applications for exempt or expedited review, and 16 copies of applications for full review. One copy will be returned to you after the committee has taken action on your request. Please keep that copy for your records. Yearly approval is required for all research projects, so please retain all materials sent to you by the URC.

7. RESEARCH OBJECTIVES

The purpose of this study is to identify common factors that may exist between critical care nurses who communicate with their non-communicative patients and those who do not. Non-communicative patient has been defined for this study as any hospitalized person, conscious or unconscious, who is not able to communicate verbally for reasons of paralysis, intubation, sedation or current disease process. The following research questions will be addressed in this study:

1. How are nurses' communication with non-communicative patients influenced by:
 - a. their communication preferences and beliefs
 - b. nursing tasks
 - c. emotional implications
 - d. treatment implications
2. Is there a significant difference in factors affecting communication, in the mean scores on the Binns Survey for nurses with more years of experience and for those with less?
3. Is there a significant difference between scores on the Binns Survey for nurses that have been or that have family members who have been non-communicative in an ICU?
4. What personal attributes are associated with nurses' communication with non-communicative patients in the ICU?

8. SUBJECT RECRUITMENT

The population to be studied will be comprised of nurses currently working in a critical care environment. Sampling criteria will be critical care nurses living and working in Florida. Nurses who are not currently involved directly with bedside care, e.g. nurse managers, assistant nurse managers, unit educators and clinical nurse specialist, will be excluded from the sample.

Non-probability convenience sampling will be used to acquire 100 voluntary participants from any and all cultural groups. Each participant should be fluent in reading and writing the English Language.

A packet, which will include cover letter, demographic information questionnaire, the research survey and an informed consent, will be distributed to potential participants outside of their work environment. The cover letter explains the purpose of the study, nature of participation and contact persons.

9. BENEFITS

No particular benefits will be promised to any participant. The benefits are to the body of nursing knowledge. Communication in the foundation of a good nurse-patient relationship. Although nurses have long since recognized this fact, barriers still exist in the ICU. If this study is able to identify some of these barriers, suggestions may be available for reshaping nursing education.

10. INFORMED CONSENT

Written consent will not be required from the participants. The cover letter included in the packet will explain that return of the completed questionnaire implies consent to participate in the study. The telephone number of the principle

investigator and of the committee chairperson will be provided if the subjects desire additional information.

11. CONFIDENTIALITY OF DATA

Study participants will be informed that confidentiality will be maintained. An unmarked envelope will be provided for the return of the questionnaires, which will be handled by the primary investigator, the research committee and the statistician only. They will be assured of anonymity and informed that the results will be reported in terms of group data.

12. METHOD AND PROCEDURE

Approval of the research protocol and permission to conduct the study will be obtained from the Florida International University Internal Review Board. Subjects will be provided with written instructions on how to complete the demographic questionnaire and research survey, which should take no more than 15 minutes.

13. STIMULUS MATERIALS

Instruments:

The Binns survey was developed for use in this study. It allows the nurses to express their views on each item, on a Likert scale, on the extent to which they agree with them. The Likert scale presented choices one through five. Choice number one corresponds with strongly agrees, two with agree, three with not sure, four with disagree, and five with strongly disagree.

In order to deter participants from intentionally scoring a false high or a false low, the numbers on the survey will be replaced by letters A,B,C,D,E

respectively. After the subject has completed the survey, the letters will then be transcribed back to numbers to enable quantitative statistical analysis.

Validity and reliability testing were completed on the survey since it was developed for this study. Content Validity was established with a 93% agreement from a panel of 5 experts. Reliability was established using the internal consistency method. A Chronbach's Coefficient Alpha of .89 was calculated. Therefore no adjustments were made.

14. RISKS TO SUBJECTS

Subjects will be informed that there are no known, expected or anticipated risks to anyone. They will also be assured that participation is voluntary and that they may choose to discontinue the questionnaire at any time.