



Research Article

Caring for non-sedated mechanically ventilated patients in ICU: A qualitative study comparing perspectives of expert and competent nurses



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ABSTRACT

Background: Sedation practice has evolved from deep to lighter or no sedation in mechanically ventilated patients in the intensive care unit (ICU). The care of conscious intubated patients constitutes a change in the nurse–patient interaction.

Objective: We aimed to compare the perspectives of expert and competent nurses regarding their interaction with non-sedated mechanically ventilated ICU patients.

Method: The study had a qualitative comparative design applying semi-structured dyadic interviews. We interviewed five pairs of expert and competent ICU nurses with respectively >8 and 2–3 years of ICU experience and performed qualitative content analysis to explore the two perspectives.

Findings: We identified four main categories illustrating complexities of nurse–patient interaction: Managing frustration, Attempting dialogue, Negotiating reality and Alleviating discomfort. Expert nurses expressed more frustration and ambivalence towards light sedation than competent nurses, who took awake patients for granted. All nurses experienced communication issues, demanding patients, and inability to provide adequate patient comfort.

Conclusion: Our study added to the knowledge of nurse–patient interaction by describing issues of frustration, ambivalence and insecurity in a contemporary context of minimal sedation. Expert nurses were more concerned by awake patients than competent nurses. Lighter sedation in ICU requires better staffing and improved communication tools.

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Implications for clinical practice

- Competent nurses express more insecurity than expert nurses in complex patient situations.
- Expert nurses express more concern than competent nurses about patient discomfort and delirium distress.
- Expert and competent nurses express a need for improved communication tools and strategies to obtain functional communication with awake ICU patients.
- According to expert and competent nurses, the patient sedation level and nurse staffing level are inversely related and should be considered jointly.

Introduction

In recent years, sedation practice in the intensive care unit (ICU) has undergone significant changes. Since year 2000 the strategy has evolved from deep to lighter or no sedation especially in the Scandinavian countries in mechanically ventilated ICU patients,

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unless deep sedation was specifically indicated (Strøm et al., 2010). This paradigm shift (Devabhakthuni et al., 2012; Kress, 2013) is the result of a 'less is more' strategy and increasing evidence that lighter sedation is beneficial to the patient by decreasing the duration of mechanical ventilation and ultimately the ICU stay (Brook et al., 1999; Kress et al., 2000).

Nurse-patient communication has always been a challenge in ICU where patients are restricted by intubation, sedation, and critical illness preventing verbal and nonverbal exchange (Albarran, 1991, Dithole et al., 2016). In the early 1990s less experienced nurses were more frustrated than experienced nurses by the initial contact with deeply sedated mechanically ventilated ICU patients (Bergbom-Engberg and Haljamäe, 1993). In 2001 lightly sedated ICU patients were less satisfied than nurses with nurse-patient communication (Wojnicki-Johansson, 2001). More recent studies describe a new complexity in the nurse-patient interaction with non-sedated patients (Everingham et al., 2014; Karlsson and Bergbom, 2014). Conscious patients that are aware of their pain and discomfort are described as more demanding than sedated patients (Laerkner et al., 2015). Non-sedated patients are described as requiring more attention than sedated patients, and studies suggest that ICU nurses are unprepared to meet the new challenges (Karlsson and Bergbom, 2014; Dithole et al., 2016; Laerkner et al., 2017).

More knowledge is needed regarding the nurse-patient interaction in conscious ICU patients. A qualitative approach is well suited to explore how nurses perceive caring for awake ICU patients and to help to uncover new skills required in this context. Also, to investigate how sedation practice affects the workload of ICU nurses. We assume that contemporary sedation practice potentially affects experienced (expert) and less experienced (competent) nurses differently as the scope of nursing education and intensive care specialisation have evolved in recent years.

The aim of our study was to compare the perspectives of expert and competent nurses regarding their interaction with non-sedated mechanically ventilated ICU patients.

Method

Design

Our study had a qualitative comparative multicentre design using inductive latent content analysis and semi-structured dyadic interviews each with an expert and competent ICU nurse.

Setting

The study was conducted at five mixed medical-surgical ICUs at two university and three regional hospitals across Denmark. The ICUs varied from 6 to 12 beds and all units had sedation protocols in place recommending minimal sedation unless otherwise required in the individual case.

Participants

Expert and competent nurses were selected strategically using Benner's theory of skill acquisition and professional growth (Benner, 1984). According to Benner, a competent nurse has typically been on the current type of job for two or three years (ibid, p. 25), whereas the expert nurse has an "enormous background of experience" (ibid, p. 32), "however not all nurses will be able to become experts" (ibid, p. 35). We pragmatically defined expert nurses as nurses with 8 years or more ICU experience, and competent nurses as having 2–3 years of ICU experience.

The nurse manager at each of the five ICUs in our study facilitated recruitment of eligible nurses using our criteria of clinical experience (>8 or 2–3 years). We included 10 nurses; 9 females and one male. All invited nurses agreed to participate. The mean duration of ICU experience in expert vs. competent nurses was 12 vs. 2 years (mean difference 10 years), Table 1.

Data generation

We conducted five dyadic interviews in November 2014 to January 2015. A dyad consists of two related individuals (e.g. family, work) with similar access to the information forming the subject matter of the interview (Sohier, 1995). Dyadic interviews can be used to obtain synergy and help the participants recall certain issues to generate a deeper understanding of the phenomenon in question (Morgan et al., 2013). Moreover, dyads enable triangulation of perspectives; views are shared and compared increasing trustworthiness of the study (Eisikovits and Koren, 2010; Morgan et al., 2013). We were aware of potential downsides of dyadic interviews, e.g. one dominating participant, or two participants consistently agreeing or disagreeing (Sohier, 1995). It is important that the researcher remains neutral and provides a balance during the interview.

The research team consisted of three critical care nurses. The first and second authors who conducted the interviews are clinical ICU nurse specialists and the third author is an academic nurse with ICU specialisation. The interviewers had no prior knowledge of the participants that all worked at other sites than the research team.

Investigator triangulation was used as a quality enhancement strategy during data collection (Polit and Beck, 2012). The first three interviews were conducted face-to-face in an undisturbed room at the ICU. To avoid long-distance travel, the two final interviews were conducted by phone with the participants together at one end and the researchers together at the other. During each interview, one investigator served as moderator ensuring that both participants had an opportunity to express their views. The second investigator acted as observer taking field notes and adding questions at the end of the interview. The informants were briefed about the study before the interview.

We used a semi-structured interview guide constructed for the study based on literature and own experience. The main questions were: What is your experience of caring for non-sedated mechanically ventilated patients? Do you experience lack of knowledge when you care for awake ventilated patients? What challenges have you experienced? What advantages have you experienced? We validated our data by clarifying the answers during the interview (Crabtree and Miller, 1999; Malterud, 2011). Although we adhered to the original interview guide, we added questions regarding the sedation strategy after the second interview. During the final interview information became redundant. The interviews were digitally recorded and lasted 25–38 min. The first and second authors transcribed the interviews.

Data analysis

We adopted a pragmatic approach to the analysis of our data. Interviews can be viewed as acts of communication shaped by the interaction between researcher and participants. As such, the theoretical assumptions underlying qualitative content analysis can be related to pragmatic communication theory, where the analytic process is an ongoing communication between researcher and text (Graneheim and Lundman, 2004). We chose latent qualitative content analysis to interpret the underlying meaning of the text.

Data were initially analysed by the first and second authors and discussed with the third author during the final stage of analysis.

Table 1
Years of ICU experience in participating nurses.

	Dyad 1	Dyad 2	Dyad 3	Dyad 4	Dyad 5
Expert nurse	10 years	10 years	16 years	8 years	15 years
Competent nurse	2 years	2 years	2 years	3 years	2 years

Table 2
Example of the process of analysis from quote to category.

Quote	Codes	Sub-categories	Categories
“No, maybe if it's a patient that's a little difficult to communicate with. Then I might wait a bit, but I think understand what they are trying to say, and we try to help each other to understand what's being said. Lip reading is necessary, but difficult”. (Expert nurse dyad 5)	Managing difficult conversations Methods to understand the patient Nurses' seeking help from colleagues	Communication Interaction Ambivalence	Attempting dialogue Managing frustration

Analysis was conducted using qualitative content analysis with inductive coding to conceptualise the experience of caring for awake ICU patients and to provide a broader description of the experience (Elo and Kyngäs, 2008). We adopted a pragmatic approach consisting of three phases: preparation phase, organising phase and reporting phase (Elo and Kyngäs, 2008; Graneheim and Lundman, 2004). During the preparation phase each investigator read the interview transcripts several times to become immersed in the data and each investigator identified initial categories using open coding and searching for meaning units in the text (Elo and Kyngäs, 2008). A meaning unit is a constellation of words or statements relating to the same central meaning or content (Graneheim and Lundman, 2004). In the organising phase the meaning units were condensed and collapsed into categories (Graneheim and Lundman, 2004), Table 2. After initial analysis the research team triangulated their perspectives by mutual discussion of the best interpretation of the findings and the final categories. All quotes were translated from Danish to English by the authors.

Analysis was supported by computer software NVivo QSR version 10. The COREQ checklist for qualitative research was used to increase the trustworthiness of the study (Tong et al., 2007).

Ethical considerations

According to the Danish National Committee on Health Research Ethics we did not need approval for our study beyond acceptance from the sites included. We obtained approval from management and the head nurse at each ICU. The participants were informed of the study verbally and in writing and informed consent was obtained from each participant in accordance with the Helsinki Declaration II. The participants interviewed by phone provided written consent via e-mail prior to the interview. All participants were anonymised, and data were handled confidentially. Before each interview the participants were reminded of the voluntary nature of the study and their right to withdraw at any time. In addition, they were asked to keep confidentiality after the interview given that the interview involved more than one person.

Findings

Our findings illustrated the complexity of nurses' experience of interacting with non-sedated ICU patients. We identified four categories: Managing frustration, Attempting dialogue, Negotiating reality and Alleviating discomfort, Table 3. Expert and competent nurses alike experienced frustration and inadequacy when trying to communicate with non-sedated intubated patients. Expert nurses recalled the ease of caring for deeply sedated patients,

Table 3
Categories and sub-categories.

Managing frustration	Attempting dialogue	Negotiating reality	Alleviating discomfort
- Ambivalence - Insecurity	- Communication - Interaction	- Confusion - Exhaustion	- Providing comfort - Alleviating distress

whereas competent nurses with less experience, were more familiar with contemporary sedation practice.

Managing frustration

This category describes how nurses managed increasing levels of frustration while adhering to the strategy of lighter sedation. Contemporary sedation practice exposed and amplified issues impacting nurse-patient interaction, and some nurses responded to frustration with ambivalence and insecurity.

Ambivalence

Expert nurses had mixed feelings about caring for conscious ICU patients. While aware of the long-term benefits of lighter sedation, they were frustrated by the immediate difficulties of interacting with the patients. Expert nurses recalled that deeply sedated patients were easier to care for, because the nurses experienced less discomfort and distress with the sedated patient.

“I'm sure it can be satisfying to care for a non-sedated ventilated patient, but it can also be very frustrating, because you simply can't communicate with them, and they point out and try to express things you don't understand, and it's one of the worst things. The frustration is that you just can't understand them, and you really want to, and you don't understand what they want. It's difficult for me as a nurse to care for awake patients, the way I look at it ... ”As far as I'm concerned, the most frustrating thing about caring for non-sedated ventilated patients is my own frustration“. (Expert nurse dyad 2)

Competent nurses expressed less ambivalence toward caring for conscious patients, because they had less experience with deep sedation.

“I haven't tried anything else... Sometimes they have been sedated, but mostly they are awake“. (Competent nurse dyad 4)

Insecurity

One of the main sources of frustration in both expert and competent nurses was insecurity in relation to nurse-patient commu-

nication. Ineffective communication caused insecurity and was experienced as a personal defeat. Some nurses admitted to avoiding patients in situations where both nurse and patient got frustrated.

“we can talk about each other’s frustrations. Sometimes I might have a tendency to avoid a patient because I get overwhelmed”. (*Expert nurse dyad 5*)

When nurses were frustrated, they needed time off from the patient, but especially the competent nurses expressed insecurity of missing something important.

“It’s no fun when we have to stay with the patients constantly because they worry and don’t understand what’s going on . . . and I worry that I might miss something important, so I stay close to the patient” (*Competent nurse dyad 1*)

Nurses agreed that caring for awake patients required better staffing, but current staffing reductions only served to escalate frustration and insecurity.

“Staying close to the patient requires a lot of staff, but at the same time, we had to cut down the staffing here . . .” (*Competent nurse dyad 5*)

Expert nurses were frustrated by ineffective nurse–patient interaction whereas competent nurses were also frustrated by insecurity caused by the complexity of care and lack of adequate staffing. All sites had a nurse–patient ratio of 1:1 during days and 1:2 during evening and night shift.

Attempting dialogue

This category describes the nurses’ efforts to establish interaction with functional two-way communication with the patients based on the principle of dialogue as an ideal in nursing.

Communication

In orally intubated patients, nurse and patient had to rely on non-verbal communication, such as body language, lip reading and eye contact. They wanted access to better communication tools to obtain functional communication.

“It’s difficult when they can’t use the spelling board or can’t write what they want to say, but I can’t read their lips. It’s frustrating . . . I hope we can get some programs for tablets or do a study focusing on communication tools”. (*Competent nurse dyad 4*)

Expert nurses did not always agree with the decision to leave an intubated patient awake, but they attempted to accommodate communication to the individual patient.

“When I take care of a patient that for some reason has to be awake and intubated, but looks uncomfortable, I have to use a different type of communication”. (*Expert nurse E3*)

If patients appeared to be comfortable with oral intubation, the nurses agreed with the decision to leave them awake and able to communicate. A competent nurse explains the benefits of non-sedation:

“Clearly communication. That we are able to ask the patients about their needs. . . does this hurt?” (*Competent nurse dyad 3*)

Expert and competent nurses alike requested better communication tools and more education in verbal and non-verbal communication. Although some communication tools were available, many patients were unable to use them.

“Our patients don’t have many communication tools. They have a spelling board . . . but only few patients are able to use it. They can’t focus or hold it.” (*Expert nurse dyad 2*)

Although competent nurses more readily accepted awake ICU patients, they were also discouraged by communication problems.

“The negative part (of awake patients) is that they can’t express themselves and experience huge frustrations. They have so many things they want to explain and . . . they are often physically unable to use the spelling board, they are really lost, except when they can read lips . . .”. (*Competent nurse dyad 3*)

Interaction

According to expert nurses, both physical and psychological care was important, but non-sedated patients required a new type of interactive care with active patient participation.

“We suddenly get answers to all kinds of things when caring for the patient. Are they in pain? Are they delirious? Is their stomach functioning?” (*Expert nurse dyad 1*)

Patient participation in care was satisfying to the nurses, but some patients became taxing when interaction became constant attention.

“These things (like patients frequently asking for water) make it more difficult to care for awake intubated patients. It’s that they make more demands and participate more”. (*Competent nurse dyad 3*)

Although expert nurses were frustrated by the potential suffering of awake patients, they appreciated nurse–patient interaction with more patient participation.

“This experience (of patient participation) is enriching. We get more in return when they are conscious”. (*Expert nurse dyad 4*)

All nurses described lack of communication tools as a common challenge. The benefits to the patients of being awake were acknowledged and supported as long as communication was successful the patient was experienced as comfortable.

Negotiating reality

The third category described how nurses attempted to sustain communication even when they were uncertain of the patient’s mental state. Nurses attempted interaction even in confused, exhausted or potentially delirious patients.

Confusion

Nurses were not always certain whether the voiceless patients were oriented, confused or delirious. Most units practiced delirium assessment, however not on a regular base. The nurses were still uncertain of the mental state of the patients and reported that some patients were non-assessable for delirium.

“I think you have a better idea of the patients’ mental state when you can communicate with them (patients with a trach) rather than when the awake patient is intubated, and you can’t communicate. . .”. (*Competent nurse dyad 2*)

Sometimes conscious intubated patients presented a challenge because it was difficult for the nurses to determine if the communication was successful.

“I doubt that they understand the information and whether they understood everything I said. Is the nod relevant or not?” (*Expert nurse dyad 1*)

ICU delirium was more noticeable in awake patients, requiring nurses to stay closer to ward off adverse events such as accidental extubation.

“Delirium can be very, very demanding. It may take much of the focus – because you have to be constantly with the patient and to ensure that the patient is AB (airway and breathing) stable”. (*Competent nurse dyad 5*)

The nurses were uncertain of the mental status in quiet non-sedated patients. They were unsure if patients chose to withdraw or were delirious.

“But the patients are frustrated. It’s like you said (addressed to the competent nurse), the patients withdraw. I agree, but I have no proof. The patients seem more confused than before. I think we see more delirium now than when I started working here”. (*Expert nurse dyad 2*)

Exhaustion (lack of sleep)

Expert nurses feared that non-sedation might precipitate exhaustion and promote delirium.

“It’s the psychological care that is challenging; it’s like walking a tight rope. Try to see how long the patient can cope with the situation (being awake) without being delirious; because it’s so uncomfortable . . . I would like to know more about the importance of being awake”. (*Expert nurse dyad 3*)

Insecurity regarding the mental state of the patient was an ongoing challenge for the nurses. Expert nurses were concerned by losing the option to sedate patients in situations that could ultimately harm the patient.

Alleviating discomfort

The nurses were aware that the new sedation regime required them to be particularly aware of addressing symptoms of discomfort.

Providing comfort

Expert nurses were concerned when awake patients appeared to be uncomfortable. It challenged the nurses’ sense of compassion and their sense of duty to reduce suffering. Conscious patients demanded more physical presence of the nurse.

“It’s like this because most patients struggle when they are awake and orally intubated. . . . I feel sorry for them . . . it makes no sense that they should be awake, it’s distressing . . . (The patient) coughs and feels nauseous because of the tube”. (*Expert nurse dyad 5*)

“They (patients) have to be awake and we unfortunately cannot extubate because the respiration is not good enough then I think it is another situation especially if you can see that the patient is suffering by being intubated. . . .that situation is hard for them and it also makes it hard to be a nurse..because it is hard to alleviate the discomfort”. (*Expert nurse dyad 1*)

Competent nurses were less concerned about the apparent discomfort of awake patients.

“They (expert nurses) talk about caring for deeply sedated patients but I feel that I’m used to awake patients”. (*Competent nurse dyad 2*)

Addressing distress

The psychological distress got to the nurses. It was difficult to care for hallucinated patients; it made nurses feel inadequate.

“The hallucinated awake patients are really difficult because I can see their suffering; yes, they really suffer”. (*Expert nurse dyad 4*)

Competent nurses were less concerned by the new sedation paradigm. They took it for granted, because they lacked experience with earlier sedation practice. But it was difficult to care for the delirious patients, who lived in another reality.

“They look up at the ceiling and point at something that isn’t there, but it is in their world and you can’t get in touch with them”. (*Competent nurse dyad 4*)

Both groups of nurses were affected when they experienced the patients to be suffering. The expert nurses in particular were challenged by lack of options to provide patient comfort.

Discussion

Our aim was to explore perspectives of expert and competent nurses regarding their interaction with non-sedated mechanical ventilated ICU patients. The main difference between the experiences of expert and competent nurses in our study was the degree of acceptance of the strategy of minimal sedation. Expert nurses showed more ambivalence toward minimal sedation because they had experienced the ease of caring for more sedated patients and questioned the comfort of being awake during mechanical ventilation and critical illness. Expert nurses experienced an increase in patient suffering and nurse frustration with lighter sedation. They were aware of the long-term benefits of lighter sedation but experienced the immediate drawbacks of keeping suffering patients awake. Competent nurses with less ICU experience accepted the sedation strategy more readily because they took awake intubated patients for granted. Nonetheless, they expressed more anxiety toward inadequate patient care and addressed the need to focus on staffing. Both groups appreciated increased interaction with the patients but were frustrated by non-functional communication and insufficient staffing.

Managing frustration

The experience of frustration was a major issue permeating all categories in our study. Expert nurses managed frustration by ambivalence toward the sedation regimen and by avoidance in uncomfortable situations. A Swedish study similarly describes frustration as the most common response to non-sedated patients, as lack of control and inability to comfort the patient is stressful and discouraging to nurses (Karlsson and Bergbom, 2014). These findings are consistent with our study demonstrating the importance of acknowledging expert nurses’ frustration as a factor affecting job satisfaction and the work environment.

Insecurity was mainly expressed by the competent nurses in our study. This finding is not new. A similar study described uncertainty in less experienced nurses that were distressed by poor communication and heavy workload even during the days of deep sedation (Bergbom-Engberg and Haljamäe, 1993).

In our study, the competent nurses expressed a need for a more appropriate staffing ratio. This is an important aspect that should be taken into consideration. We did not explore this issue farther, but studies have suggested that more patients self-extubate when the nurses are less experienced (Cosentino et al., 2017). Strategies of lighter sedation have also been associated with unplanned extubations, which are explained by the patients being more awake and restless (Tanios et al., 2014). Nursing presence is key to avoiding such unplanned events (Cosentino et al., 2017).

With reference to implementation of a protocol of no sedation, Brochard (2010) stated in the *Lancet*: “use of this strategy will mean

that more attention needs to be paid in the daily care of patients, and caregivers will need increased empathy towards patients” (Brochard, 2010) p. 438.

Some nurses in our study stated that they managed their frustration by avoiding the patient. ICU nurses are unable to avoid their patients entirely, but they can, perhaps, avoid eye-contact with a particularly demanding patient (Dithole et al., 2016). Acknowledging the influence of a no sedation strategy by the inclusion of staff skills and training is recommended and perhaps involvement of other health professionals such as speech therapists to provide nurses with competence that will ease the level of frustration and hereby improve the patient-nurse interaction (Dithole et al., 2016).

Attempting dialogue

Communication is a pillar of nurse-patient interaction. It might therefore seem paradoxical that the nurses in our study were distressed by communicating with their conscious patients. In other branches of nursing difficult communication due to physical, psychological, or developmental issues is, perhaps, to be expected. Lack of communication in ICU, however, is distressing due to the transient nature of the problem, where patients are only temporarily voiceless, uncoordinated or confused. Furthermore, nurses lack of communication skills has in previous studies led to break-down in communication with mechanically ventilated patients and showed that nurses have made wrong decisions according to the patient’s needs (Happ, 2001, Randen et al., 2013, Dithole et al., 2016).

If communication was experienced as successful and the patients were comfortable, the expert nurses in our study acknowledged the current sedation practice and found the interaction with the patients fulfilling. These findings agree with a recent study of nurse-patient interaction, where nurses found it rewarding to care for awake patients that were able to interact and express their needs (Laerkner et al., 2015). Communication is to some extent a modifiable factor. The participants in our study requested better communication technology and more education to improve nurse-patient dialogue. At present there is a proliferation of technological tools and algorithms being developed for ICU communication (ten Hoorn, 2016). Newer methods include augmentative and alternative communication (Finke et al., 2008; Happ et al., 2014, 2012) as well as the development of new speech enhancement devices (Ijsennagger et al., 2017). More studies are needed to implement new technologies to support the nurse-patient interaction.

Negotiating reality

The participants in our study stated that although non-sedated patients were more awake and aware of their condition than sedated patients, they were also more confused, delirious and exhausted due to lack of sleep. Conscious patients required more staffing, which was supported by Laerkner et al. (2015) that reported that a protocol of no-sedation required 1:1 staffing and continuous presence at the bedside. Although closer observation are required when patients are light to no sedation is challenging, nurses enjoyed the intensified nurse-patient interaction (Tingvik et al., 2013; Laerkner et al., 2015). The nurses in our study were less enthusiastic, perhaps because they represented other ICUs with less experience of minimal sedation. Being accustomed to conscious patients requires knowledge and experience (Tingvik et al., 2013). The challenges described in our study are similar to a study by Tingvik et al who explored nurses’ experience when caring for lightly sedated patients in intensive care (Tingvik et al., 2013).

Delirium detection were not performed systematically by the nurses in our study. This might be explained by a study showing lower confidence in delirium screening when evidence-based treatment options are lacking (Oxenbøll-Collet et al., 2018). Other studies have described delirium screening as reliable and alleviating concerns regarding the mental state of the patient (Vasilevskis et al., 2011).

Alleviating discomfort

Alleviating discomfort and promoting wellbeing are central goals in nursing. The nurses in our study feared that lack of sedation increased the patients’ suffering. Studies describing the patient perspective of being awake and intubated corroborate the notion that patients suffer (Prime et al., 2016; Samuelson, 2011). Patients experience stress, pain and discomfort when being awake and mechanically ventilated (Prime et al., 2016). Some studies show, however, that patients that experience discomfort still prefer to be awake during their critical illness. The patients experience a sense of control even when communication is difficult (Prime et al., 2016).

In a Swedish study expert nurses experienced a sense of failure when they were unable to meet the patients’ needs; they found that caring for non-sedated patients required a new approach (Karlsson and Bergbom, 2014). Similarly, expert nurses in our study felt powerless when they were unable to comfort the patients or assess the needs of delirious patients who are incapable of coherent communication. The competent nurses, however, did not experience the same kind of inadequacy. They were younger and had not been exposed to earlier practice and thus accepted the current state of nurse-patient interaction. The question of whether patient suffering has increased within the new paradigm of lighter sedation has not been resolved, but it appears that the next generation of nurses will have an easier time of adapting to more awake and interactive patients. We recommend an individualised approach to the sedation strategy to avoid undue suffering.

Strengths and limitations

The credibility of our study was achieved by adoption of well-established qualitative methodology, iterative questioning during the interviews and investigator triangulation during analysis. Dyadic interviews offer more than one perspective and enable participant triangulation. Our study was limited, however, by the pragmatic selection of expert and competent nurses. Transferability was increased by the multicentre approach and selection of nurses with varying experience. Dependability was achieved by transparent reporting of data collection and reflective appraisal of our findings. Confirmability was ensured by discussing our pre-conceptions to maintain objectivity. And finally, trustworthiness was increased by our knowledge of the field and qualitative research.

Conclusion

The study added to the knowledge of nurse-patient interaction by describing issues of frustration, ambivalence and insecurity in a contemporary context of minimal sedation. Nurses at different levels of experience were frustrated by communication problems in the patient-nurse interaction; they were unable to use their full potential and suffered feelings of inadequacy. Caring for awake mechanically ventilated patients requires knowledge and experience as well as adequate staffing and better communication tools to involve the patients and provide better care.

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Conflicts of interest

The authors have no conflict of interest to declare.

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