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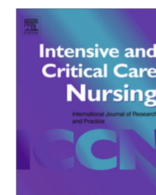

Research article

The communication experience of tracheostomy patients with nurses in the intensive care unit: A phenomenological study

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A B S T R A C T

Objectives: To describe the experience and sources of comfort and discomfort in tracheostomy patients, when they communicate with nurses in the Intensive Care Unit.
Research methodology/design: Benner's interpretive phenomenology. Data were collected through: a) semi-structured interviews conducted with the patients after leaving the intensive care unit; b) participant observation; c) situated interviews with intensive care nurses.
Setting: The intensive care unit of a hospital in Northern Italy.
Findings: Eight patients and seven nurses were included in this study. Two main themes were identified 1) *feeling powerless and frustrated due to the impossibility to use voice to communicate;* 2) *facing continual misunderstanding, resignation and anger during moments of difficulty and/or communication misunderstandings.* The main communication discomfort factors were: struggling with not knowing what was happening, feeling like others had given up on me, living in isolation and feeling invisible. The main comfort factors were: being with family members, feeling reassured by having a call bell nearby and nurses' presence.
Conclusions: This study highlights the important role of communication in tracheostomy patients in intensive care and how closely it is linked to all the aspects of a person's life, which cannot be underestimated as just not being able to use one's voice.
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Implications for Clinical Practice

- The impact of nurse-patient communication in intensive care and the sources of comfort and discomfort are highlighted.
- The results of this study could inform strategies and actions to improve the nurse-patient communication in intensive care.
- This study increases nurses' awareness about the importance of communication for patients and the meaning they give to it.

Introduction

The number of patients who undergo tracheostomy each year is unknown, however this procedure is widespread and has become common practice (Scherlock et al., 2009). Technological improvements and decreased invasiveness of the tracheostomy procedure have encouraged its more liberal use (Hosokawa et al., 2015). Particularly in Europe, when clinical conditions of the mechanically

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ventilated are favourable, there is the increasing use of light sedation or even no sedation (Karlsson et al., 2012) because this reduces time required for patients to wean from mechanical ventilation and consequently length of stay in the intensive care unit (ICU) and ensures improved health outcomes (Samuelson, 2006). This reduces complications and problems caused by immobility, as shown by Strøm et al. (2010), who compared clinical-healthcare results obtained through deep sedation with those using light sedation. Karlsson and Bergbom (2014) described the main sources of stress and difficulty in mechanically ventilated tracheostomy patients, including the impossibility to communicate. Various studies have described the experiences of these patients and how communication difficulties generate feelings of vulnerability and helplessness (Lykkegaard and Delmar, 2015; Engström et al., 2013; Meriläinena et al., 2013; Magnus and Turkington, 2006), becoming sources of anxiety, frustration, and fear (Patak et al., 2006; Grossbach, 2007).

Nurses are in the position to understand, address and mitigate the effects of impaired communication (Karlsson and Bergbom, 2014; Slatore et al., 2012; Carroll, 2007, 2004). When communicating with patients who are not sedated or under light sedation, nurses are required to have the ability to capture and correctly interpret patients' attempts to communicate and their feedback (Arrigoni et al., 2013). Difficult communication can prevent tracheostomy patients from expressing their needs, symptoms (Nilsen et al., 2014), emotions and from participating in decisions regarding their own treatment.

One study, which investigated communication with tracheostomy patients in the ICU, mainly involved the use of communication tools and their effectiveness (Nakarada-Kordic et al., 2017). Current studies mainly focus on experiences of endotracheal intubated patients, but few have explored the communication experience of tracheostomy patients in the ICU (Flinterud and Andershed, 2015; Foster, 2010). Moreover, no studies have shown whether the communication difficulties experienced by nasotracheal-intubated patients are similar to those of mechanically ventilated tracheostomy patients.

Methods

This study aimed to explore the communication experience of tracheostomy patients with nurses in the intensive care unit and identify which situations and factors made patients feel comfortable when communicating with nurses and which caused distress.

Research question

What is the lived experience of adult patients with a tracheostomy, who are not under sedation and mechanically ventilated, in their communication with nurses during their stay in the intensive care unit?

To conduct this study, the researchers used the interpretive phenomenology methodology developed by Benner (1994). The decision to use interpretative phenomenology is related to the aim of this study, which is to gain a deeper understanding of what patients experience when they communicate with nurses. The focus is on the patient's subjective experience and on the meaning each patient gives to this experience. The purpose of interpretive phenomenological investigation was to expand our knowledge by describing things and phenomena as they occur and through lived experience (Polit and Beck, 2014; Holloway and Wheeler, 2012; Sokolowski, 2000). This enables to capture any concerns or what matters to a person, by eliciting narratives about daily experience and observing how each person behaves and how much importance is given to each communication event (Benner et al., 2009). Benner (1994) provides a full discussion of the way in which this form of interpretation is articulated and various strategies and process for interpreting human concerns and actions. Therefore, we selected various methods: in-depth interviews with the patients, situated interviews with the nurses and participant observation during the patients' stay in the ICU.

Sample

We included all the patients admitted to the ICU of a teaching hospital in Northern Italy between January 1st, 2015 and December 31st, 2015, who met all our inclusion criteria.

Inclusion criteria: subjects aged $\geq$18, upon first admission to ICU, with tracheostomy, intubated for more than five days, under light sedation (i.e., level 2 of the Ramsay Scale) (Ramsay et al., 1974).

Exclusion criteria: patients diagnosed with dementia, psychiatric problems, neurological disorders, and disorientation during mechanical ventilation, or patients with language difficulties.

Considering the type of patient population and the difficulty involved in recruiting them, we decided to use convenience sampling and to recruit about 10 patients. We speculated on this sample size, understanding that this could become smaller or larger according to the density of the data we collected and the principle of saturation (Morse, 1995). We tried to ensure the highest possible level of heterogeneity in terms of gender, age, and cultural background to produce a wider range of phenomenological data for our analysis (Polit and Beck, 2014; Speziale et al., 2011; Morse, 1995).

Data collection

During the patients' stay in the intensive care unit, we conducted participant observations to describe the context in which each communication interaction with the nurses occurred, and how these interactions took place. The observations were conducted using a guide (Table 1) at different hours of the day and

Table 1
Researcher's guide on how to conduct the observation of the communication interactions between patients and nurses.

The observations have the purpose to obtain a more comprehensive understanding of the phenomenon of this study, because the analysis of the data that emerged from the interviews could be enriched and supported by the observations conducted in setting where the communication event between the tracheostomy patient and the nurse took place.
Possible observation items: • The intensive care unit environment • Conditions of the tracheostomy patient (posture, presence of infusions, sedation and level of sedations, etc.) • Time of the day • Care activities each nurse provides to each patient • Duration of the communication event • Communication contents • Communication feedbacks provide by both the nurse and the patient • Non-verbal communication of both the nurse and the patient (posture, tone of voice, silence, gestures, facial expressions, emotions, etc.) • Concurrent events

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