The Republic of Iraq

Ministry of Higher Education

and Scientific Research

University of Babylon

College of Nursing

Effectiveness of Unconscious Patient Communication Educational Program on the Critical Care Unit Nurses Knowledge and Practices

Dissertation

Submitted to The Council of Nursing College, University of Babylon

By

Kareem Waheed Mohamed Abu Kheta

In Partial Fulfillment of the Requirements for the Degree of

Doctorate Philosophy in Nursing

Supervised By

PhD. Prof. Sahar Adhem Ali

June 2022AD **Thu Al-Quadaa *1443 AH***

بِسْمِ اللَّهِ الرَّحْمَٰنِ الرَّحِيمِ

قَالَ رَبِّ اشْرَحْ لِي صَدْرِي (٢٥)وَيَسِّرْ لِي أَمْرِي (٢٦)

وَاحْلُلْ عُقْدَةً مِّن لِّسَانِي (٢٧) يَفْقَهُوا قَوْلِي(٢٨)

صدق الله العلي العظيم

سورة طه(٢٥-٢٨)

Dedication

The spirit of my father, sister, grandfather and grandmother

My dear mother, brothers and sisters

My lovely wife, daughter and son.

All friends

Kareem

ACKNOWLEDGEMENTS

First, thanks to **Allah** for providing my the willingness and strength to complete this work.

I wish to express my sincere appreciation to University of Babylon and college of Nursing for giving me the opportunity for fulfillment, accomplishment of study.

I would like to express my sincere gratitude and thanks to the Dean of the college of Nursing, University of Babylon, **Prof. Dr. Ameen A. AL-Yasiry** for his support.

My deepest gratitude and appreciation go to my supervisors **Prof. Dr. Sahar Adham Ali**, for her valuable remarks, guidance, continuing supervision, and wise suggestion throughout the study.

Thanks to all medical staff in Al-Hilla teaching Hospital, and Imam AL Sadeq Teaching Hospital(especially in critical care unit) for their help and cooperation during data collection, and agree to participant in this study.

My thanks extended to Mr. Ali Ahmed for his valuable guidance in the statistical analysis.

I gratefully acknowledge the endless generosity of the experts, who kept me on the right way , for their time and suggestions.

Thanks extended to all members of the College of Nursing, University of Babylon for their aid and to all people who helped me in my work.

ABSTRACT

One of the fundamentals of professional nursing practice and the art of holistic patient care is the ability to effectively communicate with patients. Communication is the heart of nursing, failure in communication lead to dissatisfaction for patient and their family and professional health, stressed work relation, litigation and anger, and poor health outcome. The objectives of this study is to evaluate the effectiveness of an educational program toward communication skills which used for unconscious patients on critical care nurses knowledge and practice. A quasi-experimental design started from 15th September 2020 to 23th June 2022 carried out in Al- Hilla teaching hospital and Imam Al- Sadeq teaching hospital. Purposive used to select the sample of the study to achieve the study objectives. The study sample consisted of (63) nurses divided as (30) nurses for interventional group, and (33) nurses for control group specific questionnaire prepared to collect the data by interview method. The questionnaire includes four part: first part: demographic characteristics of nurses, second part was employment information, third part knowledge of nurses on unconscious patient communication that include six domains. Part four: an observational checklist for nurses' practices regarding nurses communication with unconscious patient in critical care unit includes 17 items. The study result shows the overall of nurses knowledge about communication with unconscious patient pretest for both study group recorded unsatisfied level of knowledge as(68.88), (69.73) in pretest, during the post test the control group shows the same poor level clearly, while the nurses who attend the educational program session recorded significant improvement in their two post test as (89.90) and (85.73), related to practice the result shows there is the nurses not communicate with unconscious patient for control and pretest of study group, while the nurses shows communicate with the unconscious patients after program.

The conclusion of the study show a significant improvement appear clearly among the study group member through the result of their pre and posttest, which explain the effectiveness of the educational program session content on the nurses knowledge and practice. The study recommended to establish continuous educational sessions to enhance nurses knowledge toward communication process, strategies as a tool to provide optimal care for the patient and lover his/ her family members.

.

List of Contents

List of Tables

List of Figures

List of Appendices

List of Abbreviation

Items	Meaning
AACN	American Association of Critical-Care Nurses
Am	Morning
ARAS	Ascending Reticular Activating System
AVPU	(alert, responsive to voice, responsive to pain, unresponsive) scale
B.C.	before Christ
BCE	before the Christian Era
BPS	Behavioral Pain Scale
CCU	critical care units
CIM	complementary and integrative medicine
CNS	Central nervous system
CNS	Central nervous system
CPOT	Critical-Care Pain Observation Tool
CS	coma state
DBP	Diastolic blood pressure
Df	Degree of freedom
DOC	Disorders of consciousness
EAN	European Academy of Neurology
EEG	Electroencephalography
ENA	Emergency Nurses Association
GCS	Glasgow coma scale
H.S	High significant
LOC	Altered level of consciousness

MCS	Minimally conscious state
N.S	Non- significant
NCS	Nociception Coma Scale
NCS-R	and Nociception Coma Scale- -Revised
NVC	Non-verbal communication
OAS	organized auditory stimulation
PAE	physiological adverse events
PNS	peripheral nervous system
RAS	reticular activating system
SBP	Systolic Blood Pressure
SCCM	Society of Critical Care Medicine's
SCMs	structured communication messages
SD	Standard deviation
TBI	traumatic brain injury
VS	Vegetative state

Chapter One

Introduction

1.1. Introduction

The critical care unit is consider one of the most important area in the hospitals, since it receives patients with severe and complicated conditions. In these units, attentive and consistent supply of caring behaviors is essential. Continuous monitoring and caring, good communication with patients and their families, supporting and encouraging patients' engagement in treatment decision-making are all vital roles for critical care unit nurses to perform (Zare *et al.*, 2020) .

To increase the quality of treatment and safety with therapeutic communication should be maintained with hospitalized patients. Because of intubation, patients in the critical area often lose their ability to speak and communicate. There is a link between speech loss and strong emotional responses in critical care unit patients, including stress, high levels of frustration, depression, and anxiety (Baumgarten & Poulsen, 2015) .

The purpose of communication is to convey information, transmit messages, and develop, strengthen, or otherwise affect relationships. Communication may take both verbal and nonverbal forms. Facial expression, touch, and the timbre of one's voice are all examples of non-verbal communication. Communication serves as the foundation for the connection between a nurse and patient and is a crucial component of trust and comfort. Nurses working in the critical care units (CCU) face especial challenges when communicate with unconscious ill, mechanically ventilated or sedated patients. Communication between these patients and nurses needs specific skill of commitment, and knowledge (Dithole *et al.*, 2016) .

One of the fundamentals of professional nursing practice and the art of holistic patient care is the ability to effectively communicate with patients. Nurses employ a variety of communication strategies to accomplish a variety of tasks, including giving orders, reassuring patients, provide comfort, and information. Nurses are unable to successfully assess, plan, provide, or evaluate care if there is a lack of communication (Othman & El-Hady, 2015) .

The care of patients who are unable to communicate verbally is particularly demanding for health-care professionals because it necessitates specific skills such as clinical evaluation of level of consciousness, level of pain, and relational skills, as well as the use of nonverbal communication to maximize the likelihood of patient recovery (Foà et al., 2016) .

Communication is necessary element of the nurse therapeutic role which cannot be delegated to anyone else. The situation may challenge nurses from employing any form of communication such as communication with the mechanically ventilated patients which have a double effect including both patients and their families to insure their satisfaction with the care which given through provision of information and explaining procedures even no responses may received (Dithole, 2016) .

Critical care unit psychosis can be avoided by maintaining open communication with patients who are sedated and ventilated, allowing for information and emotional support to be exchanged, as well as eliminating a sense of isolation that can contribute to intensive care unit psychosis. A means of guiding and delivering meaningful sensory information to the unconscious patient through verbal communication. Individualizing treatment and utilizing familiar voices or just stating the patient's name may give greater sensory input (Simões *et al.*, 2012).

Annually, in the United States more than 2.7 million patients who admitted to the critical care units are unable to speak, because of the assisted ventilation (mechanical ventilation) and artificial airways. Fatigue, sleepiness, delirium, or neurological disease may further limit communication capacity in patients with critical illness. Patients in critical care units who are mechanically ventilated are more likely to experience anxiety, fear, anger, frustration, sleepiness, and discomfort because of communication difficulties. When patients loss their abilities to communicate verbally to explain their pain and needs make nurses full frustrated actually who provide direct care and spend most of their time with such patients (Happ *et al.*, 2011) .

Whens a large number of people are impacted by unconsciousness, it becomes difficult for nurses to provide consistent treatment and care for the unconscious patient (Kashyap, 2017) .

Altered level of consciousness (LOC) is a condition or symptom indicated functional disorder of the nervous system, rather than an illness. The reason could be toxicological (alcohol intoxication, drug overdose), neurologic (stroke, head injury), or metabolic (hepatic, diabetic ketoacidosis, or renal failure). Loss of consciousness refers to the inability to recognize oneself, others, outside environment, or the passage of time. A patient in a coma is unable to respond to external stimuli or to fundamental necessities like eating and drinking. In response to pain or other stimuli, automatic reflex movements or atypical body positions (posturing) may be seen. Involuntary activities like as heartbeat and breathing remain unless disrupted by damage to specific regions of the brain, while alterations in pulse and respirations may provide clues to the origin of coma (Ali, 2016) .

Coma is unresponsive state induced by a temporary or permanent disruption of the ascending reticular system in the brainstem or both cerebral hemispheres. Critical care patients who were unconscious were able to hear, because hearing is the final sensation lost in people with brain damage, touching and speaking these patients were deemed key communication aspects (Zare et al., 2020) .

Sensory stimulation, include holding a hand, may help a person in a coma recover. A study reported that scanning technology recorded brain activity in a patient who had been in a coma for twelve years following a car accident. Stimulating the sensations of smell, touch, vision, and sound may assist the person for recover, holding the person's hand or using a favorite perfume could be helpful. The client's response to health care services is influenced by clear and compassionate communication (Bello, 2017) .

1.2. Importance of Study

Stress and anxiety levels rise as a result of poor nurse-patient communication. As a result, communication within the critical care unit is key, and efficient communication is an important element of nurses' care (Alasad & Ahmad, 2005) .

Effective communication is usually seen as a significant indicator to maintain patient happiness, and enhance healing. Effective communication with hospitalized patients improve the quality of care substantially (Gorzin *et al.,* 2020) .

Failure to understand the patients need may act as negative factor on nursing care and limit the patient's reaction. Successful communication can help ventilator-dependent patients recover faster, whereas unsuccessful

communication can cause patients to recover more slowly (Otuzoğlu & Karahan, 2014) .

Critically ill patients are often unable to communicate because of changes in physiological status or level of consciousness (LOC), sedation, or intubation which may make pain assessment difficult. However, the first steps to effective pain management are assessment and pain recognition. assessment of pain is an essential critical care nursing duty, and may have an effect on patient outcomes by decreasing the period of mechanical ventilation and has a positive effect on pain management, and the incidence of nosocomial infections .

Certain behavioral and physiological parameters may be effective indicators for pain assessment. The facial expressions of patient, such as tears, frowning, grimacing, wrinkling of the forehead are possible indicators of pain. Movements of the patients', especially through procedures, are consider related to pain. Immobility of the patient can also be an indication to the present of pain. Additionally, certain physiological signs can suggests the presence of pain, such as: increased blood pressure and heart rate, so, it can be helpful in pain assessment (MokhtarAbdallah *et al.,* 2018) .

Regardless of past expertise, nurses should receive training on the importance of verbal and nonverbal communication with patients. In addition to having the information and abilities necessary to establish therapeutic communication, nurses are required to study communication-based care (Mirhaghi *et al.,* 2017) .

Communication experts highlighted the importance of integrating nonverbal communication in the form of caring touch with vocal communication for unconscious patients. It can improve the signals

patients get, assist in meeting their psychological requirements, and minimize psychosis withdrawal and delirium, which can lead to anxiety, psychological stress, isolation, and disorientation (Bickmore *et al.*, 2010) .

Communication with unconscious patients is not indication to causes any harm or severe physiological adverse events (PAE). Furthermore, according to recent advancements in the field of functional neuroimaging, unconscious patients can hear and appear to maintain some cognitive ability (Laureys & Schiff, 2012) .

Nurses in the critical care unit do not usually communicate with patients because of the nature of the critical care units environment leading to communication breakdown, however, high quality communication is important to facilitate patient-centred care. The importance of communication in the critical care units requires that nurses who work with these patients should be well equipped with the knowledge of communication (Dithole, 2016) .

The implementation of structured communication messages (SCMs) had effects on promotion of level of consciousness, level of sedation and decrease of restlessness and pain between unconscious patients, using structured communication messages to communicated with unconscious patients was associated with a decreased incidence of physiological changes such as (hypothermia, tachycardia, bradycardia, hyperthermia, hypotension, hypervolemia, hypertension, hypovolemia, de -saturation, ventilatory distress, bradypnea, hypoglycemia, or hyperglycemia). Likewise, it was effective in reducing period of critical care unit and mechanical ventilation (Othman *et al.*, 2015) .

Sensory stimulation is administered at the appropriate time to assist the unconscious patient in recovering from severe sensory deprivation.

Efforts are made to preserve a sense of daily rhythm by preserving the typical patterns of day and night for activity and sleep. The nurse touches and converses with the patient, and she/he encourages family and friends to do the same. Touching the patient and spending enough time with him or her to get attuned to his or her needs are essential components of effective communication, which is of paramount importance. It is also essential to refrain from making negative comments regarding the patient's condition or prognosis in their presence. Every eight hours, the nurse remain the patient to time and place to keep him oriented to the surrounding environment. Using a tape recorder, sounds from the patient's home and office can be added. As a means of enhancing the patient's environment and offering familiar input, family members can read aloud from a beloved book and suggest radio and television shows that the patient previously appreciated if possible (Ali, 2016).

It is important part of nursing care is to maintain communication with comatose patients. Sensory stimulation programs for unconscious patients to stimulate the level of consciousness, care, and attention with an appropriate intensity and suitable way may assistance the patients to recover their consciousness rapidly. Increased organized auditory stimulation (OAS) may benefit the unconscious patient, but studies reveal that critical care nurses are not delivering sufficient verbal communication as a goal (Hoseinzadeh *et al.,* 2017) .

Nurses working in the critical care unit were giving fewer importance to communication with patients had altered level of consciousness. Despite the fact that several of the nurses had been caring for patients with altered levels of consciousness for many years, none of them had ever attended a training session on communication for patients with altered levels of

consciousness. Critical care nurses should be trained how to communicate with patients who have a low level of consciousness (Thakur, 2016) .

1.3 Statement of the study:

Effectiveness of Unconscious Patient Communication Models Educational Program on the Critical Care Unit Nurses Knowledge and Practices.

Communication is the foundation of all nursing care and become more relevant for unconscious patient who is increase depend on the speech-hearing channel for sensory stimulation.

1.4. Hypothesis:

1. There is no significant relationship between education program and nurses knowledge and practices toward communication skill with unconscious patients**.**
2. There is a significant relationship between nurses practices and the educational program.

1.5. Objectives of the study:

This study carried out to reach the following objectives:

1- Assess critical care unit nurses knowledge and practice toward communication skills used with unconscious patients.
2- Evaluate the effectiveness of an educational program toward communication skills which used for unconscious patients on critical care nurses knowledge and practice.
3- Find out the relationship between critical care nurses knowledge, practice and their demographical characteristic such as (age, gender, educational qualification).

4- To find out the relationship between the critical care nurses knowledge and practice toward communication skills with unconscious patient.

1.6. Definitions of the Terms:

1-6-1. Effectiveness:

1-6-1-a. Theoretical Definition:

Is the capability of producing a desired result or the ability to produce wanted output. Whenever something is regarded successful, it has the desired or expected result or leaves a profound, strong impression (Bartuševičienė & Šakalytė, 2013).

1-6-1-b. Operational Definition:

Is the ability to produce a desired outcome or the capacity to provide desirable result about the communication with unconscious patient.

1-6-2. Unconscious

1-6-2-a.Theoretical Definition:

Unconsciousness is generally caused by a temporary or permanent impairment of either the brainstem reticular activating system, both bilateral thalami or cerebral hemispheres. The reasons of a patient's unconsciousness might be categorized as local brain pathology or systemic pathology (Bauer, 2019).

1-6-2-b. Operational Definition:

A lack of reaction to sensory inputs that occurs as a result of injury, disease, shock, or another physiological disorder, who have lack of one or more communication methods.

1-6-3. Patient:

1-6-3-a. Theoretical Definition:

Is any recipient who often ill or injured and in need of medical or surgical treatment by advanced health team (Reader et al., 2014).

1-6-3-a. Operational Definition:

Unconscious person who admitted to the critical care unit to receive course of treatment.

1-6-4. Communication:

1-6-4-a. Theoretical Definition:

Communication is a process to share information, exchanges ideas, it is an essential element to understand the patients' needs nursing practices for facilitating the relationship between nurses and in order to cover his/her needs and maintain comfortable (Vertino, 2014)**.**

1-6-4-b. Operational Definition:

It is an essential building block of nurse- patient relationship to understand unconscious patients' needs and enhance healing process.

1-6-5. Educational Program:

1-6-5-a. Theoretical Definition:

Its set of educational activities organized to obtain specific learning objectives by specific tasks over a sustained period (OECD, 2017).

1-6-5-b. Operational Definition:

Its sequence of activities planned to demonstrate specific content to achieve learning objectives directed to critical care nurses related to communication with unconscious patient.

1-6-6. Critical Care Unit:

1-6-6-a. Theoretical Definition:

An critical care unit (CCU) designed to deliver care to critically sick patients that involves comprehensive and specialized medical and nursing care, greater monitoring capacity, and several methods of physiologic organ aid to enable patients alive while their organ systems are malfunctioning (Marshall *et al.*, 2017).

1-6-6-b. Operational Definition:

Special unit quipped with sophistical devices to provide continuous care for patient life- threating condition or unconscious.

1-6-7. Nurses Knowledge:

1-6-7-a. Theoretical Definition:

Knowledge is a sense of awareness of reality gained through study or exploration. Every person gathers, organizes, and arranges data in order to

create a knowledge base that is relevant to specific situation **(** Lillis et al., 2010).

1-6-7-b. Operational Definition:

Information, facts, skills acquired through an educational sessions prepared for critical care nurses to enhance their skills related to communicational with unconscious patient.

1-6-8. Nurses Practice:

1-6-8-a. Theoretical Definition:

Is processes of diagnosis and treatment which applied to individuals of all ages, groups, families, and communities, well or sick and in all settings **(**Buhler-Wilkerson & D'Antonio, 2022).

1-6-8-b. Operational Definition:

Actual performance of activities carried out by critical care nurses directed to unconscious patients to cover their needs.

Chapter Two

Review of Literature

Chapter Two

2. 1. Historical Background:

History of Communication

Human communication began with the invention of speech nearly 100 million BCE. Symbols were created approximately 30,000 years previously. The imperfection of speech facilitated the spread of ideas and eventually led to the development of new means of communication, this expansion enhance the durability of knowledge. All of these innovations were established on the symbol's central idea.

The oldest created symbols were found in cave paintings , a form of rock art, dating to the upper paleolithic period are the first documented symbols used for communication. The oldest cave artwork is found at Chauvet Cave and dates back to approximately 30,000 B.C. (Paul Martin Lester, 2005, & Miyagawa et al., 2014).

In Iraq humans have communicated with one another in some shape or form ever since time ancient. But to understand the history of communication, all we have to go by are written records that date as far back as ancient Mesopotamia, while every sentence starts with a letter, back then people began with a picture. The Kish tablet, discovered in the ancient Sumerian city of Kish, has inscriptions considered by some experts to be the oldest form of known writing. Dated to 3500 B.C., the stone features proto-cuneiform signs, basically rudimentary symbols that convey meaning through its pictorial resemblance to a physical object. Similar to this early form of writing are the ancient Egyptian hieroglyphs, which date back to around 3200 B.C.(Nguyen & Tuan, 2021).

2.2. Anatomy and Physiology of Nervous System

Nervous System:

The nervous system subdivides into the central nervous system and the peripheral nervous system. The central nervous system is the brain and spinal cord, while the peripheral nervous system consists of everything else (Lentz et al., 2021).

The peripheral nervous system (PNS) is therefore made up of nerves, ganglions, various receptors and synaptic and motor nerve endings, which carry CNS commands to the effector organs and return internal and external sensory information's (Ohana et al., 2014).

The central nervous system's responsibilities include receiving, processing, and responding to sensory information.

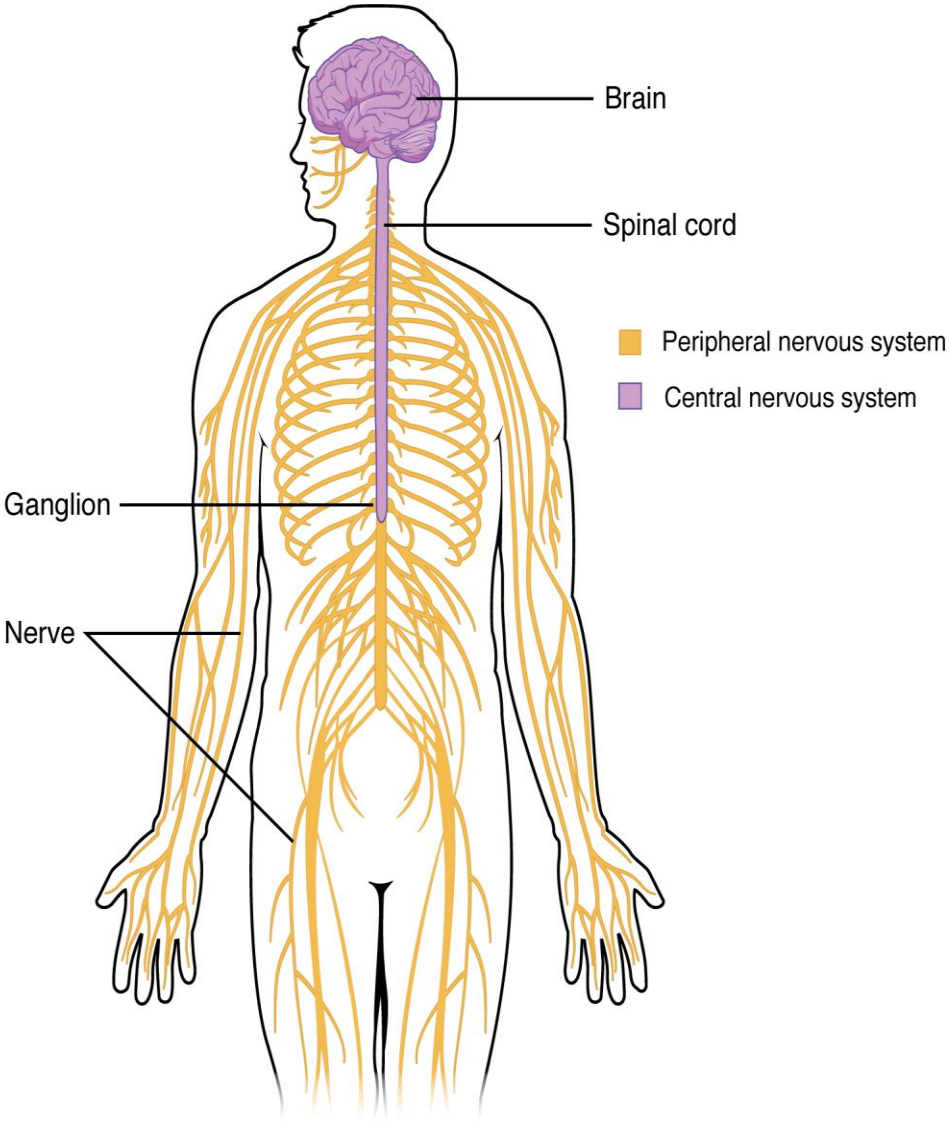
The brain weighs about 1,500 grams (3 pounds) and constitutes about 2 percent of total body weight. It consists of three major divisions: (1) the massive paired hemispheres of the cerebrum, (2) the brainstem, consisting of the thalamus, hypothalamus, epithalamus, subthalamus, midbrain, pons, and medulla_oblongata, and (3) the cerebellum (Lentz et al., 2021)**.**

The brain contains nerve cells known as neurons and supporting cells known as glia. The brain lies within the skull and is shaped like a mushroom. The brain consists of four principal parts: the brain stem, the cerebrum, the cerebellum and the diencephalon (Mandal & Ananya, 2021).

The brain is an organ composed of nerve tissue that controls responses, sensation, motion, emotions, communication, thinking processing, and memories. The human brain is protected by the skull,

meninges, and cerebrospinal fluids. The nervous tissue is highly fragile and it can be harmed by the simplest force. In addition, it has a blood-brain barrier that prevents dangerous substances may envision the brain through the blood. Spinal cord act as a vital part of the CNS which located within the vertebral column. In addition to transmitting movement commands from the brain and other parts of the body, the spinal cord relays sensory information from the sensory organs to the brain. The protection of the spinal cord is provided by bone, and cerebrospinal fluids (Thau et al., 2019).

The brain sends signals to the spinal cord, which is a long tube-like structure. The spinal cord is made up of 31 different parts. The spinal segment is the part of the spinal cord where two spinal nerves originate from. In the spinal cord, there are nerves for both moving and feeling. In an adult woman, the spinal cord is about 43 cm long, while in an adult man, it is about 45 cm long and weighs about 35–40 grams (Mandal & Ananya, 2021).



Anatomy of CNS adapted from

Biga et al., 2020

2.3. Communication

Communication act as a heart of good medical and nursing practice (Lee et al., 2021). Failures in communication may lead to poor health outcomes, strained working relations, produce dissatisfaction, anger and litigation of patients or their families (Walker & Colledge, 2013).

Effective communication is a cornerstone of professional nursing practice and the skill of providing patients with holistic care (Sibiya, 2018).

2.4. Principles of Communication

Principles of communication can be summarized in the following points according to Sibiya, 2018:

- Communication is a process
- Communication is circular, not linear
- Communication is complex
- Communication is permanent
- Communication includes the whole personality

2.5. Definition of Communication

Communication is a process by which information idea is exchanged between individuals through specific system of signs, system and behavior. Communication require not only to exchange information and knowledge, but also to interact to one another as humans in the situation of organizations, nations and relationships and families (Vertino, 2014).

2.6. Communication Element

The basic element of communication includes, message, sender, and receiver. Communication is a two-way process comprising the sender and receiver of a message. Since the purpose of communication is to elicit a reaction, the process is continuous; the recipient of the message becomes the sender of a response, and the sender becomes the listener.

2.6.1. Sender

The source-encoder is the sender, the person or organization wishing to convey a message with another's. This word means that the individual creating and sending clear, relevant message . Encoding requires the choosing of particular symbols or sings as a proper way to link the message, including used language and phrases, words organization, voice tone and body movement (Nugent & Vitale, 2013).

2.6.2. Message

The message consider the second element of communication, which includes verbal or written, or non- verbal methods. The approach employed to transmit the message may relate to any senses of the receiver. It is essential that the procedure be suitable for the message and that it aid clarify the communication's intent. Frequently, the touch is nonverbal channel and very effective in communication.

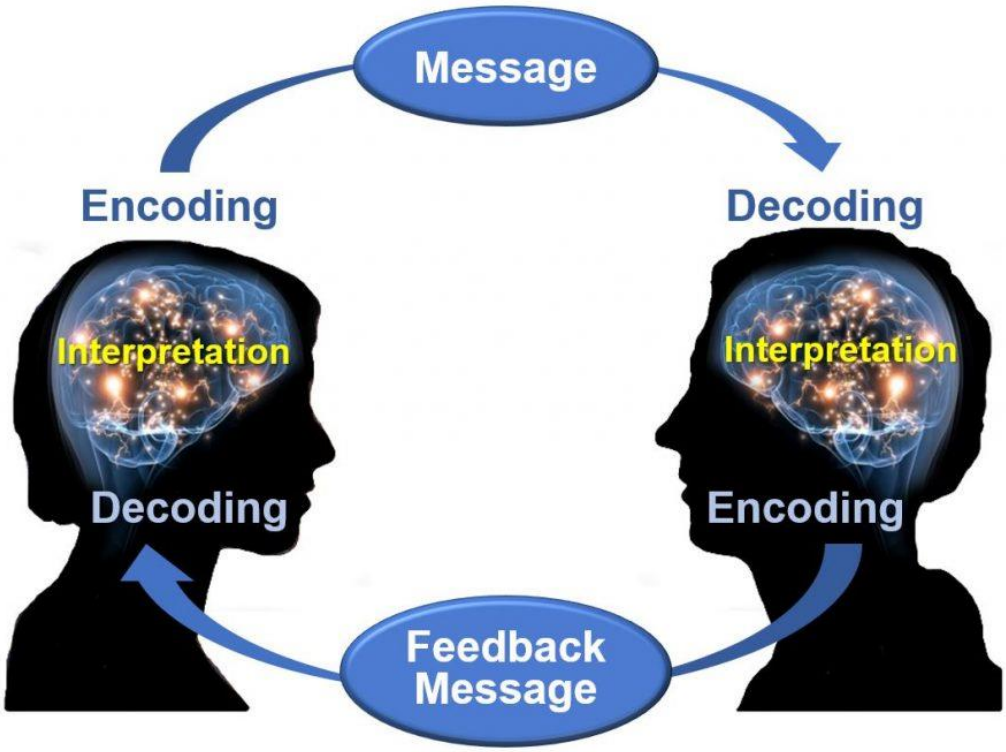
2.6.3. Receiver

Third element of communication, the receiver who is required to watch, listen. This individual is the decoder and must comprehend what the sender means (interpretation). Perception involves all senses to

receive verbal and nonverbal communications. To decode is to match the observed message to the receiver's experience and knowledge and to determine the message's meaning. If the communication is correctly decoded by the recipient according to the intent of the sender is primarily dependent on the similarity of their experience, knowledge, and sociocultural background. If the meaning of the decoded message corresponds with the sender's aim, then communication has been successful. Infective communication is ineffective when the recipient misunderstands the delivered messages (Kozier *et al*., 2018).

2.7. The Communication Process:

Communication is the exchange of information and consists of three components: the sender, the message, and the receiver (Achury Saldaña et al., 2015).



The Osgood-Schramm model of communication. Sources: Kisspng, 2018; Web Editor 4, 2017

According to Sanchez, 2002, communication process can be systematically arranged as the following:

(a) Ideas – Is the topic of communication. This could be an attitude, opinion, mood, viewpoint, command, or recommendation, etc.

(b) Encoding - Since the content of communication is impalpable and its transmission needs the use of particular symbols such as actions, words, or images, encoding is the process of converting the content into these symbols.

(c) Channel – The symbols are conveyed to the other end called receiver through certain channels such as TV, radio, newspapers, etc.

(d) Receiver –the fourth part for whom the message is meant. Receiver receives the message transmitted by sender.

(e) Decoding – Next receipt the message in symbols, receiver converts the symbols into meaning or plain language which is easy to understand.

(f) Feedback – consider the process of ensuring that the person understanding the message after receiving also, It is the confirmation of the comprehended message.

According to (Indeed Editorial Team, 2021) to develop communication skills and the communication process the following steps preferred to follow:

- **Simplify of message:** language should be clear and direct.

- **Know the audience:** In addition, it is essential to consider the audience and their requirements and preferences.

- **Active listening:** As a communicator, it is essential to listen carefully to what others are saying. This will ensure that the right message is conveyed.

- **Ask questions:** Also, it is important to ask important questions to keep the discussion flowing.

- **Take the time to respond:** To ensure the transmission of a message, it is essential to assess how an individual might respond when communicating.
- **Body language:** communication through a different medium, it's important to be mindful of body language.

- **Maintain eye contact:** It's also important to make contact with the person or group who involve in communication.
  - **Clarifying message:** If the recipient of your communication does not understand what you are saying, it is essential to explain your message. This will aid the recipient's understanding.

2.8. Mode of Communication (type of communication):

Typically, there are two main types of communication, nonverbal and verbal. The verbal communication involves the use of the spoken or written word, whereas nonverbal communication involves the use of gestures, touch and facial expressions. Although all types of communication happen at the same time, nonverbal communication predominates. Understanding nonverbal communication is essential for nurses to build good communication styles and client interactions. Electronic communication has changed as a result of technological advancements. It is important that nurses are aware of the situation in which it is and is not appropriate to contact with patients through email (Berman *et al*., 2015).

2.8.1. Verbal Communication:

The exchange of information through speech or writing. Nurses depend greatly on verbal communication. They engage in conversation with patients, assessments, draw care plans, and document all information, enter the data into the computerized system, and provide verbal or written shift change reports. Significant relationships exist between vocabulary, sentence structure, spelling, and pronunciation. During verbal communication, individuals convey their education, intellectual abilities, ethnic, interests, national background or regional. Voice arrangement can be made and noises convey meaning. However nurses wants to hear the tone of voice their patients which may convey new message. (This is a sample of inconsistent non- verbal and verbal communication). The individual may create sounds that reveal their real emotions (Rosdahl, 2012).

2.8.2. Non-verbal Communication (NVC):

Nonverbal communication is a silent form of connecting with a group or person without requiring any type of speech to attract an audience's attention or convey a message. Sometimes, nonverbal communication is performed to convey an idea or thoughts and make a message more attractive and interesting to the recipient. Nonverbal communication has a significant impact on our social surroundings and the communication process as a whole. Nonverbal communication provides four significant purposes. These functions may supplement, regulate, replace, or emphasize a verbal message. In addition to these roles, there are numerous sorts of nonverbal communication, including paralanguage, facial emotions, eye messages, body linguistic,

attractiveness, body ornamentation, clothes, distance and space, time, touch, smell, and attitudes (Phutela, 2015).

Nonverbal communication consists mostly on body language, although other aspects, such as the architecture or design of a place, or a person's clothing or look, can also convey signals. Body language is a complicated interaction of elements according to **(** Borg, 2012 and Ali, 2018) include the following:

- Posture: how we position our bodies (folding arms or tilting the head) and where we place ourselves in relation to others.

- Expressions of the face: smiles, grimaces, and raised eyebrows

- Eye contact: whether and how we stare at others (staring; gazing away, sideways, or over someone's shoulder).

- Touch: how and where we physically interact with ourselves, others, and objects (spectacles, clothing or pens).

- Physical responses: perspiration, flushing, or fast breathing.

There is a correlation between nonverbal behavior and patients' views of therapists' empathy, according to research. Eye contact and social touch (a handshake or slap on the back) increased patients' perceptions of the empathy of health care personnel.

The proportion of non-verbal communication in communication has been estimated differently by scholars, with estimates ranging from 60 to 90 percent. In addition, scholars have described various modalities of non-verbal communication (NVC), such as chronemics (use and perception of time), artefacts (environmental and physical objects),

kinesics (form of body movement), haptics (use of touch), physical appearance (body type and clothing), proxemics (use of distance and space), vocalics (aspects of the voice), and silences. Nonverbal communication is independent of the use of words. It is transmitted through the body rather than through writing or word. This form of communication, known as body language, can reveal a great lot or provide the incorrect impression. It is important to note that body language may convey a different meaning than words. Often non-verbal statements offer greater signals than verbal messages (Sibiya, 2018).

According to (Wertheim, 2008). Nonverbal communication contains the following parts:

2.8.2.a. Visual:

This is commonly referred to as body language and consists of, eye movement, facial expression, gestures and posture,. The face is the most prominent aspect of this. We all "read" people's faces to analyze their words and emotions. This becomes increasingly clear when dealing with someone wearing dark sunglasses. However, it is easy to misinterpret these signs, especially when conversing across cultures where gestures can have wildly different meanings. In the American culture, the agreement may be conveyed by an up-and-down head movement, while in the India, a side-to-side head movement may serve the same purpose. We also look to the communicator's posture for information; posture might imply self-assurance, aggression, fear, guilt, or worry. Similarly, we consider how we hold our hands and handshakes. Numerous gestures are culturally specific and subject to misunderstanding.

2.8.2.b. Tactile:

This is the use of physical contact to convey message, such as pat on the back, arm around the shoulder, a handshake, hug, or kiss.

2.8.2.c. Vocal:

Changing one's voice's tone can strongly influence the meaning of words. Consider how many ways there are to say "no"; you can express doubt, fear, wonder, and rage, among other emotions. The meanings of vocal sounds differ throughout civilizations. In one culture, tonality can indicate support but in another culture mean anger.

2.8.2.d. Use of Time as Nonverbal Communication:

The way that spend the time can convey how feel about the status and authority in comparison to that of others. Think around how a subordinate and his or her boss would approach the arrival to a location for a meeting that had been previously agreed upon.

2.8.2.e. Physical Space:

When someone is standing extremely close to us, the majority of us feel a bit uncomfortable about the situation. We have the feeling that our "space" has been violated. People do this in a variety of different ways in order to achieve power and intimacy with one another. We have a propensity to mark our territory by building permanent walls or by using our coat, pen, paper, and other items in the classroom. It is important to us to maintain and exercise authority over our region. It's been said that the "intimate zone" for Americans is somewhere about 2 feet, however this can shift from culture to another. This area is really off to everyone but our closest friends. The "personal zone," which extends from around 2 to 4 feet out, is normally set aside for the use of close friends and

relatives. The social zone, which extends from four to twelve feet in size, is where the majority of business transactions take place. Lectures typically take place in the "public zone," which extends beyond 12 feet (Burton & Ludwig, 2014).

2.8.2.f. Image:

Express the ideals through clothing and other aspects of physical appearance. The use of gestures, motions, material time, objects, time, and place can either clarify or confuse the meaning of verbal communication., the tone of the boss will likely have a greater impact on how his message is received than his actual words.

2.9. Therapeutic and Non Therapeutic Communication:

Communication is the sharing of information, ideas, and emotions between individuals through talk or other means. Therapeutic communication focuses on the effective information exchange between the nurse and the client in order to address the client's needs (Videbeck, 2020).

The concept of therapeutic communication refers to the process in which the nurse consciously influences a client or helps the client to a better understanding through verbal or nonverbal communication. Therapeutic communication involves the use of specific strategies that encourage the patient to express feelings and ideas and that convey acceptance and respect (Sherko *et al*., 2013).

Florence Nightingale described therapeutic communication as the manifestation of care, through which a nurse may interpret any change in a patient's condition without speaking. Therapeutic communication is a vital component of nursing care that promotes patients' involvement in

their care and improves their recovery through educating patients (Victor Obosinde Adika, 2021).

Therapeutic communication has the potency of increasing patients' knowledge and understanding, enhancing trust and self-health skills, increase adherence, providing comfort and facilitating the management of emotions key to patients' health and well-being (Amoah et al., 2019).

Nurses use different type of effective communication strategies and interpersonal skills to appropriately maintain, establish, re-establish the nurse-client relationship, College of nurses of Ontario, 2008, suggest many strategies such as:

a) Introducing herself/himself to the client by name.

b) Using the client's preferred name or title when calling the patient.

c) Giving the patients space, time, and the ability to express himself/herself, as well as listening to understand without minimizing the patient's feelings or giving advise instantly.

d) Notifying the patient that information would be discussed with the health care team and describing the team's general organization.

e) Being conscious of his or her verbal and nonverbal communication style and how it may be perceived by clients.

f) Changing communication style as required to address the client's needs.

g) Assisting a client in determining the optimal care solution by evaluating the patient's of knowledge and addressing his values and preferences.

I) Giving information to enhance client choice and benefit measurement decision-making.

j) Listening, recognizing, and respecting the patient's beliefs, needs, opinions, and ethno cultural beliefs, as well as implementing these factors in the care plan with the patients assistance.

k) Knowing that all behavior has meaning and attempting to identify the cause of an unexpected comment, attitude, or behavior displayed by a client.

l) Listening to the problems of the client's family and important others and acting on those problems when suitable and consistent with the client's wishes. m) Preventing people from personality unless it meets a specific, recognized therapeutic client need, rather than the nurse's need.

n) Frequently reflecting on communication with patients and the health care team and spending time and effort to improving communication skills.

o) Throughout nurse-client relationship, discussing, continuing preparations for meeting the client's care needs after the nurse-client connection has ended such as discharge planning of the patient and/or referral to community groups.

2.9.1. Therapeutic Communication Techniques:

Reviewing the literature which published by Rosdahl, 2012 and The Humour Foundations, 2017, they focused on the therapeutic communication techniques which by the nurses during their daily work as:

- Put the patient at comfort and develop rapport.

• Provide privacy.

• Respect the patient's rights.

• Respect the patient's personal space.

• Try to be at eye level with the patient.

• Proper eye contact may used.

• Attentive listener.

• Keep the information confidential.

• Start conversation with general information and pose emotionally challenging questions only after the client has demonstrated his or her trust.

• Modify the language level for the client as needed.

• Do not use medical jargon or "speak down" to the client.

• Request the assistance of an interpreter if the patient speaks a language other than that of the team or has a hearing impairment.

• Ensure that interpreters are approved and certified by the facility before involving them in client care.

• Begin a method of communication to be used if the patient not hear or talk, or patient speaks a language different from the nurse.

• Pay close attention to what the person is saying.

• Maintain proper and consistent eye contact.

• Avoid writing or computer use through the interview. Most careful attention, for clarify details with the client.

• Express real interest in the patient's feedback.

• Question about the client's ideas.

• Pay close attention to the patient's word choice, replication, fluctuations in tone of voice, assertiveness, body language, silence, anxiousness, repetitive behaviors, distinctive motions, such as unique speech patterns or tics.

• Determine the patient who is not making sense or confused.

• Assess the client's attitudes about touch or talk about contact before employing this strategy.

• Patient family included in chats, if desired. Always be mindful of client confidentiality. If the customer appears uneasy in the presence of others, request to talk with the client alone.

• Consider the client's cultural background and life experiences in all interactions and assessments

• Using humor: in health care is often described as a complimentary treatment. It has been seen to enhance care relationships, coping and healing while reducing anxiety, lowering blood pressure and releasing endorphins

2.9.2. Non Therapeutic Communication

2.9.2.a. Non-Therapeutic Communication Techniques

The nurse needs to be well trained in order to prevent using non therapeutic techniques. Nontherapeutic communication techniques according to (Sherko *et al.*, 2013)include:

• Asking personal questions, giving personal opinions.

•Changing the subject tends to block further communication.

• Automatic responses show that the nurse is not taking the situation seriously.

• False reassurance which is not supported by facts may do more harm than good.

• Sympathy is subjective. It prevents a clear picture of the patient's situation.

• Asking for explanation, questions can cause resentment.

• Approval or disapproval. These may send the message that the nurse has the right to make judgments.

• Defensive responses. The patient might feel that s/he has no rights to an opinion.

• Passive or aggressive responses. Passive responses avoid the issues and aggressive responses maybe confrontational.

• Arguing. It might imply that the patient is lying or misinformed.

2.10. Communication Barriers:

Numerous individuals are incapable of verbal participation in communicative relationships. In addition to their primary medical diagnosis, these patients are therefore considered as having serious communicative problems (e.g., Cerebrovascular Accident, traumatic brain injury, etc.). Severe communication impairment is described as where speaking is temporarily or permanently inadequate to meet all of the individual's communication demands and the inability to speak is not related to a hearing impairment. Many patients who require nursing care are unable to speak temporary or permanent due to physical,

developmental, or acquired impairments. Patients with severe communication impairment and complicated communication demands usually need augmentative and alternative communication equipment and techniques to facilitate communication (Wune *et al.*, 2020).

The factors leading to non-effective communication and consider barriers with the patients are language, lack of time, lack of knowledge, cultural differences, shortage in nursing staff and nurse's discomfort (Albagawi, 2016).

All individuals participating in the communication process must be capable of understanding the language used, a sense of safety and protection, increased recovery rates, more patient satisfaction, and greater adherence to therapy are positive outcomes of good communication (Wright, 2012).

People that have differing views, values, and discrimination are a typical reason of communication barriers in the workplace. Behaviors such as discrimination, biases, and stereotyping can impede communication. However, empathy is essential for overcoming culturally-based communication barriers. When persons do not speak the same language or do not have the same degree of proficiency in a language, linguistic barriers also occur. Many environmental factors, including time limits, language and cultural barriers, as well as nursing discomfort and lack of understanding, also can inhibit successful communication (Wune et al., 2020). The environment in which communication happens, previous experiences, the sender's or recipient's personal perspectives, and the content of the message are crucial factors of whether or not communication and safety are effective (Hemsley & Worrall, 2012). According to studies, inefficient communication between patients and nurses leads in an increase in hospital length of

stay, resource waste, patient dissatisfaction, as well as a loss of trust and frustration for both patients and nurses (E., 2014).

2.11. Effective Communication Barriers:

According to Bello, (2017). Barriers to effective communication can be crystalized as the following:

2.11.1. Environment:

- High workload on nurses
- Lack of privacy nurse or patient
- Lack of sufficient time
- Noise

2.11.2. Personal Characteristics

- Poor self image/self esteem
- Unresolved emotional issue
- Hidden unknown or unknown Agendas
- Nurse's cultural Taboos about communication
- Personal history and background
- Psychosocial level
- Literacy, financial and cultural factors.

2.11.3. Poor Communication Skills

- Lack of empathy or understanding of others
- Lack of active listening skills
- Poor conflict management skills

- Nurse's inability to set boundaries
- Language barrier

2.11.4. Health

- Physical or mental illness (Pain depression, ability to focus or listen, inability to talk etc) (Bello, 2017).

2.12. Critical Care and Communication:

Critical care is the process of caring for individuals who suffer from or are at danger of having life-threatening illnesses. The critical care unit (CCU) is a geographically distinct entity in which high staffing ratios, enhanced monitoring, and organ support may be provided to reduce patient morbidity and death. However, successful intensive care requires an approach that extends beyond the boundaries of the intensive care unit. It requires for preventive, early warning and response systems, a multidisciplinary approach before to and during an critical care unit stay, as well as extensive follow-up care or high-quality palliative care (Jackson & Cairns, 2021).

Florence Nightingale is largely recognized for founding the precursor of the modern intensive care unit (CCU). During the Crimean War in 1854, she and a number of nurses established a part of the military field hospital where the most badly injured soldiers could get more extensive nursing care. Prior to the mid-1950s, intensive care consisted largely of intensive nursing care. After World War II, with the development of hemodialysis procedures and the broad use of mechanical ventilation, the modern critical care unit began to take shape. Ibsen in Denmark was the first to use extended mechanical ventilation to aid victims of the 1952 polio outbreak, and in 1953 he established the first critical care center. Critical care unit was created in France in 1954,

in Baltimore in 1957 (Marshall et al., 2017), and Toronto in the late 1950s as discrete geographic areas within the hospital that brought together developing technologies for organ support such as positive pressure ventilation, hemodialysis, and invasive cardiovascular monitoring. Within a decade, the ICU had become an essential element of hospital-based health care, and intensive care emerged as a distinct medical sub-specialty (Weil & Tang, 2011).

Patients are immediately attacked to a barrage of physical and emotional stresses upon admission to a critical care hospital, according to Credland et al., 2021, that include the following:

- Physical discomfort
- An foreign environment; procedures and equipment
- Disturbances in the Sensory
- Separation from family
- Autonomy loss
- Communication impaired
- Worry for their lives

Psychosocial care is frequently seen as the cornerstone of person-centered care; in this context, it refers to supportive measures that may alleviate the stresses associated with critical illness. Bani Younis et al., 2021; Alaparthi et al, 2020; Parsons and Walters, 2019, reported evidence-based measures that may be beneficial include:

- Offering information and clarifications.
- Consistently orienting the patient to date, time, and location

- Reassurance
- Empathetic touch
- Early mobilization
- Visiting relatives
- Ability to maintain clear night and day routines
- Reducing noise

Critical care units are specialist hospital wards that try to treat patients with a possibly reversible failure of one or more of the body's major systems, like the central neurological systems, circulatory or respiratory. The basis of critical care is the application of particular measures, including non-invasive and invasive monitoring, as well as pharmacological and mechanical support for organs or systems which unable to function normally (Tomaszewska & Gronowska, 2020).

2.13. Unconscious Patient:

2.13.1. Definition of Unconscious:

Unconsciousness is a state of total absence of awareness and the ability to respond, even when stimulated, or it is the abnormal state of complete or partial unawareness of self or environment. Since all complex waking behavior requires the extensive participation of the cerebral cortex, consciousness cannot occur without the activity of this structure. The reticular activating system (RAS), a collection of neurons in the upper brainstem and medial thalamus, keeps the cerebral cortex in a state of wakefulness (Jaddoue, 2011).

Coma is defined as having a GCS <8 or scoring U on the AVPU (alert, responsive to voice, responsive to pain, unresponsive) scale(Cooksley, 2018).

Disorders of consciousness (DOC) are conditions characterized by a persistently disturbed reaction to environmental stimuli, with significant diagnostic and therapeutic challenges. Disorders of consciousness are divided into 3 stages regarding the level of conscious and the personality and environmental awareness: Vegetative state (VS) is characterized by the appearance of and spontaneous, awake-sleep cycle and stimulus-induced arousal, coma state (CS) is characterized by a complete absence of response to environmental stimuli, and minimally conscious state (MCS) is characterized by behavioral evidence of awareness (Raciti *et al*., 2021).

A coma is a deep condition of unconsciousness that the patient is unable to wake up. Stupor relates to lower degree of unresponsiveness in which the patient can only be aroused by forceful stimulation. There are three distinct states of altered awareness. A persistent vegetative state is characterized by an unconscious and unresponsive condition. These individuals have woken from a coma after days or even weeks to a condition of unresponsiveness with open eyelids. Locked-in syndrome is a pseudocoma in which a conscious patient is incapable of making speech or volitional movement to signal that he is awake. This characteristic is related with brain death. Severe brain damage (Alexander *et al*., 2006).

Depressed state of consciousness is the most common neurologic problem in intensive care units ranging from lethargy to coma **(**Irwin & Rippe, 2008).

Comatose patient cannot be aroused. Electroencephalography (EEG) shows no sleep-wake cycles, there is no indication of purposeful behavior or comprehensible communication and the eyes are closed,. When acquired brain damage (hypoxic-ischemic events, trauma, metabolic problems) occurs, coma generally progresses to Vegetative State (VS) or consciousness within 2 to 4 weeks. The patient in Vegetative State (VS) has sleep-wake cycles, spontaneous eye opening but no signs of self or environmental awareness, and no ability to communicate with others. VS can either stay the same (i.e., a permanent state of unconsciousness) can progress to greater degrees of consciousness (Giacino *et al*., 2002).

2.13.2. Causes of Unconscious:

Generally, permanent or a transient disruption of the reticular activating system in the brainstem, bilateral thalamus or both cerebral hemispheres causes unconsciousness. Three primary mechanisms are structural brain injuries, widespread neuronal malfunction resulting from a systemic illness, and rarely psychological reasons for unconsciousness (Edlow *et al*., 2014).

Therefore, the following should be considered the primary causes of coma:

A- Lesion causing harm to the RAS or its projections.

B- Massive destruction of both brain hemispheres.

C- Drugs, poisons, or metabolic abnormalities such as hypoglycemia, anoxia, azotemia, or hepatic failure that inhibit reticulocerebral activity. The organization of consciousness has been notably bifurcated (content and arousal) (Jaddoue, 2011).

The reasons of a patient's unconsciousness might be categorized as systemic pathology or local brain disease. This activity explains the evaluation, management, risk factors of comatose patients, as well as the role of the inter - professional team in improving care delivery for impacted patients (Bauer *et al*., 2019).

2.13.3. Pathophysiology of Unconscious Patient

The pathophysiology of unconsciousness is characterized by neuronal dysfunction caused by a reduction in glucose or oxygen delivery to the brain. Coma may result from direct destruction of arousal regions of the brain or indirect damage from changing intracranial structures, increased intracranial pressure or vascular compression caused by structural diseases of the central nervous system (Huff & Tadi, 2021) (Bauer *et al*., 2019).

The brainstem ascending reticular activating system is the anatomical site of arousal. This system's neurons begin in the dorsal pons and midbrain, link in the thalamus, and project to a number of cortical regions. The cortex processes, integrates, and contextualizes the information it receives, therefore forming consciousness. The spinal cord and brain transmit impulses to the reticular activating system, which is responsible for environmental awareness. The numerous causes of unconsciousness in a patient can be categorized as impacting three major brain regions (Bauer *et al*., 2019).

2.13.4. Epidemiology

The occurrence of unconsciousness and its respective causes differ by institution and patient group. A trauma center with a large patient load will certainly treat a considerable number of unconscious patients

with traumatic brain injury. Ischemic or hemorrhagic stroke was the leading cause of non-traumatic coma (6 to 54 percent), followed by anoxia damage (3 to 42 percent), poisoning (1 to 39 percent), and metabolic causes (1 to 29 percent). Despite the fact that stroke is the leading cause of non-structural and non-traumatic coma factors (37 to 75%) tend to significantly exceed structural reasons (28 to 64 percent). Global mortality rate is (25-87 percent). Anoxic and Stroke coma had the greatest fatality rates, ranging from 60 to 95% and 54 to 89%, respectively. The conditions with the lowest fatality rates were epilepsy and poisoning, both of which had rates of less than ten percent (Horsting, 2015).

2.13.5. Anatomy and Physiology Change of Unconscious

Physiology and Neuroanatomy of Wakefulness

The connection between the rostral reticular activating system (RAS) in the upper brainstem and cerebral hemispheres maintains a normal state of awareness. The RAS is a broad projection, the regions of the RAS between the diencephalon and rostral pons are particularly important for the regulation of consciousness. Consciousness, on the other hand, is not focally reproduced in any of the cerebral hemispheres, associated with the functional cortical mass. Thus, bilateral hemisphere lesions or lesions of the brainstem may lead in an altered state of consciousness (Bersten & Handy, 2013).

Acoma is caused by a dysfunction of either the brainstem reticular activating system (RAS) above the middle pons or both cerebral hemispheres (Greenberg *et al*., 2012).

2.13.6. General Examination of Unconscious Patient

A general patient examination may indicate the etiology of coma. Carbon monoxide toxicity (cherry-red skin), alcoholic liver disease (telangiectasia, clubbing), hypothyroidism (puffiness of the face), and hypopituitarism can cause skin abnormalities (sallow complexion).

Coma may be caused by meningococcaemia, rickettsial infection, or endocarditis if cutaneous petechiae or ecchymoses are present. Needle pricks may indicate drug addiction. A barbiturate overdose is marked by bullous skin lesions. Extremely dry skin may suggest diabetic ketoacidosis or an overdose of anticholinergics. Periorbital hemorrhages (raccoon eyes) suggest an anterior basal skull fracture, especially if cerebrospinal fluid rhinorrhea is present. Battle's sign and cerebrospinal fluid otorrhea are further symptoms of a basal skull fracture. Meningoencephalitis and subarachnoid hemorrhage may be accompanied by nuchal stiffness, however this symptom may be absent in older patients and those in a profound coma. Chronic liver disease or The presence of hepatomegaly symptoms may indicate hepatic encephalopathy. Enlargement of the both kidneys may be indicative of polycystic kidney disease and may warrant consideration of subarachnoid hemorrhage as a potential cause of unconsciousness. The breath may smell of alcoholic beverages or other toxins (organophosphates). Ketones on the breath are an inaccurate indicator, and hepatic and uraemic foetuses are uncommon (Bersten & Handy, 2013).

The examiner must conduct a methodical and exhaustive examination. The general assessment begins by noting the patient's immobile position on the bed and limb position. Document any spontaneous or semi-purposeful movements of all four limbs,

respirations, and oropharyngeal reflexes, such as coughing, swallowing, hiccuping, or yawning. Inspecting for indicators of trauma, including as blood, scars, track marks, and post-operative drainage catheters, can help determine the location of an injury. In an critical care setting, all intravenous infusions are screened for sedatives and/or vasopressors. This is crucial if there is any doubt as to whether a medicine or intervention has an influence on the patient's degree of consciousness. When a patient is on a mechanical ventilator, the settings indicate whether the patient takes spontaneous breaths (Zakaria *et al*., 2020).

2.13.7. Evaluation the Level of Consciousness:

The current recommendation by the European Academy of Neurology (EAN) is that the Full Outline of Un Responsiveness (FOUR) score is to be used for a comatose patient in intensive care unit (ICU) setting, instead of the Glasgow coma scale (GCS) score. The examiner must document what the patient did in response to particular stimuli. The stimuli are either peripheral or central (Zakaria *et al*., 2020).

2.13.8. Pain and Unconscious Patient:

Pain is a subjective symptom, difficult to measure and traditionally evaluated using self report. In sedated patients, unconscious or incapable to tell the presence and intensity of pain, it is important to have other means to assess pain, including objective indicators that can be confirmed without oral communication**.** Several scales based on behavior indicators of pain are being applied to assess and register this symptom in critical patients being considered important tools to assess pain in patients incapable of communicating (Kawagoe et al., 2017).

2.13.8.a. Pain Assessment for Unconscious Patient:

Pain evaluation in the critical care unit (CCU) is frequently delayed as a result of altered states of consciousness after head trauma or any other alterations in physiological condition and sedative usage. In several nursing care settings, assessment is a crucial concept and a basis for intervention. Evaluation of a patient's clinical status is important for making an accurate diagnosis (Asadi-Noghabi, 2015).

Pain is a subjective symptom, difficult to measure and traditionally evaluated using self-report. In sedated patients, unconscious or incapable to tell the presence and intensity of pain, it is important to have other means to assess pain, including objective indicators that can be confirmed without oral communication (Kawagoe, 2017).

Specifically, the assessment will establish the method employed to alleviate discomfort. A correct pain diagnosis can facilitate the administration of appropriate pain medicines. Therefore, nurses must spend great effort to pain assessment (Ofori, 2010). It is impossible to evaluate pain-relieving therapies without proper assessment and a reliable record (Baumann and Sahn, 1990).

2.13.8.b. Pain Assessment Tools in Critical Patients:

Pain is the common phenomenon among the patients in Intensive Care Unit and is more prevalent than the other symptoms. Pain as a natural threat needs to pay attention . Due to its importance, American Pain Society considers it as the fifth vital sign (Yaghoubinia *et al.*, 2016).

Methods of pain measurement should take into account a patient's ability to communicate. The Behavioral Pain Scale is used to assess pain

in non-verbal individuals using behavioral measurements. Use of behavioral techniques to assess pain in unconscious individuals is strongly recommended (Asadi-Noghabi *et al*., 2015).

The four observational and behavioral tools to assess pain in critical, sedated, unconscious patients or with oral communication difficulty: Behavioral Pain Scale (BPS), Critical-Care Pain Observation Tool (CPOT), Nociception Coma Scale (NCS) and Nociception Coma Scale- -Revised (NCS-R) (Kawagoe, 2017).

Behavioral pain scale the BPS was developed by Payen et al to assess pain among unconscious, mechanically ventilated patients. The BPS is based on the total score of three behavioral expressions: 1) facial expression, 2) upper limb movements, and 3) compliance with mechanical ventilation. The BPS allows the assessor to derive a score between 3 (no pain) and 12 (highest pain score) **(** Hsiung *et al*., 2016).

Behavioral Pain Scale (BPS) Tool include the following:

Item	Description	score
Facial expression:	-Relaxed Partially	1
	-tightened (e.g., brow lowering)	2
	-Fully tightened (e.g., eyelid closing)	3
	Grimacing	4
Upper limbs	-No movement	1
	-Partially bent	2
	-Fully bent with finger flexion	3
	-Permanently retracted	4
Compliance with ventilation	-Tolerating movement	1
	-Coughing with movement	2
	-Fighting ventilator	3

	-Unable to control ventilation	4

Adopted from Gomarverdi *et al*., 2019.

The Critical-Care Pain Observation Tool (CPOT) is a behavioral pain scale used to assess the presence of pain in persons who are critically ill and unable to communicate verbally. It was approved for usage in the Society of Critical Care Medicine's (SCCM) most recent clinical practice recommendations (Barr *et al*., 2013).

The Critical-Care Pain Observation Tool consists of four behavioral classifications: body movements, muscular tension, facial expressions, and compliance with the ventilator in ventilated patients, and vocalization in non-ventilated patients. Each behavior is assessed on a scale of zero to two, with a total score range of zero to eight available (Gélinas *et al*., 2014).

The Critical-Care Pain Observation Tool (CPOT) (Gélinas *et al*., 2006).

Item	Score	Explanation
Facial expression	Relaxed, neutral 0	No muscle tension observed
	Tense 1	Manifestation as: orbit tightening brow lowering, any other change and elevator contraction (eye opening or tear production during nociceptive procedures)
	Grimacing 2	All previous facial motions in addition to eyelid closure (the patient may present with mouth open or biting the endotracheal tube).

Body movements	Lack of movements or usual position 0	Normal posture or does not move at all (does not always imply lack of pain) (movements not focused at the source of pain or not performed for protection)
	Protection 1	Slow, careful motions, touching or massaging the source of discomfort to attract attention through movement
	Restlessness/ Agitation 2	Pulling tube, attempting to sit up, moving limbs/thrashing, disobeying directions, assaulting personnel, and attempting to climb out of bed are all signs of agitation.
Compliance with the ventilator (intubated patients)	Tolerating ventilator or movement 0	Alarms not activated, easy ventilation
	Coughing but tolerating 1	Coughing can cause alarms to sound, but they will turn off on their own.
	Fighting ventilator 2	Asynchrony: alarms frequently activated, blocking ventilation
Vocalization (extubated patients)	Talking in normal tone, no sound 0	Talking in normal tone or no sound
	Sighing, moaning 1	Moaning, Sighing
	Crying out, sobbing 2	Sobbing, crying out
Evaluation of muscle tension via passive flexion and extension of the upper limbs while the patient is at rest or evaluation when the patient is being rotated.	Relaxed 0	No resistance to passive movements.
	Tense, rigid 1	Resistance to passive movements
	very tense or rigid 2	Strong difficulty to or inability to perform passive motions.
Total	___ / 8	

Adopted from Gélinas *et al.*, 2006.

Inadequate communication between nurses and patients results in elevated levels of stress and anxiety. Consequently, communication inside the ICU is of the utmost significance, and good communication is a crucial component of nurses' care (Alasad and Ahmad, 2005).

In critical care units (CCU), the communication process is difficult to observe. This situation is influenced by the patient's dynamics in intensive care, which are more focused on technological management, regular tasks, and physiological demands. Poor communication has been demonstrated to impair patient recovery and increase hospitalization duration. Similarly, care is deemed insufficient if it is not accompanied by communication interventions that address emotional and physical situations, which will contribute to minimize the feelings of fear, anxiety, lack of trust, and weakness experienced by patients in a critical state (Achury Saldaa *et al*., 2015).

Medical malpractice is the result of the communication failures. Better communication can reduce medical errors and patient injury. Poor communication can result in various negative outcomes, such as decreased adherence to treatment, patients dissatisfaction and inefficient use of resources (Tiwary *et al*., 2019).

Poor communication can lead to various negative outcomes: discontinuity of care, compromise of patient safety, patient dissatisfaction and inefficient use of valuable resources, both in unnecessary investigations and physician worktime as well as economic consequences (Vermeir *et al*., 2015).

2.14. Role of Critical Care Unit (CCU) Nurses:

Critical care unit (CCU) nurses are responsible for good patient communication, patient support, the continuation of care, and the enhancement of patient engagement in treatment. Caring behaviors in the critical care unit (CCU) include all life-saving treatments. These actions related to the well-being of patients, including their sensitivity, comfort, tranquility, and involve focusing and listening to them, honest with them, and accepting without judgment. Therefore, patients' sense of security is enhanced (Zare *et al*., 2020).

2.15. Communication with Unconscious Patients:

Every person has the right to know what has been done to them whether they are aware or unconscious. Verbal communication is crucial for the providing of competent health and nursing care. Individualized care and the use of the patient's favorite name or familiar sounds may improve sensory input. This provides care which is more humane than technological care. Therefore, communication is the cornerstone of socialization. Critical care unit staff nurses were placing less attention on communication to patients with altered levels of consciousness (Thakur *et al*., 2016).

Critical care unit patients who were unconscious were able to hear. The hearing is the last sense to be lost in individuals with brain damage, touching and talking patients were considered essential for communicating with patients (Tapson *et al*., 2015).

2.16. Important of Communication to Unconscious Patient:

Nurses neglected to provide adequate verbal and non-verbal communication, concluded that at times verbal communication with unconscious patients was so nominal that any potential benefit to the

patients would have been negligible. The critical care nurses may not think on and understand the importance of communication in the practice (Jesus *et al*., 2013).

Patients who are unconscious have a great need for knowledge and support, therefore vocal communication can give these patients with orienting and meaningful sensory input. The information obtained by unconscious patients may aid in the reduction of stress, preservation of self-identity and self-esteem, and reduction of social isolation. In addition, communication specialists underlined that the combination of nonverbal communication in the form of a caring touch and verbal communication has a significant effect on unconscious patients. It can improve the messages that patients get, assist in meeting their psychological requirements, and reduce psychotic withdrawal and delirium, which can lead to psychological stress, confusion, anxiety, and isolation. Despite its significance, there is evidence that communication in intensive care units is not adequately implemented (Othman & El-Hady, 2015).

2.17. Strategies used to Communicate with Unconscious Patients:

Auditory stimulation by a familiar voice may promote level of consciousness (LOC) in patients who are unconscious (Goudarzi *et al*., 2010).

Providing information regarding the environment, procedures, sensations, and time of day is important for patients who are unconscious and may help to decrease immediate physiologic stress (Urden, 2013).

The patient may appear unresponsive and unable to communicate when provide care. The question is—do nurses talk to a patient who is

unconscious? The answer is yes. Quality care requires to engage the patient any way, telling the patient about procedure before doing it. Talk to the patient regardless of level of consciousness. Assume the patient can hear and understand, a sedated patient can hear and may be aware that something is happening that make them to be anxious because they can't see and can't communicate. Imagine somewhere lying with a tube his down throat he is unable to move, talk, see, and someone is shining a light in his eyes, sticking him with a needle, and moving him without any explanation why, where that's happing, it is like being in a horror movie, but it isn't a movie, for this reason **Jim Keogh and his colleagues in 2021**, recommended the nurse should assume the unconscious patient can hear and has a sense of what are doing, so they should think about the following:

- Introduce self to the patient.
- Orient the patient each time when enter the room.
- Tell the patient the day, date, time, and weather.
- Engage in small talk as do to all patients.
- Acknowledge that the patient might be frightened and ensure that the patient is safe.
- Remind the patients where they are and how they got there.
- Give the patient an appropriate update on their condition.
- Tell the patient what will be doing and why are doing it. Then pause briefly to give the patient time to comprehend before do it. Repeat this for each intervention.
- Tell the patient when finished the interventions.
- Explain to patient when return to assess the patient.

• Assure the patient that the ICU team is constantly monitoring him using electronic monitoring devices..

• Tell the patient when leaving the room.

On the other hand Rosdahl, (2012), suggested that:

• Specify what the patient may expect (wet, pressure, cold).

• Do not discuss about patient or his or her family in the patient's presence (ensure that the client's family is not doing thus.) When they regain consciousness, many patients who have been unconscious for some time recall everything that happened while they were unconscious.

2.18. Methods of Communication with Unconscious Patient:

2.18.1. Verbal Communication to Unconscious:

Verbal communication is typically considered as an interactive process; yet, unconscious patients have a major need for information and assistance, highlighting its importance. The receipt of information by unconscious patients may aid in stress reduction. The unconscious patients are anxious because they are likely to misinterpret and be unclear about what is happening. Through encouraging the use of appropriate coping mechanisms, verbal communication with unconscious patients can alleviate stress (Othman & El-Hady, 2015).

Communication with critically ill patients in critical care units presents nursing personnel with special problems and requires highly developed skills. There are several barriers to communicating, including sedation, impaired consciousness and the use of mechanical airways. Early studies on nurse-patient communication in critical care indicated that this part of treatment appeared to be given with less skill than other,

more technical aspects of care and was directly associated with patient response (Jesus *et al*., 2013).

2.18.2. Nonverbal Communication to Unconscious

Nonverbal communication include facial expressions, gestures, paralinguistics such as loudness or tone of voice, body language, proxemics or personal space, eye gaze, haptics (touch), appearance, and artifacts (Cherry, 2021).

2.18.2.a. Touch

2.18.2.b. History of Massage and Touch

The word of massage comes from the Arabic "Mas'h," which means to lightly push (Wigforss Percy, 2006). Chinese documents from 3000 BCE have been found that explain the massage technique. Hippocrates described the therapeutic efficacy of touch about 380 B.C., and massage was a highly regarded medical therapy in Europe until the fall of the Roman Empire. During the Christian revolution, attitudes toward touch and massage modified throughout Europe. For a considerable amount of time, massage was seen as sexual and forbidden, along with bodily pleasure. Per Henrik Ling (1776–1839), a Swede, created a systematic technique of massage and exercise based on physiology in the early eighteenth century (Taylor, 1991; Zottele, 1999; Eklof, 2004; Wigforss Percy, 2006). Taylor now uses Swedish massage (defined as the manipulation of soft tissue for therapeutic purposes) as an adjunct to school medicine. Dolores Krieger was a pioneer in the United States during the 1960s; she promoted therapeutic touch (laying-on hands, which is a way of utilizing the hands to direct human energies to treat or heal someone who is unwell) as healing and essential for humans, especially preterm and newborn infants (Krieger, 1979). Touch was

established as a treatment in Sweden in the late 1960s, when the nurse Siv Ardeby massaged preterm infants (Ardeby, 2005). In the 1980s and 1990s, the phrase tactile stimulation referred to a mild massage with firm pressure applied to adults that activates the touch receptors. This stimulation is now utilized in palliative and geriatric care (Socialstyrelsen, 1997, Birkestad, 2001, Alexandersson et al., 2003). Complementary techniques such as tactile massage and tactile stimulation provide the same function as tactile contact, which is to apply strong pressure to the body. The notion of tactile touch will be employed in this thesis. Before the trials began, the three ideas of touch, tactile massage, and stimulation were validated with critical care unit nurses and patients. Tactile massage was linked to sports and athletics rehabilitation, tactile stimulation to Transcutaneous Electrical Nerve Stimulator (TENS), and tactile contact to gentle touch (Henricson, 2008).

Touch is a basic reflex for expressing compassion and comfort. This is especially true in nursing, where contact is an main aspect of the care process. Touching is viewed as a form of communication, physical contact is an essential and universal component of nursing care," and "nurses touch from a caring viewpoint," according to the study. Touch has the ability to reduce the gap between people and provide respite from pain. Touch, more than sight or hearing, is a more engaging form of interaction because it denotes vulnerability. Touch is a strong and visceral form of communication. Helen Keller, a blind and deaf author, activist, and educator, is regarded as one of the most eminent observers of the quality of touch (Leonard & Kalman, 2015).

Touch is essential to the practice of nursing to communicate comfort, affection, and intent. The hand is the most common area

touched. Most patients view comforting touch positively (Osmun *et al*., 2000).

Physical touch is a fundamental component of medical treatment and care, playing a vital role in caring, medical examination, and a variety of therapies. In a broader sense, touching has a variety of symbolic meanings, such as the politeness involved with comfort and social greetings. Patients report being dissatisfied by the lack or infrequency of physical touch with their caregivers. In complementary and integrative medicine (CIM), physical touch treatment (e.g., healing touch, therapeutic touch) is used to treat a variety of conditions, such as stress, pain, fear, agitation, and depressive symptoms, as well as to promote overall wellness and relaxation. Physical touch treatment is performed in surgery to improve wound healing and perioperative nausea. It is also improves therapeutic connections and communication (Stockigt *et al*., 2019).

2.19. Therapeutic Communication of Nurses with Unconscious Patient:

Therapeutic communication is the interpersonal, information-transmitting process based on the knowledge, attitudes, and abilities of both parties that leads to patient understanding and engagement (Victor Obosinde Adika, 2021).

Each patient need individualized therapy strategies, medications, diets, psychological approaches, and sensitivity to cultural factors of disease and treatment. In the situation of unconscious patients, however, the situation is different because they are unable to independently select whether or not to cooperate effectively with medical workers. Regarding the treatment of such a patient, it is necessary that all personnel of the

therapeutic team work closely together. However, the treatment team must respect the patient's rights. The right of each patient to personal autonomy and independence, conduct and behavior that deviates from commonly accepted norms and models of life, distinctive reactions to many external and internal stimuli, as well as to other individuals, must be acknowledged (Tomaszewska, & Gronowska, 2020).

2.20. Sensory Stimulation for Unconscious Patient:

The coma can continuous from hours to days, according to the severity of brain damage. Some patient remain in a unconscious state for months or even years(White & Giacino, 2013). Sensory deprivation is defined as a sensory restraint related to speech, sight, and feelings and a reduction in the quality and quantity of sensory input such as loneliness, isolation, and restriction of movement (Arslan & Ozer, 2010).

Sensory deprivation is one of the most frequent consequences of coma and ICU admission. It significantly inhibits healing. Therefore, strategies are required to provide sensory stimulation to unconscious ICU patients in order to prevent sensory deprivation (Mohammadi *et al.*, 2019).

Sensory stimulation is a therapeutic technique that stimulates the brain's reticular activating system, allowing for the remodeling of brain activity by forming new neural connections (Shaffer, 2016).

Reduced consciousness occurs when certain sensory inputs in the forebrain are blocked or disrupted, impacting the Ascending Reticular Activating System (ARAS), that consider one of the centers of consciousness. Depending on the level of brain injury, loss of consciousness can be temporary or prolonged, with particular symptoms including breathing difficulties, decreased physical mobility, poor

hydration, impaired swallowing, weakened communication abilities, and impaired excretion (Faozi *et al*., 2021).

Adequate and safe sensory stimulation can facilitate the formation of synaptic connections to provide adequate stimulation for ARAS. Stimuli of the proper intensity and frequency can increase the process of consciousness recovery, so improving the recovery of sensory function and shortening the period of coma (Gorji MAH *et al*., 2014).

The stimulation element is based on the patient's experience, and a family style is used to address the emotional component. In addition, stimulation is often delivered across many sensory channels with varying intensities ranging from moderate to high (Abbate *et al*., 2014).

2.20.1. Type of Sensory Stimulation for Unconscious Patient:

Different kinds of sensory stimulation such as auditory, visual, olfactory, tactile, gustatory, and equilibrium stimulation can be used or applied to the unconscious patients (Moattari *et al*., 2016). Sensory stimulation, including hearing, touch, vision, taste, and olfaction, which is non-invasive, economical, and simple. Some studies reported that sensory stimulation was beneficial in improving arousal, consciousness, neural response, motor function, and brain function, shortening hospital stay, and reducing disability rate (Zuo *et al*., 2021).

Patients who are unconscious require more assistance from nurses than other patients. Multimodal sensory stimulation therapy is a simple, cost-effective, and risk-free treatment option in this case. Families can also be included in this form of treatment to assist create awareness (Zuo *et al*., 2021).

Auditory stimulation is the easiest method used by nurses to communicate verbally with patients during regular health care tasks. Auditory stimulation can be done using various voices with varying results, such as a familiar voice that the patient can recall more rapidly (Mohammadi, et. al., 2017). Auditory stimulation is one of the sensory stimuli that family members or nurses may provide to critical care unit patients (Grap MJ *et al*., 2016).

Auditory stimulation with a familiar voice improved levels of consciousness in comatose patients with a brain injury after three days from condition (Mohammadi *et al*., 2019).

Numerous researches on various auditory stimulations reveal decreased anxiety and drowsiness, but no measurable impact on physiological indicators like body temperature and blood pressure. Han, *et al.*, 2010 suggested that music can lower pulse rate, blood pressure and respiratory rate in mechanically ventilated patients, whereas Boukje, et al., 2010 found that music had no significant effects on physiological manifestation such as Diastolic blood pressure (DBP), Systolic Blood Pressure (SBP), heart rate and respiratory rate in unconscious patients, despite reporting significant sedative effects (Boukje *et al*., 2010).

The sensory stimulation can stimulate post-traumatic brain injury (TBI) plasticity, enhance neurologic function, promote brain regeneration, reduce critical care unit stays, and reduce anxiety (Alashram *et al*., 2020).

A coma patient may benefit from sensory stimulation, such as handholding. There is evidence that coma patients may hear and comprehend oral instructions. Using functional MRI (fMRI) scanning equipment, neuroscientists recorded brain activity in a man who had

been in a coma for 12 years following a car accident. Additionally, research suggests that activating the senses of touch, smell, sound, and sight may aid in recovery. A visitor might assist by wearing a beloved fragrance or holding the individual's hand (Yvette Brazier, 2017).

Multimodal sensory stimulation involves stimulating the senses of hearing, sight, smell, touch and taste. Olfactory stimulation, as provided by aromatherapy, can aid in the release of G-protein, hence boosting antibodies and enhancing blood circulation. In the meantime, acoustic techniques can excite brain nerve cells. For instance, stimulation through music therapy can enhance awareness in individuals with serious brain injuries. Regarding touch, stimulation therapy can improve the blood flow system by returning blood to the cerebral circulation system, successfully compensating for obstructions that may cause a stroke. Lastly, visual and gustatory stimulus can boost autonomic nervous system activity. Interventions can raise patient awareness and avoid ischemic brain cell damage by targeting several senses that can trigger ARAS concurrently (Faozi *et al*., 2021).

Some coma patients are gradually awakened and begin to respond normally. Sensorial and motor stimulation during coma arousal method has been proposed as a means to improve coma recovery. The nurse is advised to engage comatose patients through all of their senses. Nurses that care with comatose patients might benefit from researching the local coma arousal techniques to determine what they can give unconscious patients and their families (Zasler *et al*., 2007).

According to Mohammed & Hassane, 2017, from Egypt that use the Coma arousal technique included the following stimulations for unconscious patient:

A- **Kinesthetic stimulation (Motor)**: This was performed either while seated in a wheelchair or while lying in bed, one limb at a time. Arm motions being made. The arm was then raised gently over the head to its maximum possible position. Leg action and movement Head motion observed here.

B- **Tactile stimulation (Sensory)**: The procedure was repeated on the right and left upper extremities, followed by the right and left lower extremities. The materials utilized were a brush, several fabric textures, sandpaper, and cotton ball.

C- **Auditory stimulation (Sensory):** It was accomplished by initiating a conversation with the patient and orienting him or her to his or her name, time, location, and date. Various stimuli were applied in sequence. Using ear pieces, materials included a ringing bell, familiar voices, and religious chanting.

D- **Visual stimulation (Sensory**): It was administered by stimulating normal attention and directing the eyes toward visual stimuli. Materials included a mirror, brightly colored pen lights, images of recognizable individuals or things, and family photographs.

Mohammed & Hassane. (2017), discovered that the use of coma arousal technique was related with an increase in consciousness and sensory and motor modalities and a decrease in the occurrence of negative physiological parameters (hypervolemia, tachypnea, tachycardia, desaturation, hyperglycemia and hypertension). In addition, patients who had the coma arousal technique tended to remain calm, cooperative, and touch-sensitive. In addition, it was helpful at reducing critical care unit stay and mechanical ventilation time.

2.21. Communication with Patient Family

The presence of family members in the ICU has been forbidden for many years and there is a common belief among the staff that visits by family members have no effect on comatose patients and that the visits interrupt nursing duties. Several studies have shown that the family's presence has no negative effect on the patient care or illness duration (Abbasi *et al*., 2009).

The patient who is comatose (unarousable and unaware) consider the one of the most challenging problems in critical care practice, and management includes the patient, his family and other relatives (Agarwal *et al*., 2014).

The communication between nurses and patients' families impacts patient well-being as well as the quality and outcome of nursing care High quality family Communication is the backbone of the art and science of nursing (Loghmani *et al*., 2014).

2.22. Family Presence during Resuscitation:

During resuscitation, family members were traditionally requested to leave the room. Families should be allowed to be present during CPR and invasive procedures, according to the American Association of Critical-Care Nurses (AACN) and the Emergency Nurses Association (ENA). The presence of family members is a crucial source of support for the patient, and the family may benefit from seeing the resuscitation since they will know that all possible has been done (Urden, 2016).

2.23. Visiting Hours

It is unethical to limit visiting hours for patients in the intensive care unit who are dying. Providing time for family members to say their final goodbyes is an essential role. In the presence of all the tubes, it may

be difficult for family members to recognize the dying individual. It is possible to offer guidance on how to approach the patient and how the patient may still be able to hear although looking unresponsive. Visitors should be permitted as much as feasible without interfering with the privacy or rest of other patients. Children should be permitted to say goodbye, unless they are a substantial source of illness; nonetheless, they may require adult assistance to understand what is happening. Prior to the patient's death or the withdrawal of life support, families may have religious or cultural rituals that are necessary to fulfill. These practices should be supported and facilitated to the greatest extent practicable. Important is the continuity of care by the same nurse. As the patient nears death, nurses have occasionally stayed with the family after the end of their shift so that they would not have to transition to another person during this trying time (Urden, 2016).

2.24. Nurses Communication with Patients on Mechanical Ventilation:

Related to a lack of skills and knowledge, critical care unit nurses difficulty to communicate with mechanically ventilated patients. Therefore, they require training in communication skills that enhance the quality of patient care (Dithole, 2016).

Happ (2013) directed a study in the United States on the effectiveness of intervention on the nurse-patient interaction in the intensive care unit among intubated, responsive and aware patients. The study indicate that communicating with intubated patients was a frequent source of anxiety for patients and stress for nurses (Happ *et al*., 2014).

2.25. Communication and the Nursing Process:

Communication is essential to the nursing process. In each step of the nursing process, nurses work communication skills.

2.25.1. Assessing:

The nurse evaluates communication barriers or impairments and communication style in order to evaluate the client's communication ability. Consider that a client's culture may affect when and how they talk. Clearly, language changes as a function of age and development. The nurse watches children's noises, gestures, and words (Berman *et al*., 2015).

2.25.2. Diagnosis:

Impaired verbal communication can be used as a nursing diagnostic when a patient has a "reduced, delayed, or impaired ability to receive, process, transmit, and/or use a system of symbols" (Herdman & Kamitsuru, 2014). Expressive (difficulty speaking) or receptive (trouble hearing) communication difficulties are possible (e.g., difficulty speaking). The nursing diagnostic of impaired verbal communication may not be applicable when a mental disorder is the source of a patient's communication problems. Additional NANDA nursing diagnoses (Herdman & Kamitsuru, 2014) used for patient having communication issues with decreased verbal communication as the cause include:

• Anxiety related to decreased verbal communication

• Powerlessness related to decreased verbal communication

• Situational Low Self-Esteem related to diminished verbal communication

2.25.3. Planning

Planning requires proper communication between all members of the healthcare team, the client, and his or her family (Rosdahl, 2012).

2.25.4. Implementing:

Nursing interventions that assist communication with patients who have language or speech issues include altering the environment, providing support, implementing communication enhancement techniques, and educate the client and support people (Berman *et al*., 2015).

Through the application of the nursing care plan, the nurse talks with the patients and their family, shares his or her thoughts and observations with the other healthcare provider (Rosdahl, 2012).

2.25.5. Evaluating

• Ongoing evaluation of the success of nursing treatments is dependent upon clear and coherent communication between all individuals involved.

• Instruction of clients and preparation for release depend on precise, empathetic communication and client comprehension. The nursing process cannot survive without precise and therapeutic communication (Rosdahl, 2012).

2.26. Theoretical framework:

Theories that specials in(Nurses- patient relationship) there are three theories included:

1- Hildegard Peplau's (Nurse–Patient Relationship and Its Applications).

2- Ida Jean Orlando's (Dynamic Nurse–Patient Relationship).

Hildegard E. Peplau was born September 1, 1909, in Reading, Pennsylvania; she died in 1999 at the age of 89 years. Interpersonal

Relations in Nursing (1952), defines the importance of the nurse-patient relationship as a “significant, therapeutic interpersonal process”. Peplau identified five phases of the nurse-patient relationship: orientation, identification, exploitation, resolution and termination phase (Alligood, 2014).

According to Neese, (2015), focuses on the nurse-client interaction and the therapeutic process. Communication in this setting is complicated by elements such as beliefs, prevailing cultural attitudes, surroundings, and behaviors,. According to Peplau's interpersonal relations theory, there are four stages of a relationship that all work toward a common goal:

1- Orientation Phase: The nurse involves the patient in therapy, and the patient has the opportunity to ask questions and get answers and information. This stage aids in the patient's development of trust and marks the emergence of initial perceptions of the nurse and health care system..

2- Working Phase : includes exploitation and identification. This phase focus on the patient, who resources to improve health and the nurse, who enacts the roles of resource person, counselor, surrogate, and teacher in facilitating development toward well-being” (Smith & Parker, 2015).

3- Resolution Phase: As a result of effective communication, the patient’s needs are met, and he or she moves toward full independence. The patient no longer needs help, and the relationship ends.

4- The final phase is the termination phase, which is more commonly thought of as discharge planning. The success of the termination

phase is dependent on how well patients and nurses navigated the orientation and working phases. A major part of the termination phase occurs when nurses teach patients about symptom management and recovery at home (Hagerty *et al*., 2017).

When a person's needs cannot be satisfied independently due to physical limits, bad responses to an environment, or an experience that stops them from articulating their wants, they become a patient who requires nursing care, according to Orlando. Patients endure anxiety or feelings of helplessness when their requirements for assistance are not addressed. Orlando hypothesized a link between the length of time a patient's unmet demands persist and the severity of their suffering. Therefore, her whole theory emphasizes immediacy. Individuals who are able to fulfill their own needs, according to Orlando, do not experience anguish and do not require professional nursing care. For inference testing, practice guided by Orlando's theory applies a reflexive principle. It is essential for nurses to express their observations, ideas, and feelings in order to establish whether their conclusions are consistent with the patient's need, as emphasized by Orlando (Alligood, 2014).

Abraham (2011) applied Orlando's theory to assist nurses in achieving more favorable patient outcomes, such as the reduction of falls. Orlando's theory continues to be a highly successful practice theory that is especially beneficial to novice nurses just beginning their careers.

According to Smith & Parker, (2015), the major components of Orlando’s work:

1- The nursing process consists of detecting patients' needs, the nurse's reaction, and nursing action.

2- The nurse's views, thoughts, and emotions impact her capacity to comprehend the significance of patient behavior. It may be validated through nurse-patient conversation. Utilizing both direct and indirect observations of patient behavior, nurses determine distress and significance.
3- Nurse–patient relationships are special, complicated, and dynamic processes. Nurses aid patients in articulating and comprehending the significance of their conduct.
4- Professional nurses are autonomous from physicians and other health care practitioners.

2.26.1. Application of Theory:

Hildegard Peplau's theory.	**Jean Orlando's theory.**	**Application the theory.**
Orientation Phase: nurses introducing himself/ herself as a start point of communication which consider as a first phase of communication (introductory). -During this first phase, the nurse collect relevant data to recognize and identify problems -Trust: nurses develop trust by many strategies in order to facilitate problem solving process	**The nursing process:** includes identifying the needs of patients, responses of the nurse, and nursing action.	Assess the nurses knowledge and practice related to communication with unconscious patient through the need assessment.by using multiple-choice questionnaire, and observable checklist
Working Phase: Identification of problem, introduce diagnosis, act	**Understanding the meaning** of patient behavior is influenced by	During the pretest assessment for both group (control and interventional) find the deficit

effectively to improve interpersonal relationship. -Put aplan and assign proper pathway (alternative) for solving problem.	the nurse's perceptions, thoughts, and feelings. Nurses determine distress and severity by using both direct and indirect observations of patient behavior.	in knowledge and practice of nurses to communicate with unconscious patient, so through this phase plan and building the program to increase the nurses knowledge and practice related to communication with unconscious patient.
Resolution (termination) Phase: This phase helping a client to move from dependence to independence role. Measuring effectiveness of the steps.	**Nurse–patient relationships**: Nurses aid patients in explaining and comprehending the significance of their conduct. The basis for nursing action is to evaluate the patient discomfort	After giving the communication program models to critical care unit nurses evaluate the effective of communication models on nurses knowledge and practice through two posttest.

2.27. Previous Study:

First study

Zare *et al* (2020). Study **"Therapeutic Communication Skills Training: An Effective Tool to Improve the Caring Behaviors of ICU Nurses".** This study aimed to assess the impact of therapeutic communication skills training on the caring behaviors of critical care nurses. Materials and Procedures: In 2019, an experimental pre-test/post-test research was conducted on 105 Iranian Critical care nurses associated with Yazd University of Medical Sciences. Random assignment of nurses to the control (52 nurses) and intervention (53 nurses) groups. The participants participated in a two-day therapeutic communication training seminar. Using a demographic information questionnaire and a caring behaviors questionnaire, data were gathered prior to and one month after the intervention. The result: after implementing the training program, the data showed a significant difference in the mean scores of caring behaviors between the two groups. Conclusion: according to the findings, the training of Critical care nurses in therapeutic communication skills had a favorable impact on their caring behaviors. Therefore, we recommend that the authorities develop and implement a consistent teaching program for other nurses that includes therapeutic communication skills. As a result, caring behaviors and the quality of patient care can be enhanced the patient.

Second study

Thakur *et al.,* (2016). **Nurses Communication with Altered Level of Consciousness Patients** Aim: To evaluate current communication pattern between ICU nurses and altered level of conscious patients, explore the Nurses Knowledge, and also fi nd the

need for Structured Nursing care Protocol on communication with altered level of conscious patients. Methodology- A Exploratory descriptive design was used for study the knowledge and practice of the nurses in intensive care unit. Selected forty communication events were observed and the same nurses were enumerated to study their knowledge. The nurses who were caring more than one patient and the patient GCS>8 were excluded from the study. Results: The practice score of the staff nurses were10.08±3.24 which is ranged from 1 to 32. This practice score denotes nurses were rarely communication with altered level of conscious patients. The knowledge score of the staff nurses was 13.05±2.38 which is ranged from 1 to 24 also depicts that they were having average awareness. Conclusion: The present communication pattern between nurses with altered level of conscious patients and nurse's knowledge score, indicating the great need of Structured Nursing Care protocol regarding communication with altered level conscious patients, where highquality communication is a key determinant and facilitator of patient-centered care.

Third study

Alsharari. (2019). Study **"The needs of family members of patients admitted to the intensive care unit"**. The purpose of this study was to evaluate the association between the most essential needs of family members of ICU patients and their sociodemographic variables. This was a cross-sectional research done from April to August 2017 on adult family members of CCU patients at four public hospitals in the northern area of Saudi Arabia. To identify the family requirements, questionnaire was presented to all consenting relatives of CCU patients. The information was evaluated with descriptive statistics. Result: the t-tests and ANOVAs were conducted on the students' data. The family

members rated assurance as the most significant requirement (3.620.44), followed by information (3.470.59), closeness (3.340.44), comfort (3.010.72), and support (2.910.68). A higher education level was substantially related with a greater desire for assurance (P = 0.001), information (P = 0.001), and closeness (P = 0.001). (P,0.001). In addition, those with an unconscious/semiconscious relative in the ICU rated information need as more important (P 0.001) than those with a conscious relative. Conclusion: This findings show that family members of critical care unit (CCU) patients have heightened requirements in the assurance, closeness, and information dimensions that must be fulfilled. This should lead the establishment of connection, efficient communication, and constructive teamwork to provide CCU patients and their families with the greatest possible care and support.

Fourth study

Adika, (2020). Study the **"Unconscious Patients Related Therapeutic Communication of Nurses: A Concept Analysis"**. *Aim*: To conduct a concept analysis on unconscious patients related therapeutic communication of nurses. *Method*: A Walker and Avant's concept analysis method was used to clarify the concept's context, alternate terms, antecedents, attributes, and consequences. *Data Source*: Literature review was conducted using keywords from the concept analysis topic in English databases from the (EBSCOHOST, Medline via PubMed and Google Scholar search) for relevant studies. No restriction of time was enforced on publication date. Inclusion criteria included peer reviewed articles. Twelve (12) articles that met the inclusion criteria were included in the study. *Results:* Unconscious patients therapeutic communication can be defined by five attributes: "a means in building interpersonal relationships", "a process of information transmission",

—An important means of clinical competency", "a structure with two different sections" i.e., verbal and nonverbal communication and "a significant tool in patient-centered care". Antecedents of the unconscious patients therapeutic communication of nurses included education and clinical practice, receiving feedback during clinical practice and application of theoretical knowledge, and skills such as listening and empathy while respecting interpersonal space. *Conclusion:* The findings of this concept analysis clarify the need for nurses in their training programs to have the necessary competencies to support the inability of unconscious patient's therapeutic communication and build on interpersonal relationship.

Fifth study

Mohammadi *et al* (2017). Study **Effects of organized auditory stimulation by familiar voice on blood pressure and body temperature in comatose patients.** The main objective of this study was to assess the effects of structured auditory stimulation by a familiar voice on blood pressure and body temperature in critical care unit (CCU) patients. Materials and Procedures: Sixty unconscious patients with traumatic brain injury (TBI) hospitalized to the critical care unit (CCU) of Poursina Teaching Hospital in Rasht, Iran, participated in the present clinical trial. Patients were randomly allocated to the intervention (N=30) and control (N=30) group. In the intervention group, significant others' voices were used to provide auditory stimulation during three consecutive 10-minute nightly shifts. A checklist was used to measure blood pressure and body temperature, and the results were analyzed using ANOVA, the t-test, and the Chi-square test. Results demonstrated significant changes in the intervention group's mean blood pressure and body temperature before and after auditory stimulation (P0.001),

whereas these differences were insignificant in the control group. It was also determined that there were no significant differences between the two groups in terms of three-day changes in the mean blood pressure and the mean body temperature. Conclusion: Given the strong benefits of auditory stimulation on hemodynamic indicators, auditory stimulation by familiar voice is advised for unconscious patients admitted to critical care unit (CCU) through face-to-face contact with family or by hearing their recorded voice.

Sixth study

Moattari *et al.*, (2016). **"Study the Effects of a sensory stimulation by nurses and families on level of cognitive function, and basic cognitive sensory recovery of comatose patients with severe traumatic brain injury: a randomized control trial"**. The objectives of this study: To investigate the benefits of a sensory stimulation program administered by nurses and family members on the degree of awareness, cognitive function, and fundamental cognitive sensory recovery of unconscious head injury patients. Patients and Procedures: This was a randomized clinical trial conducted at the level I trauma hospital in Shiraz including 60 unconscious head-injured patients with an initial Glasgow coma score (GCS) of less than 15. (8). Patients were randomized assigned to receive sensory stimulation from a skilled nurse (n = 20), from family members (n = 20), or standard care (n = 20). The nurses and patients' families participated in the sensory stimulation program twice daily, morning and evening, for seven days. The baseline features, degree of awareness, level of cognitive function, and fundamental cognitive sensory recovery of all patients were equivalent, as indicated by GCS, RLA, and WNSSP. Although the two intervention groups improved, those who got the sensory stimulation program from

their families had substantially higher GCS (P = 0.001), RLA (P = 0.001), and WNSSP (P = 0.001) scores 7 days later compared to the other two groups. The application of sensory stimulation by families resulted in substantial gains in awareness, cognitive function, and fundamental cognitive sensory recovery in unconscious patients with serious injuries.

Seventh study

Asadi-Noghabi *et al*., (2015). Study the **Nurses use of critical care pain observational tool in patients with low consciousness.** objective: identification of pain in patients with limited awareness is a significant barrier in the critical care unit (CCU). The use of behavioral methods for pain evaluation may indeed be a helpful method for managing pain in this group of patients. The study aimed to assess the effects of a critical care pain observational tool on the pain treatment of patients with a lower degree of awareness. Methods: The study employed a before-and-after design to assess nurses' pain management skills in patients with poor consciousness. 106 critical care nurses were involved in the study. The study consisted of three phases: before implementation, during implementation, and after implementation. Following tracheal suctioning and position shift operations, the researchers initially evaluated the nurses' pain management of their patients three times using a checklist. The nurses were then instructed on how to use the pain observation instrument for critical care (CPOT). After using the instrument, the researchers reevaluated the nurses' pain management training. After training, performance ratings increased in connection to the nurses' diagnosis of pain, pharmacological and nonpharmacological interventions, reevaluation of pain, and re-relief of any pain. The instrument did not, however, enhance the recording of the patient's

discomfort and the relief techniques utilized. The CPOT increases nurses' sensitivity to pain in unconscious patients and motivates them to monitor and administer pain care.

Eighth study

Othman & El-Hady, (2015). Study the **Effect of implementing structured communication messages on the clinical outcomes of unconscious patients.** Method of study: A quasi-experimental design was implemented. Sixty unconscious patients were selected from three critical care unit (CCU) at the Mansoura University Emergency Hospital and two ICUs at the Mansoura University Main Hospital. Thirty patients were assigned randomly to each of the two groups (intervention and control). Four instruments were used to collect data: the physiological adverse events (PAE) assessment instrument, which measured (hypothermia, tachycardia, bradycardia, hyperthermia, hypovolemia, hypervolemia, hypertension, hypotension, desaturation, bradypnea, ventilator distress, hyperglycemia or hypoglycemia), Full Outline of Un-Responsiveness (FOUR) scale, Behaviour pain scale and Motor Activity Assessment Scale (MAAS). The application of structured communication messages (SCMs) was related with a reduction in the incidence of PAE and a statistically significant improvement in degree of awareness as measured by the FOUR scale. The Motor Activity Assessment Scale (MAAS) level of patients in the intervention group remained unchanged (2-3) (calm, cooperative and responsive to touch). The Behaviour pain scale (BPS) in the intervention group reduced much more than the control group after the administration of SCMs. Moreover, the intervention group had significantly shorter mean durations of mechanical ventilation and critical care unit (CCU) stays than the control group. Conclusions: The created SCMs have been demonstrated to

promote communication with unconscious patients; consequently, they are suggested for use in the everyday care of unconscious patients by nurses.

Ninth study

Abbasi *et al*., (2009). Study the **"Effect of a regular family visiting program as an affective, auditory, and tactile stimulation on the consciousness level of comatose patients with a head injury".** The objective of this study was to investigate the effect of a regular family visitation program, which included auditory, emotional, and tactile stimulation, on the awareness level of patients with unconscious head injuries. A randomized controlled trial design was implemented. Fifty patients with unconscious head injuries were randomly assigned to either a control or intervention group. The Glasgow Coma Scale was used to assess and record the state of consciousness of patients in both groups before and 30 minutes after the visiting program. The independent t-test revealed that the mean state of consciousness on the first day prior to intervention did not differ significantly between the two groups. The findings of the repeated-measures ANOVA revealed that the consciousness level differences between the two groups during the course of the 6-day intervention were statistically significant. The findings of this study provide evidence that a regular family visitation program can stimulate unconscious patients. Consequently, it can be regarded a possible nursing intervention.

Tenth study

Finke, E. H., et al (2008). **A systematic review of the effectiveness of nurse communication with patients with complex communication needs with a focus on the use of augmentative and alternative communication.** Aims and objectives. To systematically review the research regarding communication between nurses and patients with complex communication needs (CCN). A discussion of augmentative and alternative communication (AAC) options that nurses may use to promote more effective communication with CCN patients. Design. Systematic evaluation. Method. This work examined the existing literature on the viewpoints of nurses, patients with CCN, and their carers about the obstacles to successful communication between nurses and CCN patients. In addition, practical solutions (such as the use of AAC) that nurses might employ to improve and facilitate communication with CCN patients are presented. Conclusions. Communication between nurses and patients is essential for the delivery and receipt of excellent care. Concern and irritation have been expressed by nurses and patients when communication is inadequate. When speech is not an option, AAC practices will help nurses and patients communicate more effectively. Relevance to clinical practice. Communication with all patients is essential for providing great nursing care. Speech cannot always be used as a means of communication. Nurses must have the tools and abilities necessary to interact with all of their patients, regardless of their ability to talk.

Chapter Three

Methodology

Chapter Three

Methodology

In this chapter the researcher will reviewing the design of the study and all the steps and preparations that performed to complete it, started with administration of permission, choose of study setting, sampling, validity, pilot study, data collection methods, and analysis of data statistically.

3.1. Study Design:

A quasi-experimental design was used with the application of pre, and posttest to achieve the study objectives which directed to evaluate effectiveness of unconscious patient communication models educational program on the critical care unit nurses knowledge and practice at Al-Hillah teaching hospitals started from 15th September 2020 to 23 June 2022.

3.2. Administrative Arrangement:

The started point of the administrative arrangement begin with proposal presentation which consist the study title and objectives. In the college of nursing- University of Babylon after discussion by the scientific committee of adult nursing department approval obtained.

The next step include obtaining the agreement of the ethical committee of the college of nursing after submission of the full protocol form and educational program plus prepared questionnaire (Appendix 1), formal request sent from the college of nursing university of Babylon to the Ministry of health directorate training and development to obtain their agreement to collect data from the related health setting which is consider as a proper sitting for collecting data to reach the study objectives (Appendix 2), after submission of all needed forms formal agreement obtained(Appendix 3).

3.3. Setting of the Study:

Al- Hilla teaching hospital and Imam Al- Sadeq teaching hospital consider proper setting to collect the data to achieve the study objective because they consist of critical care units which designated to receive adult patients with complex health status. The general intensive care at Al- Hilla teaching hospital consist (12) beds, while the capacity of the unit at Al-Imam Al- Sadeq is (18) bed, most of the patients who admitted to these units suffer from complex health condition with multi- organic dysfunction, most of them need mechanical respiratory support.

3.4. Study Sampling and sample:

Non- probability purposive method used to select the sample of the study to achieve the study objectives. The study sample selected related to specific criteria. The total number of nurses who work in the critical care units in Al-Hillah Teaching hospitals are (74) nurses Imam al sadeq teaching hospital are (51) nurses and that leads to consist of (125) nurses totally. The study sample consisted (63) nurses.

3.4.1. Inclusion Criteria:

The criteria for the selection of the study sample:

3.4.1. 1. Working in intensive care unit

3.4.1. 2. Agreed to participate in the study.

3.4.1. 3. Provide direct care to the patients.

3.4.1. 4. Nurses who scored less than 60% on pre-test.

3.4.2. Distribution of the Sample:

The rest of the nurses who didn't participate in the original study sample distributed as

1- Nurses participate to assess the need of the communication principles with unconscious patients during their admission in the intensive care units (11)
2- Nurses assigned in the pilot study (10).

3- Nurses didn’t provide direct care to the patient (8).

4- Nurses refuse to participate in the study (12).

5- Nurses withdraw from the original sample (6) from control group during the second posttest, (4) nurses didn’t complete the educational session, (5) didn’t attend during the first post test and (6) during the post test.

The original study sample consisted of (63) nurses was selected from these two hospitals allocated into two groups about (125), the number of control group (33) nurses who didn’t expose to the educational program, while the other (30) nurses assigned as interventional group , who attended the educational program sessions.

3.5. The Study's Steps:

The current research was carried out by performing the following step:

3.5.1. Assess the needs of nurses toward educational communication with unconscious patient:

To accomplish this phase of the study, use a multiple choices questionnaire form prepared which content of (11) items after reviewing of related. A test was administered to (11) nurses working in the critical care unit male, and female, with mean of age (24.2), each nurse need about (15-30) minutes to complete all answers (appendix 4 a). The assessment the need for program doing during the 15 April 2020.

Most of the nurses (100%) were found to be deficient in knowledge. The nurse needs to an educational program for the nurses to improve their knowledge toward communication with unconscious patient (Appendix 4 b).

3.5.2. Nursing Educational Program Development:

Based on the findings of the nurse's assessment of the educational needs, the program was developed.. The program was designed to provide the nurses with information and practice related to communication with

unconscious patient , anatomy of nervous system, basic element of communication, therapeutic and non-therapeutic communication, communication with mechanical ventilator patient and the patient family communication (Appendix 7). which presented as five sessions each session required about (30-40) minutes as following:

First session:

Title: Nervous system and unconsciousness

Time: 9.30 am- 10.10 am, for evening group from 3.30 pm-4.10 pm

Duration: 40 minute

Place: Al- Hilla teaching hospital

Teaching method: lecture

Teaching aids: presentation, pictures and video.

Specific objectives:

1- Describe the anatomy, physiology of brain and physiological alteration of brain for unconscious patients.
2- Identify alteration of the level of consciousness, Pathophysiology which occurs in the nervous system.
3- define the unconsciousness and the stages of alteration in consciousness**.**

Second session:

Title: Basic communication skills

Time and date: 10.20 am- **11.00** am**, for evening group from 4.20 pm-5.00 pm**

Duration: 40 minute.

Place: Al- Hilla teaching hospital

Teaching method: lecture

Teaching aids: PowerPoint

Specific objectives: -

1- Define the communication and the identify the basic elements of communication
2- Identify the communication modes and the factors that influencing communication process.
3- Numerate the communication phase.
4- Identify the communication process.
5- Make an integration between communication and nursing process.

Third session:

Title: Therapeutic communication

Time and date: 9.30 am- **10.10** am**, for evening group from 3.30 pm-4.10 pm**

Duration: (40) minutes

Place: Al- Hilla teaching hospital

Teaching method: presentation and video.

Specific objectives:

1- Define the therapeutic communication**.**
2- Identify the goal of therapeutic communication.
3- Describe the barriers to therapeutic communication.
4- Describe the therapeutic communication techniques.

Fourth session:

Title: Communication with unconscious patients

Time and date: 10.20 am- **11.00** am**, for evening group from 4.20 pm-5.00 pm**

Duration: 40 minute

Place: Al- Hilla teaching hospital

Teaching method: lecture and practice

Specific objectives:

1- Identify The importance of communication to unconscious patients.
2- Identify the important of nurses communication to unconscious patients.
3- Describe guidelines in communicating with a patients who is unconscious.

Fifth session:

Title: Communication with mechanically ventilated patients and their family.

Time: 9.30 am- **10.30** am**, for evening group from 3.30 pm-4.30 pm**

Duration: 60 minutes

Place: Al- Hilla teaching hospital

Teaching method: lecture

Specific objective:

1- introduction to mechanically ventilated patients
2- Identify the Methods to enhance communication with patients under the mechanical ventilated

3- Identify the importance of the nurses role to explain the patients condition for the family members(nurse family relationship).

3.5.3. Questionnaire of study:

To evaluate the educational program's effectiveness directed on the nurses communication skills with unconscious patients who admitted to critical care units multiple choice form consist of (67) items prepared (Appendix 6). The questionnaire divided to four parts distributed as the following:

Part: I: Demographic Characteristics of Nurses:

This section is devoted to the compilation of data regarding the demographic characteristics of nurses such as(age, gender, marital status, level of educations).

Part: II: Employment information:

This part content the years of employment in nursing filed and years of critical care unit experience, and attendance of course training about communication with unconscious patient or no.

Part III: knowledge of nurses on unconscious patient communication:

This part was constructed to assess nurses' knowledge about communication with unconscious patient .It consisted of 50 multiple choices questions in six domains:

1-Domain one: Knowledge of nurses about anatomy of nervous system which involved of 9 items.

2- Domain two: Basic communication principals involved of 12 items.

3- Domain three: therapeutic and non-therapeutic communication involved 4 items.

4- Domain fourth: communication with unconscious patient involved of 12 items.

5- Domain fifth: communication with patient under mechanical ventilator involved 10 items.

6- Domain sixth: education for unconscious patient family (3) items.

These items of knowledge were rated and scoring (2) for right answer, while (1) for wrong answer.

Part IV. An observational checklist for nurses' practices regarding nurses communication with unconscious patient in critical care unit:

An observational check list to evaluate the nurses' practices regarding to communication with unconscious patient , The researcher observed and evaluated the performance to see if it was correct or incorrect.

The nurse's practice checklist was composed of 17 items toward communication with unconscious patient is adapted from (Thakur *et al*., 2016, and Thomas, 2006).

3.5.4. Rating and scoring:

Rating and scoring system which used are the following: for knowledge questionnaire two level used as correct given: 2score, which incorrect answer take 1, mean scores (1.5) due to(correct) and (incorrect) scales through two levels of assessment, under cut off point (1-1.5), and above cut off point (more than 1.5); and items based assessment based on the mean of scores (1.5) by two levels of assessment, poor (1-1.5), good (more than 1.5).

For the practice checklist three likert scale used as: always: 3, sometime: 2, never : 1. The calculated mean scores the cut of point(.66) from (1-1.66) never, (1.67- 2.33) sometime, (2.34- 3) always.

3.5.5. The Questionnaire's and Program's Validity:

In order to obtain the content validity of the educational program and the study tool two version of the educational program and the tool Arabic and English were (questionnaire and checklist), two version distribution among (13) experts, who had experience in their field for more than 10 years to review the educational program's content and the questionnaire of communications with unconscious patient (Appendix 5).

3.5.6. Pilot Study:

To determine the adequacy of the data collection plan and the reliability of the prepared tool, a pilot study on (10) nurses working in critical care unit in Al- Hilla teaching hospital from the period (15 -30 December 2021) were carried out. The participants were selected after obtaining the participant agreement. One week later re-test was performed up on the same participants.

3.5.6.a. The purpose of the pilot study:

1- Determine if study participants understood the questions.

2. Estimate time for each question.

3. Assess questionnaire reliability.

3.5.6.b. A Reliability of the tool:

The reliability coefficients is an important indicator of an instrument's quality. The pilot study performed as a small and primary study before starting the study procedures in order to assess the stability of the instrument which is prepared to collect the data. The results of the pilot study were statistically managed and the results revealed that the reliability which estimated for used instrument was **Reliability Coefficients** (*r* = 0.80) which is statistically acceptable.

Tool	N	Rating
Knowledge	10	0.80
Practice	10	0.92

Reliability for practice by using the inter-observer or inter rater method used to obtain reliability in order to determine the checklist stability the researcher enlisted the help of two nursing college graduates to complete this phase, with each participant in the pilot project being viewed by three observers at the same time for each practice, each participant has three observations for each practice. The reliability of the checklist calculated by special equation, the statistical results recorded (r: 0.92), which is statistically accepted.

3.5.7. Ethical consideration:

One of the most significant aspects of quantitative research is ethical consideration, since this type of study often employs human beings. Ordinarily the consent may be obtained verbally (oral or written), counter the nature of the study, this kind of an ethical grade may protect confidentiality and dignity of the study subjects. For this reason formal

consent form applied for each participant after explaining the research objectives in order to obtain their formal agreement (Appendix 6A).

3.5.8. Data Collection:

Data were collected during the period between (3 January to 19 March. 2022), after obtaining the nurse agreement to participate in the study the following steps followed:

1- Pretest was distributed among the study sample (both group), self- report method selected as suitable method to complete the questionnaire related to nurses knowledge which take about (30- 50 minutes). Nurses who recorded less than (60 out of 100) were assigned to participate in the study. One the other hand checklist used to assess the nurses practices through three observation, this step takes about (18 day).

2- After the pretest of the nurses who assigned to involve as an interventional group the educational program sessions started for the morning shift it take (7) days to complete all sessions, while for nurses who schedule in evening duties it takes about (12) days.

3- The first post- test for the interventional group implemented immediately after finishing the last session, step takes about (10) days to complete the nurses practices checklist.

4- Post- test performed for the control group member (33) nurses related to their knowledge and practices which takes about (7) days.

5- The data related to the second posttest collected after (21) days later for both group (control and interventional).

3.6. Statistical Analysis:

Excel and SPSS (Statistical Package for the Social Sciences) version 26.0 are used to analyze the data, respectively. The outcomes of the research were analyzed and assessed using the following statistical data analysis approaches:

3.6. 1. Descriptive statistic includes the following methods:

a- Percentages and frequencies.
b- Tables and figures (Charts and Bar).
c- Mean score and standard deviation.

3.6.2. Inferential data analysis:

These were used to reject or accept the hypotheses, which involved the following:

Chi-Square test: It examines the deviation between observed and expected values. It is determined by calculating the difference between the frequencies actually seen in a sample data set and the probabilistically predicted frequencies..

a- Reliability of the questionnaire estimated by .
b- Testing the independency and measuring the association between the variables.
c- P- value.

Chi-square Test: . $\chi^2 = \sum_{i=1}^{k} [\frac{(o_i - e_i)^2}{e_i}]$

Independent samples t-test: Make comparisons by comparing the mean values of random samples drawn from two distinct populations. Under the null hypothesis, the chance of attaining these mean values is

calculated. Nursing knowledge and practice are linked using this method (gender and training course).

Pearson correlation coefficient (r): The test is used to determine the instrument's test-retest reliability.

Chapter Four

Results

Chapter four

Results

Table(4.1) Distribution of the study and control group members according to the demographical characteristic.

Demographic characteristic	Rating	Control group		Study	
		frequency	percent	frequency	percent
Age/ years	21-22	4	12.1	3	10.0
	23-24	8	24.2	10	33.3
	25-26	11	33.3	13	43.3
	27-28	7	21.2	2	6.7
	29-30	7	6.1	2	6.7
	31-32	1	3.0	0	0
	total	33	100.0	30	100.0
Gender	Male	18	54.5	19	63.3
	Female	15	45.5	11	36.7
	Total	33	100.0	30	100.0
Education status	Nursing school graduate.	0	0	2	6.7
	Graduate Diploma in Nursing	11	33.3	9	30.0
	Bachelor of Nursing graduate	22	66.7	18	60.0
	Postgraduate	0	0	1	3.3
	Total	33	100.0	30	100.0
Marital status	Single	16	48.5	17	56.7
	Married	17	51.5	13	43.3
	Total	33	100.0	30	100.0

Table(4.1) : the distribution of this table shows that most of participants 11(33.3%) and 13(43.3%) in both group (control and study) were between age group(25-26) years, 18(54.5%), 19(63.3%) were male, most of them bachelor holder 22(66.7%) and 18(60.0%), and related to their marital status 17(51.5%) in the control group were married, while 17(56.7%)in the interventional group were single, when most of the demographical characteristics matched among the study group it mean the equivalence of the group.

Table(4.2): Distribution of the study sample (study and control) related to their employment information.

Item	Rating and intervals	Control group		Study group	
		frequency	percent	frequency	percent
Years of employment in nursing	1-2	13	39.4	18	60.0
	3-4	16	48.5	6	20.0
	5-6	4	12.1	3	10.0
	7-8	0	0	3	10.0
	Total	33	100.0	30	100.0
Years of employment in ICU	1-2	20	60.7	23	76.6
	3-4	12	36.3	5	16.8
	5-6	1	3.0	1	3.3
	7-8	0	0	1	3.3
	Total	33	100.0	30	100.0
Participated in courses on communication with unconscious patients	yes	3	9.1	7	23.3
	no	30	90.9	23	76.7
	total	33	100.0	30	100.0

This table shows that the higher percentage of the control group 16(48.5 %) were within (3-4)years, while 23(76.6%) from study group were within (1-

2) years related to experience in field of nursing, years of experience among the intensive unit nurses distributed as 20(60.7%) were between(1-2) years for the control group, 23(76.6%) of study group were within one year and less. All the participant(both group) didn't attend any specific course related to communication skill with unconscious patients, 30(90.9%), 23(76.7%).

Table(4.3): Responses of the study sample(both group) related to their knowledge regarding nervous system anatomy and physiology.

N	Items	Control			Study		
		Pre	Post-1	Post2	pre	Post.1	Post.2
		Mean	Mean	Mean	Mean	Mean	Mean
1)	Functions of the nervous system include information reception, integration, and nerve impulse conduction to recipient cells.	1.88	1.82	1.76	1.83	1.9	1.9
2)	The majority of nervous system activity originate from sensory receptors including auditory, tactile, and visual receptors that transferred to the central nervous system by:	1.58	1.39	1.7	1.33	1.8	1.57
3)	The primary functions include sensory, motor, and cognitive is performed by:	1.09	1.09	1.24	1.03	1.37	1.2
4)	The largest lobes of the brain which control voluntary function such as, motor, cognitive(memory, orientation, judgment, arithmetic, insight, and abstraction extended to expressive written and language verbal is	1.55	1.42	1.55	1.5	1.97	1.67

5)	The lobe concerned with the sensory functions which includes association of sensory information; awareness of body parts; interpretation of touch, pressure, and pain is	1.45	1.39	1.36	1.3	1.9	1.43
6)	Verbal memory, visual memory such as: interpreting the emotions, understanding language, and reactions of others are coordinate by the	1.27	1.33	1.27	1.37	1.8	1.47
7)	Located in the back of the brain, below the occipital lobes involved with motor skills, which refers to the coordination of finer, or smaller, movements, especially those involving the feet and hands is referred to:	1.42	1.45	1.45	1.4	1.48	1.33
8)	The immediate coma caused by destruction of the	1.33	1.3	1.39	1.4	1.8	1.6
9)	Deep Coma my due to small lesions developed in the	1.24	1.3	1.33	1.27	1.7	1.53
General mean		1.42	1.38	1.45	1.38	1.74	1.52
Assessment		Poor	Poor	Poor	Poor	Good	Good
N		33	33	33	30	30	30

Mean of score (1.5), equal or more than 1.5 mean good, less than 1.5 mean poor.

This table presented that the responses of the participants in both group recorded poor related to their knowledge in the anatomy and physiology of the nervous system in their pretest the general mean(1.42), (1.38), during the post test the control group the poor level clearly, while the nurses who attend the educational program session recorded significant improvement in their two

posttest as(1.74) and (1.52). This indicated the effectiveness of the content which presented in the educational program related to this issue.

Table(4.4): Responses of the study sample(both group) related to their knowledge regarding basic communication principals.

N	Items	Control			Study		
		Pre	Post-1	Post.2	pre	Post1	Post.2
		Mean	Mean	Mean	Mean	Mean	Mean
1.	Verbal communication is essential part of	1.48	1.52	1.52	1.43	1.57	1.50
2.	The nurse should be maintain communication with the unconscious patient during	1.85	1.45	1.48	1.73	1.87	1.93
3.	Master of all senses is	1.33	1.30	1.27	1.47	1.73	1.70
4.	The nurse used task touch during caring out their work with the patients such kind of touch mean	1.73	1.76	1.61	1.63	1.43	1.40
5.	One of the following actions will promote recovery of the unconscious patient	1.67	1.73	1.70	1.73	1.93	1.97
6.	The dynamic process which used to gather data, teach and persuade, express caring and comfort is:	1.48	1.55	1.48	1.43	1.83	1.77
7.	When the nurses provide care for patients during direct contact which made there be close with 0 to 1 1/2 feet from the patient, this distance referred to	1.3	1.21	1.18	1.27	1.97	1.57

8.	Before the initial face-to-face contact, the nurse may get information such as the patient's name, age, address, medical history, and/or social background, which consider as the …communication phase.	1.3	1.30	1.27	1.3	1.80	1.57
9.	Interaction between a health care provider and a patient that enhances the patient's comfort, trust, safety, and well-being is referred to:	1.3	1.27	1.21	1.3	1.83	1.63
10	The essential core of the patient care is	1.21	1.30	1.24	1.33	1.97	1.87
11	Two- way process in communication may used as an essential part to reduce the patient anxiety and emotional stimulation, through sending message understanding and feedback this referrers to	1.61	1.58	1.64	1.57	1.77	1.80
12	Body language which includes gestures, postures, touch and physical appearance referred to	1.64	1.61	1.70	1.7	1.83	1.77
General mean		1.49	1.46	1.44	1.49	1.79	1.71
Assessment		Poor	Poor	Poor	Poor	Good	Good
N		33	33	33	30	30	30

Mean of score (1.5), equal or more than 1.5 mean good, less than 1.5 mean poor.

This table shows that the pretest of both study group recorded unsatisfied level of knowledge related to basic communication principles with the

unconscious patients as (1.49 ± 0.206), (1.49 ± 0.175). During the post test the control group shows the same poor level clearly, while the nurses who attend the educational program session recorded significant improvement in their two posttest as(1.79± 0.158) and (1.71± 0.176). This indicated the effectiveness of the content which presented in the educational program related to this issue.

Table(4.5): Responses of the study sample(both group) related to their knowledge regarding therapeutic and non-therapeutic communication.

N	Items	Control			Study		
		P re	Post-1	Post.2	pre	Post-1	Post.2
		Mean	Mean	Mean	Mean	Mean	Mean
1.	Many factors contribute as barriers of therapeutic communication such as	1.33	1.18	1.21	1.33	1.76	1.53
2.	One of the goals of therapeutic communication is	1.55	1.3	1.33	1.30	1.67	1.5
3.	Non-therapeutic communication techniques include the following	1.27	1.45	1.39	1.37	1.60	1.53
4.	Is it considered as one strategy of a therapeutic communication	1.06	1.24	1.21	1.23	1.90	1.63
General mean		1.30	1.29	1.29	1.31	1.73	1.54
Assessment		Poor	Poor	Poor	Poor	Good	Good
N		33	33	33	30	30	30

Mean of score (1.5), equal or more than 1.5 mean good, less than 1.5 mean poor.

This table shows that the pretest of both study group recorded unsatisfied level of knowledge related to therapeutic and non-therapeutic communication with the unconscious patients as (1.30), (1.31). During the post test the control group shows the same poor level clearly, while the nurses who attend the educational program session recorded significant improvement in their two

posttest as(1.73) and (1.54). This indicated the effectiveness of the content which presented in the educational program related to this issue.

Table(4:6): Responses of the study sample(both group) related to their knowledge regarding communicating with unconscious patients.

N	Items	Control			Study		
		Pre	Post-1	Post.2	pre	Post-1	Post.2
		Mean	Mean	Mean	Mean	Mean	Mean
1.	Touch should be used cautiously with patients who are	1.55	1.73	1.61	1.57	1.93	1.90
2.	Communication with unconscious patients creates injury or major harmful physiological effects on the patient.	1.91	1.64	1.85	1.77	1.93	1.97
3.	The communication barriers includes the following	1.67	1.61	1.67	1.43	1.47	1.50
4.	The most common aftermaths of coma and hospitalization in ICU for patient is	1.61	1.48	1.48	1.43	1.83	1.73
5.	The information received by unconscious patients contributes to	1.24	1.30	1.33	1.37	2	1.97
6.	Intensive care unit syndrome, which includes the following	1.18	1.39	1.33	1.47	1.7	1.57
7.	The nurse must introduce himself to the unconscious patient when providing care	1.15	1.18	1.15	1.23	1.97	2
8.	The nurse should communicate with the unconscious patient as she/ he communicate with other alert patients	1.30	1.21	1.18	1.30	2	1.93

9.	It is not necessary to inform unconscious patients of current events, such as diagnosis, treatment, medical and nursing interventions	1.12	1.12	1.06	1.17	1.83	1.87
10.	When the nurse provided nursing care of the patient, such as withdrawing fluids or changing the patient's position, she/he should:	1.27	1.27	1.48	1.27	1.97	1.97
11.	The nurse directs the unconscious patient to the time and place at least once every-------- hours	1.27	1.24	1.39	1.37	1.97	1.97
12.	Lack of communication or insufficient communication between the nurse and the unconscious patient leads to	1.12	1.09	1.42	1.33	1.9	1.93
General mean		1.37	1.36	1.41	1.39	1.87	1.86
Assessment		Poor	Poor	Poor	Poor	Good	Good
N		33	33	33	30	30	30

Mean of score (1.5), equal or more than 1.5 mean good, less than 1.5 mean poor.

This table shows that the pretest of both study group recorded unsatisfied level of knowledge related to communicating with unconscious patients as (1.37), (1.39). During the post test the control group shows the same poor level clearly, while the nurses who attend the educational program session recorded significant improvement in their two posttest as(1.87) and (1.86). This indicated the effectiveness of the content which presented in the educational program related to this issue.

Table(4.7): Responses of the study sample(both group) related to their knowledge regarding communication with patients under artificial ventilation.

N	Items	Control			Study		
		Pre	Post-1	Post.2	pre	Post-1	Post.2
		Mean	Mean	Mean	Mean	Mean	Mean
1.	There are several ways to enhance communication with ventilated patients such as:	1.18	1.27	1.24	1.13	1.60	1.67
2.	The most appropriate method of communication which preferred to use is for a patient on short-term ventilation who is alert and can move at least one hand	1.48	1.52	1.36	1.47	1.63	1.43
3.	Which of the following are alternative methods of communication for ventilator-dependent patients except:	1.33	1.48	1.18	1.40	1.33	1.37
4.	It is necessary to encourage the family of the unconscious patient to participate in patient care	1.39	1.48	1.52	1.60	1.90	1.93
5.	Visiting concept for dying patients in the critical care unit should be	1.06	1.15	1.21	1.27	1.93	1.97
6.	As the patient approaches death, it is important to continue care by the same nurse even after the shift is over	1.55	1.36	1.39	1.57	1.80	1.90
7.	Families must be allowed to be present during CPR and all respiratory procedures	1.15	1.24	1.21	1.07	1.90	1.80

8.	Unconscious patients have a great need support and information	1.06	1.18	1.03	1.13	1.63	1.63
9.	is the unconscious patients hear and understand conversations around him	1.06	1.15	1.21	1.10	1.93	1.70
10.	Nurses should speak in a normal conversational tone while providing care to unconscious patients.	1.33	1.27	1.33	1.30	1.97	1.97
General mean		1.26	1.31	1.27	1.30	1.76	1.74
Assessment		Poor	Poor	Poor	Poor	Good	Good
N		33	33	33	30	30	30

Mean of score (1.5), equal or more than 1.5 mean good, less than 1.5 mean poor.

Artificial ventilation consider one of the most tool used in the critical care unit, which act as un effective factor upon the patient physical and psychological aspect, for this reason communication in this situation is critical of the patient to maintain his comfortably and security feeling. This table shows that the pretest of both study group recorded unsatisfied level of knowledge related to Communication with patients under artificial ventilation as (1.26), (1.30). During the post test the control group shows the same poor level clearly, while the nurses who attend the educational program session recorded significant improvement in their two posttest as(1.76) and (1.74). This indicated the effectiveness of the content which presented in the educational program related to this issue**.**

Table(4.8): Responses of the study sample(both group) related to their knowledge regarding educating the patient's family.

N	Items	Control			Study		
		Pre	Post-1	Post.2	pre	Post-1	Post.2
		Mean	Mean	Mean	Mean	Mean	Mean
1.	The nurse should advise the families of unconscious patients to	1.00	1.18	1.12	1.2	1.77	1.70
2.	It is important to encourage the patient's family and friends to remain positive when visiting their unconscious patient because	1.70	1.48	1.61	1.73	2	2
3.	Visiting the family of the unconscious patient my stimulated(auditory, emotional and tactile) senses as	1.36	1.12	1.21	1.5	2	2
General mean		1.35	1.26	1.31	1.47	1.92	1.90
assessment		Poor	Poor	Poor	Poor	Good	Good
N		33	33	33	30	30	30

Mean of score (1.5), equal or more than 1.5 mean good, less than 1.5 mean poor.

This table shows that the pretest of both study group recorded unsatisfied level of knowledge related to educating the unconscious patient's family as (1.35), (1.47). During the post test the control group shows the same poor level clearly, while the nurses who attend the educational program session recorded significant improvement in their two posttest as(1.92) and (1.90). This indicated the effectiveness of the content which presented in the educational program related to this issue**.**

Table(4.9): overall the all mean of scale of knowledge for both control and study groups

Value	Control groups			Study groups		
	Pretest	Posttest1	Posttest2	pretest	Posttest1	Posttest2
Mean of scale	1.38	1.37	1.38	1.40	1.80	1.71
Stander deviation	0.229	0.184	0.193	0.184	0.175	0.214
Assessment	Poor	Poor	Poor	Poor	Good	Good

Mean of score (1.5), equal or more than 1.5 mean good, less than 1.5 mean poor.

This table show there is the nurses have poor knowledge about communication with unconscious patient for control and pretest of study group, while the nurses have good knowledge about communication with the unconscious patient after program.

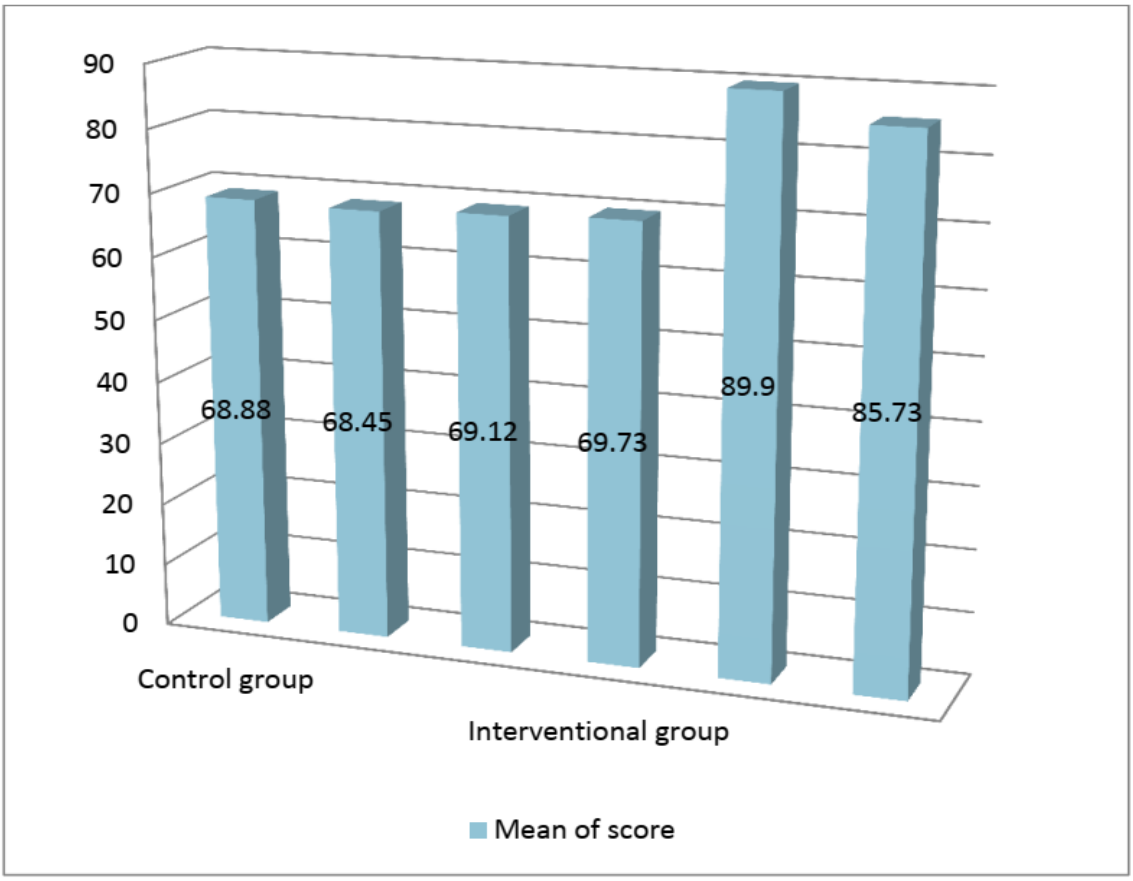
Table(4.10): overall score the nurses knowledge of the study sample(both group) related to communication with unconscious patients.

Participant	Control group			Study group		
	Pretest	Posttest1	Posttest2	pretest	Posttest1	Posttest2
Minimum of score	**63**	**62**	**62**	**65**	**78**	**76**
Maximum of score	**75**	**77**	**80**	**75**	**97**	**93**
N	**33**	**33**	**33**	**30**	**30**	**30**
Mean of score	**68.88**	**68.45**	**69.12**	**69.73**	**89.90**	**85.73**
Stander deviation	**3.638**	**3.401**	**4.748**	**3.028**	**4.037**	**4.456**
Assessment	**poor**	**poor**	**poor**	**poor**	**good**	**good**

Cutoff point (25), poor knowledge(50-74), good(75-100).

This table show the overall of nurses knowledge about communication with unconscious patient pretest for both study group recorded unsatisfied level of knowledge as(68.88), (69.73) in pretest, during the post test the

control group shows the same poor level clearly, while the nurses who attend the educational program session recorded significant improvement in their two post test as (89.90) and (85.73).



Cutoff point (25), poor knowledge(50-74), good(75-100).

Figure(4.1) overall score the nurses knowledge in both group related to communication with unconscious patient.

This figure show the overall of nurses knowledge about communication with unconscious patient pretest for both group recorded unsatisfied level of knowledge as(68.88), (69.73). during the post test the control group shows the same poor level clearly, while the nurses who attend the educational program session recorded significant improvement in their two posttest as (89.90) and (85.73).

Table(4.11): Mean of score comparing regarding pretest knowledge for (both group) control and study group.

Independent Samples T- test						
Groups	N	Mean	SD	SD/error mean	P. value	assessment
Control	33	68.88	3.638	.633	.221	N.S
Study	30	70.00	3.553	.649		

This table shows the comparison between pretest knowledge for both control and study group, there is no significant differences between responses of control and study group for pretest(P value=.221).

Table(4.12): Analysis of variance (ANOVA) test for nursing knowledge about communication with unconscious patient for study group

ANOVA						
Between Groups	Sum of Squares	Df	Mean Square	F	Sig.	assess
	6800.556	2	3400.278	225.058	.001	H.s
Within Groups	1314.433	87	15.108			
Total	8114.989	89				

This table show high significant differences between pretest and posttest 1, and posttest 2, for nurses knowledge regarding to communication with unconscious patient at p- value 0.001.

Table(4.13): Analysis of variance (ANOVA) test for nursing knowledge about communication with unconscious patient for control group

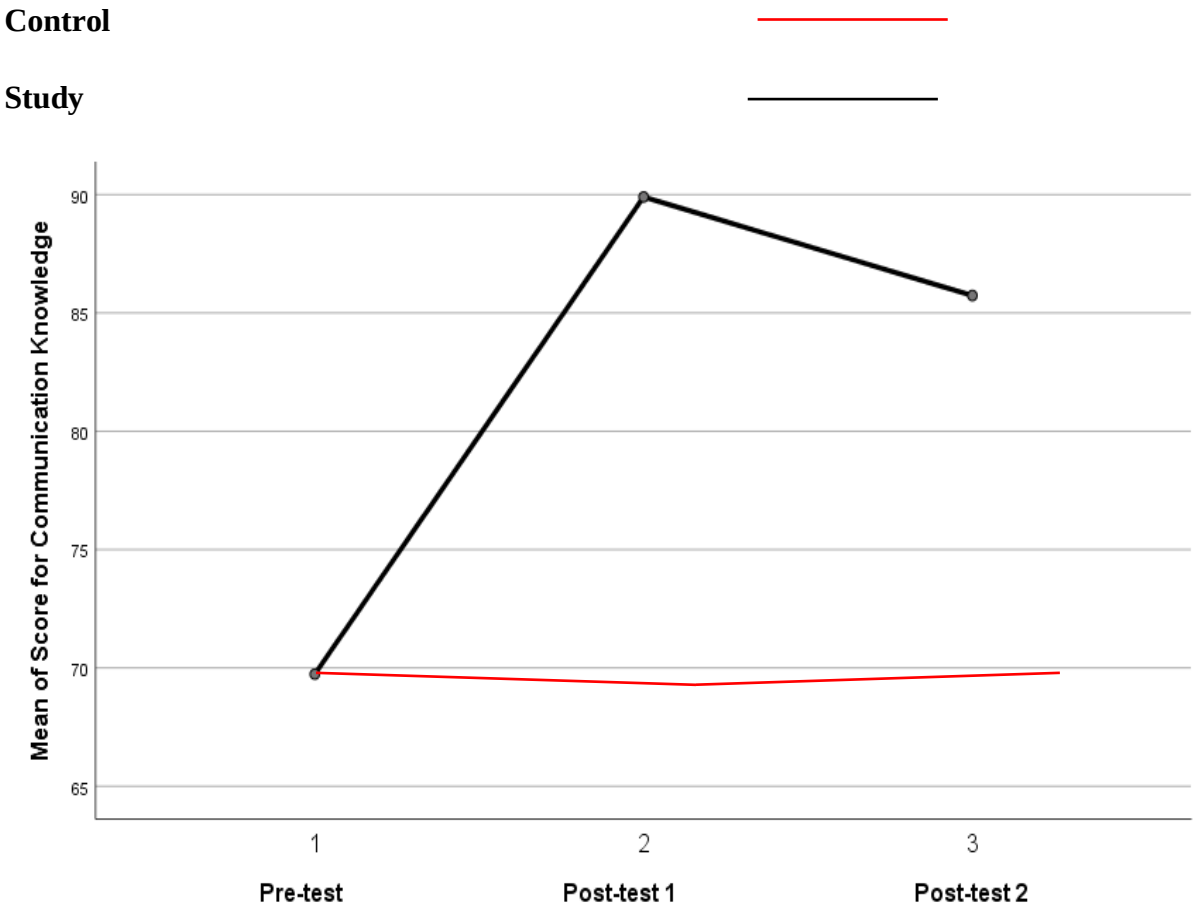
ANOVA						
	Sum of Squares	Df	Mean Square	F	Sig.	assess
Between Groups	7.515	2	3.758	.238	.789	N.S
Within Groups	1515.212	96	15.783			
Total	1522.727	98				

This table show non-significant differences between pretest and posttest 1, and posttest 2, for nurses knowledge regarding to communication with unconscious patient at p- value 0.789.

Table(4.14): Mean of score comparing regarding pretest and posttest1 knowledge for study group.

Paired Samples Statistics							
	Mean	N	Std.	Std. Error Mean	df	sig	assessment
Post-test Study Knowledge	89.90	30	4.037	.737	29	0.001	H.S
Pre-test Study Knowledge	69.73	30	3.028	.553			

This table shows the comparison between pretest and posttest 1knowledge for study group, there is a significant differences between pre and posttest 1for study group (P value= 0.001).



Figure(4.2) estimated marginal knowledge mean for both group.

Figure(1) show changes in the levels of the nursing knowledge about communication of unconscious patients in (both groups) control and interventional through the three phases of pre- test, posttest1, and posttest2.

Table (4.15): Association between nursing knowledge for control group and demographical characteristics .

Demographic characteristic	Chi-square	Df.	P- Valuee	Assessment
Age	111.535	5	.183	N.s
Gender	10.817	1	.459	N.s
Educational status	8.250	3	.691	N.s
Marital status	12.982	1	.295	N.s

The result in this table show that non-significant relationship found between nurses knowledge and demographical characteristic for control group.

Table(4.16): Association between nursing knowledge for interventional group and the demographic characteristic.

Demographic characteristic	Chi-square	d. f	P- Valuee	Assessment
Age	67.633	5	.624	N.s
Gender	8.254	1	.509	N.s
Educational status	21.528	3	.761	N.s
Marital status	11.538	1	.241	N.s

The result in this table show that non-significant relationship found between knowledge and nurses demographical characteristic for study group.

Table(4.17) Responses of study sample(both group) related to nurses practice during communication with unconscious patient.

N	Items	Control			Study		
		Pre	Post-1	Post.2	pre	Post-1	Post.2
		Mean	Mean	Mean	Mean	Mean	Mean
1.	Calling the patient by name	1.00	1.00	1.00	1.00	2.83	2.83
2.	Greeting the patient	1.00	1.00	1.00	1.00	2.47	2.47
3.	Introducing herself/himself to the patient	1.00	1.00	1.00	1.00	2.43	2.43
4.	Providing privacy	2.27	2.27	2.27	2.17	2.80	2.83
5.	Giving Therapeutic touch while calling/caring	1.00	1.00	1.00	1.00	2.87	2.87
6.	Orienting the patient about day and time/place	1.00	1.00	1.00	1.00	2.13	2.13
7.	Explaining the procedure to the patient	1.00	1.00	1.00	1.00	2.43	2.40
8.	Uses appropriate non-technical language	1.00	1.00	1.00	1.00	2.50	2.50
9.	Communicating with the patient while performing procedures	1.00	1.00	1.00	1.00	2.50	2.53
10.	Informing the patient about his/her near and dear ones	1.00	1.00	1.00	1.00	2.31	2.33
11.	Uses verbal and non-verbal communication free of abuse with patients and their families	3.00	3.00	3.00	3.00	3.00	3.00
12.	Communicating with hopeful word about the progress patient	1.00	1.00	1.00	1.00	2.67	2.70
13.	Maintains an environment	1.91	1.76	1.73	1.80	2.60	2.57

	feasible for effective communication - a noise-free environment						
14.	Communicates respectfully and professionally with family members	3.00	3.00	3.00	3.00	2.90	2.87
15.	Communicates according to stages of development	1.00	1.00	1.00	1.00	2.33	2.30
16.	Communicates according to cultural background	1.00	1.00	1.00	1.00	2.00	1.97
17.	Use short, simple words and sentences	1.00	1.00	1.00	1.00	2.77	2.77
General mean and SD		1.36	1.35	1.35	1.35	2.55	2.55
Assessment		never	never	never	never	always	always

Cut of point(.66) from (1-1.66) never, (1.67- 2.33) sometime, (2.34-3) always.

This table show there is the nurses not communicate with unconscious patient for control and pretest of study group, while the nurses always communication with the patient after program.

Table(4.18): Overall score for practice for study sample (both group).

	Control group			Study group		
	Pre	**Post1**	**Post2**	**Pre**	**Post1**	**Post2**
Minimum of score	22	22	22	21	37	37
Maximum of score	24	24	24	24	51	51
N	33	33	33	30	30	30
Mean of score	23.03	23.00	23.07	22.97	43.33	43.37
Stander deviation	.683	.728	.661	.964	3.565	3.567
Assessment	**Never**	**Never**	**Never**	**Never**	**Always**	**Always**

This table shows that the pretest of both study group recorded unsatisfied level of practice related to communication with the unconscious patients as (23.3 _+ 0.683), (22.97 _+ 0.964). During the post test the control group shows the same poor level clearly, while the nurses who attend the educational program session recorded significant improvement in their two posttest as(43.33_+3.565) and (43.37_+ 3.567). This indicated the effectiveness of the content which presented in the educational program related to this issue.

Table(4.19): Analysis of variance(ANOVA) test for nursing practice for communication with unconscious patient for control group.

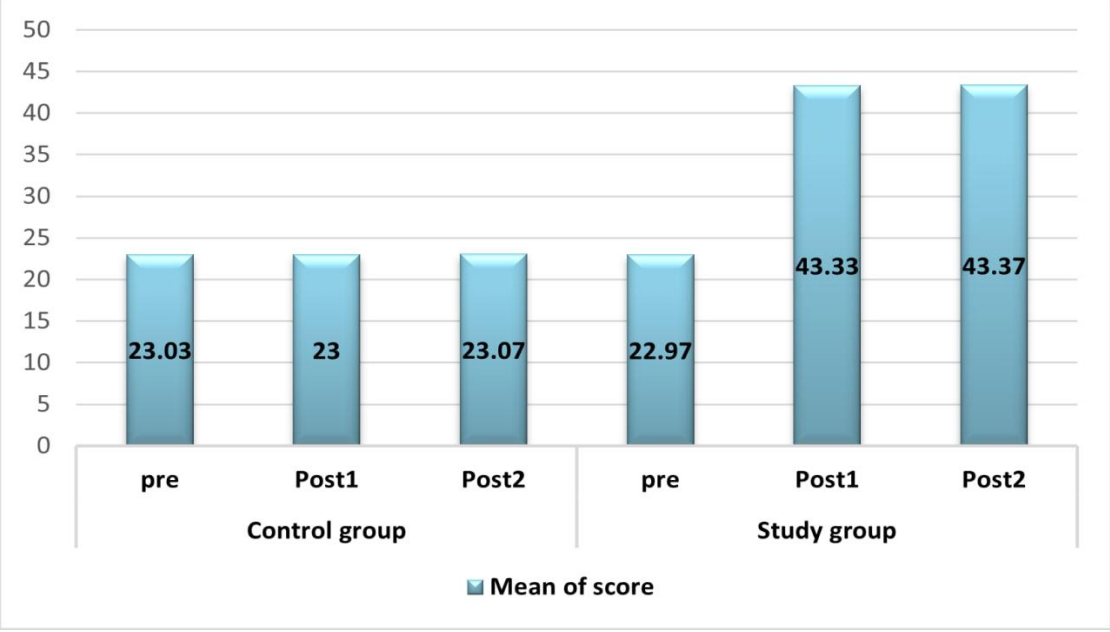
ANOVA						
Between Groups	**Sum of Squares**	**Df**	**Mean Square**	**F**	**Sig.**	**assess**
	.626	2	.313	.655	.522	N.s
Within Groups	45.879	96	.478			
Total	46.505	98				

This table show non- significant differences between pretest and posttest 1, and posttest 2, for nurses practice regarding to communication with unconscious patient for control group at p- value 0.522.

Table(4.20): Analysis of variance(ANOVA) test for nursing practice for communication with unconscious patient for study group.

ANOVA						
	Sum of Squares	df	Mean Square	F	Sig.	Assess
Between Groups	8309.622	2	4154.811	472.755	.001	H.S
Within Groups	764.600	87	8.789			
Total	9074.222	89				

This table show high significant differences between pretest and posttest 1, and posttest 2, for nurses practice regarding to communication with unconscious patient for study group at p- value 0.001.



Cut of point(.66) from (1-1.66) never, (1.67- 2.33) sometime, (2.34-3) always.

Figure(4. 3) estimated marginal practice mean for both group.

Figure(1) show changes in the levels of the nursing practice about communication with unconscious patients in interventional group through the three phases of pretest, posttest1, and posttest2, while the control group not changes.

Table(4.21): Association between nurses practices for the control group and the demographic characteristics.

Demographical characteristic	Chi-square	d. f	P- Valuee	Assessment
Age.	16.875	10	.532	N.s
Gender	15.098	2	.001	H.s
Educational status	1.707	6	.426	N.s
Marital status	.320	2	.852	N.s

This table presented that there no- significant relationship connected between practice and nurses demographical characteristics for control group except gender which recorded high significant.

Table(4.22): association between nursing practice for interventional group and the demographic characteristic.

Demographical characteristic	Chi-square	Df	P- Valuee	Assessment
Age	40.448	10	.019	S
Gender	11.992	2	.007	H.s
Educational status	12.014	6	.213	N.s
Marital status	.172	2	.982	N.s

The results in this table recorded significant relationship connected between nurses practice, and age for interventional group, while no significant relationship founded with gender, educational qualification and marital status

Table (23) Relationship between knowledge and practice of critical nurses communication with unconscious patient for study sample(both group).

	N	Person correlation	P-value	Assessment
Interventional	30	.875	0.001	H.s
Control	33	.153	.130	N.s

This table show the high significant between knowledge and practices related to interventional group, while no significant relation founded for control group.

Chapter Five

Discussion

Chapter Five

Discussion

The following chapter discuss the results of the study

Part I: The demographical data of study sample:

The result that presented in table (1) show the equivalence of the study sample (both group) in their demographical characteristics as most of participants 11(33.3%) and 13(43.3%) in both group were between (25-26) years old, 18(54.5%), 19(63.3%) were male, most of them bachelor holder, related to their marital status 17(51.5%) in the control group were married, while 17(56.7%)in the interventional group were single.

This results agree with a study which carried out on critical care unit nurses in st. John's medical college hospital the results revealed that the majority of the nurses (92%) between (22-29) years old (Thomas, 2006). Ayuso-Murillo *et al*., 2017, found that most of the nurses who work in the critical care unit were female (89.6%), who find that female nurses have well skills than male when it comes to listening to professional and personal problems, in addition to making good environment that promotes exchange, participation and communication. Na'el K, & Mohammed, W. K, 2019, found that most of the ICU nurses who provide direct care for patients in Al- Hilla teaching hospital were male, because of long time duty and overload hardworking made the female nurses prefer to work in the general units.

The result in table (1) go a line with the study which carried out to evaluate the effects of humanistic knowledge and communication skills on professional quality of life in the critical care unit nurses, the study found

out that most of the nurses (77.6%) were single and (77.7%) were with bachelor education (CHO *et al*., 2020).

Part two: Employment information

Table (2) showed that the most of the control group members 20(60.7%) were with (1-2) years of experience in the ICU, 23(76.6%) of interventional group were within (1-2) years of experience in the ICU. All the participant(both group) didn't attend any specific course related to communication skill with unconscious patients, 30(90.9%), 23(76.7%).

This finding go a line with Dawood & Hassan, 2018, who demonstrated in their quoin 2 experimental study that the years of nurses experience in the ICU was (62.5%) and (56%) were between (1-5) years in both group. While most nurses in the CCU recorded between (1-5) years of experience.

Most of hospitals prefer to assign your nursing to work in the critical care unit related to working overload and multiple responsibilities which can be carried by them easily.

Part three: knowledge of nurses related to unconscious patient communication:

Table (3) presented that the responses of the participants in both group recorded poor in level related to their knowledge to anatomy and physiology of the nervous system in their pretest, during the two posttest the control group responses recorded poor level clearly, while the nurses who attend the educational program session recorded significant improvement in their two posttest.

Our result agree with Thomas, D. (2006, who Find that the pretest of the nurses related to the anatomy for the CNS show unsatisfactory level,

the nurses knowledge recorded high mean score in their posttest, which indicate the effectiveness of the training program.

Table(4) Responses of the study sample related to their knowledge regarding basic communication principals. This table shows that the pretest of both study group recorded unsatisfied level of knowledge related to basic communication principles with the unconscious patients as (1.49 _+ 0.206), (1.49 _+ 0.175). Also the post test of the control group shows the same poor level, while the nurses who attend the educational program session recorded significant improvement in their two posttest as(1.79_+0.158) and (1.71_+ 0.176), this indicated the effectiveness of the content of the educational program related to this issue, this change stand after the presentation of the educational program sessions.

This results supported by Khatib Zanjani & Moharreri, 2012, who carried out a study to "assess the nurses' knowledge and awareness of effective verbal communication skills", in Iran they find out that nurses knowledge related to verbal communication skills recorded poor level, the finding recorded only (36%) of them shows interest related to listening skill. Every day conversation sharing information explain emotions consider a cornerstone in nursing practice (Khatib Zanjani & Moharreri, 2012).

A study entitled "Effect of the planned therapeutic communication program on therapeutic communication skills of pediatric nurses" in Egypt revealed that pretest and posttest knowledge of nurses in therapeutic communication about the Basic elements of communication process shows that more than (53.8%) of nurses with poor knowledge in pretest while posttest show that more than (62.9%) increase their knowledge about therapeutic communication, Following the implementation of a designed therapeutic communication program, the pediatric nurses skills and

knowledge in therapeutic communication with the child patients in hospitalize improved significantly, for this reason they recommendation that pediatric nurses should continue to use programs about therapeutic communication to create trust, foster, healthy interactions, safe and assistance in the recovery of the children in the hospitals (Younis et al., 2015).

Table(5) Responses of the study sample(both group) related to their knowledge regarding therapeutic and non-therapeutic communication.

The finding in table (5) shows that the pretest of both study group recorded unsatisfied level of knowledge related to therapeutic and non-therapeutic communication skills with the unconscious patients as (1.30 _+ 0.120), (1.31 _+ 0.056). During the post test the results didn't show any change for control group, while the nurses who attend the educational program session recorded significant change through their two posttest as(1.73_+0.129) and (1.54_+ 0.056). This finding indicated that the educational program sessions it positively and improve the nurses knowledge.

This finding was supported by Prasad & George, 2014, who find that the majority of staff nurses (92 %) had inadequate knowledge regarding therapeutic communication on pre-test, whereas (8%) of them had average knowledge.

This result also go a line with Yoo *et al*., 2020, whom revealed that communication and nursing are related communication is difficult when caring for patient in critical care unit, the therapeutic communication consider essential for the patients' and their families' well-being. In an critical care unit, communication foundation of trust and experience is a crucial factor in enhancing patients' perceptions of their illnesses.

Table(6) Responses of the study sample(both group) related to their knowledge regarding communicating with unconscious patients.

Results in table (6) shows that the pretest of both study group recorded unsatisfied level of knowledge related to communicating skills with unconscious patients as (1.37 _+ 0.254), (1.39 _+ 0.160). During the post test the control group shows knowledge deficit, while the nurses who attend the educational program session (interventional group) recorded significant improvement in their two posttest as(1.87_+0.154) and (1.86_+ 0.167). This indicated that the effectiveness of the content which presented in the educational program related to communication strategies which can be use for.

Ebi is a nursing student who works at a hospital committed to education. She views therapeutic communication as her responsibility and attempts to perform her duties, but she finds it extremely difficult to communicate with unconscious patients. She believes that patients should be left alone, despite her clinical training, because they are unconscious and cannot hear her compassionate behavior. Therefore, she rarely speaks with patients, and since they do not respond to her questions and greetings, she will no longer communicate with unconscious patients. She performs her duties with solely stress-free patients (Victor Obosinde Adika, 2021).

Most of the healthcare providers who provide direct care to the unconscious patient believe that the patient loss all their sense for this reason communication discontinued and become poor.

Artificial ventilation consider one of the most tool used in the critical care unit, which act as un effective factor upon the patient physical and psychological aspect, for this reason communication in this situation is critical of the patient to maintain his comfortably and security feeling.

Table (7) shows that the pretest of both study group recorded unsatisfied level of knowledge related to communication with patients under artificial ventilation as (1.26 _+ 0.181), (1.30 _+ 0.197). During the post test the control group shows the same level of knowledge, while the nurses who attend the educational program session recorded significant improvement through their two posttest as(1.76_+0.206) and (1.74_+ 0.216).this results indicated clearly the effectiveness of the educational session which presented for the interventional group members, the scientific content play as a positive factor to enhance nurses knowledge regarding communication strategies which may be used during their day- work with patients undergoing artificial ventilation supported .

According to Momennasab et al., 2019, they revealed that challenges in communicating and understanding the patients, the nurses avoided contact with mechanically ventilated patients. the nurses avoid to contact with difficult and critical patient, there are many factors that make the nurses to avoid the communication with patient such as lack of communication training skill, no present of communication aid, and heavy workload. The important factors that pushed intubated patients to communicate were their basic physical needs, pain, and discomfort.

Because of the link to mechanical ventilation (MV), patient- nurse communication is limited during the critical phase, and the therapeutic effort is focused on saving lives. Implementing communication skills training enhances clinical performance while also lowering patient stress and anxiety (Espinoza-Caifil et al., 2021).

According to Langlume et al., 2017, the finding revealed that when “assess the ability of families of critically ill patients and the critical care team caring for the patient to accurately communicate and identify patient complaints” found insomnia, pain , difficulty to speaking, thirst, existence

of the endotracheal tube play as the most common symptoms during this period. Because of the workload, lack of time, and communication tools, so the patient is rated as unsatisfactory related to communication.

Table (8) shows that the pretest of both study group recorded unsatisfied level of knowledge related to family communication principles which may used with unconscious patient, as (1.35 _+ 0.348), (1.47 _+ 0.265). During the post test the control group shows knowledge deficit, while the nurses who attend the educational program session recorded significant improvement in through their two posttest as(1.92_+0.132) and (1.90_+ 0.173). this finding cleanly indicated the effectiveness of the education program sessions on the nurses knowledge.

According to Yoo HJ, et al., 2020, families of severely ill patients are fearful and anxious about their loved ones' health, and they want to save them. As a result, nurses must take this into account while interacting with vulnerable patients and their families, as well as aggressively identify and treat sources of discomfort in patients on mechanical breathing (e.g., using suitable sedatives/ analgesics and disconnecting the ventilator). Furthermore, according to the review, the electronic communication devices allow for effective communication with critically sick patients by eye blinks or touch.

Kynoch et al., 2016, suggested that communication interventions improve parental participation in caring for the ICU patient, facilitate their decision-making abilities, and enhance their interactions with medical staff.

Table (9), which presented overall the all mean of scale of knowledge for both control and study groups, show poor knowledge about communication with unconscious patient for control and pretest of interventional group, while the nurses knowledge about communication

with the unconscious patient after involvement in the educational program session recorded significant changes .

Nurses show little interest in speaking with unconscious critically sick patients of knowledge about communication methods which should be take place during management protocol (Thakur et al., 2016), according to nursing theories which explain the importance of maintaining communication with patients consider a cornerstone in nursing practice which enhance feeling of security and safety for patient and enhance healing process. Related this issue communication protocol should be developed.

Critical care unit now have a organized education structure in place for nurses that focuses on therapeutic techniques such as ventilation, aspiration, mechanical, extracorporeal membrane oxygenation and hemodynamic monitoring, though, they deficiency a program that attentions on effective therapeutic communication with caregivers and patients. Without this supplementary program, nurses' communication problems will continue; therefore, its implementation is crucial to improving nursing quality of care and patient satisfaction. Additionally, rather than imposing unilateral effort on critical care nurses, nurse management must attention to their emotional well-being and build methods to avoid burnout, for example volunteer counseling systems or strategies to "refresh" nurses, as soon as possible (Yoo et al., 2020).

According to Adams et al., 2017, overall, the workshop that was used to study “evaluate the effectiveness of a one day interactive educational workshop in improving complex communication skills, ethical and legal knowledge and comfort levels” was has been shown to be an effective way

for healthcare providers to establish their skills and confidence in End-of-life communication, as well as their knowledge of ethics and the law.

Farmanbar & Hosseinzadeh, 2018, stated that is very important the teaching communication skills to nursing students. It appears that providing a conducive environment to modify the curriculum to increase students' communication skills is beneficial.

Table(11) present the comparison between the study sample (both group) knowledge , the results of the pre- test recorded , there is no significant differences between responses of control and interventional group through their pretest by using independent samples test (P value=.221). This finding supported by Zare et al., 2020. This research examines Therapeutic Communication Skills Training: An Effective Tool for Improving ICU Caregiver Behaviors. In the pretest, there were no significant differences in the nurses' caring behaviors between the control and intervention groups (P = 0.148).

Table (12) show high significant differences between pretest and two posttest of the interventional group, related to nurses knowledge regarding to communication with unconscious patient at p- value 0.001.

This result agree with the finding of the study carried out by Padmavathi & Rajasankar, 2013, whom find that there was a significant difference found in the knowledge of the staff nurses regarding communicating with an unconscious patient between the pre-test and post-test scores Thus, the significance of the post-test knowledge score was greater than the significance of the pre-test score. It's easy to see that the self-instructional Module is effective because of this difference in the stats.

According to Saleh & Ragab, 2021, who carried out a study entitled as(Effect of Communication Competence Program on Nurses' Self-

Advocacy) show the highest means scores were recorded during post intervention of the program and a high significant variances between studied nurses on pre, posttest which follow up intervention related to all communication competencies dimensions P<0.001, significant differences in nurse's quality of communication skills after intervention.

Table(13) analysis of variance (ANOVA) test for nursing knowledge about communication with unconscious patient for Control Group

This table show non-significant differences between pretest and posttest 1, and posttest 2, for nurses knowledge regarding to communication with unconscious patient at p- value 0.789.

Table (15 and 16) show there is non- significant relationship between knowledge and nurses demographical characteristic for (both group). This similar to Padmavathi & Rajasankar, 2013, they found there is no significance association between the knowledge of staff nurses regarding communication with unconscious patient and marital status, gender, qualification religion, area of working critical care unit & Experience in critical care unit.

Finding in table (17) which presented critical care nurses (both group) responses related to their practices of communication with unconscious patient shows unsatisfactory level of practice among both group member in their pre- test, while significant change indicated in nurses practices after their attendance to the educational sessions.

Communication between the nurse and the patient is difficult. The nurses are alert for communication strategies (non- verbal), poor communication skills in clinical setting. Patients' psychological and physiological needs must be conveyed effectively in order to create an acceptable treatment plan. Effective communication interventions require

training and planning on suitable strategies(Dithole et al., 2016), (Espinoza-Caifil et al., 2021).

Communication with ventilated patients is difficult for nurses, and this ability needed to learn so that all nurses can communicate successfully with patients on ventilators (Dithole et al., 2016).

Table(18) presented the overall score for practice for study sample (both group), the result shows that the pretest of both study group recorded unsatisfied level of practice related to communication with the unconscious patients as (23.3 _+ 0.683), (22.97 _+ 0.964). During the post test the control group shows the poor level practice, while the nurses who attend the educational program session recorded significant improvement through their two posttest as(43.33_+3.565) and (43.37_+ 3.567). This indicated the effectiveness of the content which presented in the educational program.

Radtke et al., 2012, shows change and increase attitude and practice of nurses participant regarding to communication with nonspeaking ICU patient after basic skill training. Also Happ et al., 2014, say the communication training may improve nurses' communication skills.

According to Dawood & Hassan., 2018, who reported that the nurses practice shows significant improvement after attendance of specific educational sessions which directed to therapeutic communication skills strategies which may used during nursing intervention in the critical care units context.

Badiyepeymaiejahromi et al., 2018, reported that communication skills quality of nurses was weak (55.8%), moderate (44.2%), and (0%) consider bad evaluation. Most nurses related to communication skills show weak for conscious start (75.8%), non- verbal and verbal communication methods (86.5%), external, internal organization principle (92.6%),

showing respect for patients (94.4%) with absolute acceptance of patients (100%).

The results which find by Badiyepeymaiejahromi et al., 2018, shows that nurses' ability to communicate with patients is limited. Teaching communication skills, and also reorganizing management, defining job responsibilities, improving job independence, and giving nurses additional decision-making power, appear to be effective approaches to increase patient- nurse communication and therefore improve patient care quality. It also appears to be critical that nursing educators and authorities change present programs and place a greater emphasis on improving nursing students' communication skills in clinical and academic settings in an objective manner, in order recorded effective changes and increase the future nurses communication competences.

Most nurses felt improving their communication skills, as evidenced by post-survey scores. This result may be related to most of staff before program has difficult to communicate effectively with their patient and peers but after the program learn more communication competences which help them to improve their skills in the work place (Baer & Weinstein, 2018).

The highest percentage of the study sample 78.6% has low communication competencies pre study, 73.8% and 90.5% has moderate competencies as regard to post and follow up respectively (Saleh & Ragab, 2021).

The results in table (19 and 20) shows the level of nurses practices, for control group no significant differences recorded among the pretest and two post test., which significant recorded among the pre and two post test of the interventional group who assigned to attend the educational sessions.

Dawood & Hassan, 2018, find that nurse's contact with CCU patients scores were low in most of the pretest items, but they quickly improved

when the program was implemented. When comparing posttest nurses' practices between the interventional and control groups, it was discovered that there was a statistically significant difference recorded between the values of the nurses' practices in CCU, with the interventional group significantly higher than the control group at P0.001. The interventional group's mean scores were higher than the control group's.

Mahmoud & Hassan (2018) they showed that, there was significant improvement in communication and empathetic skills for nurses' after implementing the training.

Table(21) Association between nursing practice for control group and their demographical characteristic .

This table shows non- significant relationship between practice and demographical characteristic except the gender there is significant for control group.

There were no significant correlations between the marital status, work experience, age, workplace satisfaction, job interest, childbirth experience, or life satisfaction and communication skills. While finding which presented by Brunero et al., 2010, reported that nurses communication skills competences was influenced by many factors such as age and gender.

Table(22) association between nursing practice for interventional group and their demographic data.

This table shows that there is a significant relationship between practice and age and gender, for study group, while non- significant related to educational status, and marital status.

There was non- significant relationship between the nurses' communication skills and age, position, education or marital status, which

was steady with the finding that done by Ahmadi et al., 2013 and Amiri et al., 2013, while the finding of Barati et al., 2012, find that there was a significant relationship between the gender, age, education, work experience, employment status, place of work, and nurses' communication skills. Gholami et al., 2015, find that a significant relationship between the education, age, and position and nurses' communication skills (Gholami et al., 2015)

Table (23) Relationship between knowledge and practice of critical nurses communication with unconscious patient for study sample(both group).

This table show the high significant between knowledge and practice related to interventional group, while non-significant for control group.

As the finding which presented in the tables and analysed in chapter four and five the researcher accept the hypothesis which estimated a significant relationship between nurses practices, knowledge and the educational program. The tabled data clearly reported that the educational program play as effective factor which at positively to improve nurses communicable competence.

Chapter Six

Conclusion& Recommendation

Chapter six

Conclusions

Conclusions of the study regarding to the presented results are the following:

Most of the participant in the both group recorded unsatisfied level of knowledge in pretest.

overall nurses knowledge and practice for the participants (both group) recorded unsatisfactory level for all communication skill domains through their pre- test. While significant differences found among interventional group members through the first and second post- test, the content of the education program act as a positive factor to improve the knowledge and practice. The research finding reject the hypotheses which directed to show no significant relationship between the educational program and nurses knowledge and practices. The results show significant difference in nursing knowledge and practices before and after attendance of the educational program.

As general there is non- significant relationship found between the critical care unit nurses knowledge and their demographical characteristics(age, gender, marital status, and educational qualification). The statistical findings fail to reject hypothesis which directed to investigate how demographical data of the participants affect their knowledge.

while significant relationship founded between control group gender and practice, also significant relationship founded between interventional group age, gender, and practices.

Recommendations

1- Special instructional booklets prepared to increase nurses knowledge regarding communication skills with unconscious patient.
2- Establish continuous educational sessions to enhance nurses knowledge toward communication process, strategies as a tool to provide optimal care for the patient and lover his/ her family members.
3- Further studies may be carried out to assess healthcare providers knowledge and practices related to therapeutic communication skills in the health setting

References

References

- Abbasi, M., Mohammadi, E., & SHEAYKH REZAYI, A. (2009). Effect of a regular family visiting program as an affective, auditory, and tactile stimulation on the consciousness level of comatose patients with a head injury. *Japan Journal of Nursing Science*, *6*(1), 21-26.
- Abbate, C., Trimarchi, P. D., Basile, I., Mazzucchi, A., & Devalle, G. (2014). Sensory stimulation for patients with disorders of consciousness: from stimulation to rehabilitation. Frontiers in Human Neuroscience, 8, 616.
- Abraham, S. (2011). Fall prevention conceptual framework. *The Health Care Manager, 30,* 179–184.
- Achury Saldaña, D. M., Pinilla Alarcón, M., & Alvarado Romero, H. (2015). Aspects that facilitate or interfere in the communication process between nursing professionals and patients in critical state. Investigación y educación en enfermería, 33(1), 102-111.
- Adams, A. M. N., Mannix, T., & Harrington, A. (2017). Nurses' communication with families in the intensive care unit–a literature review. Nursing in critical care, 22(2), 70-80. https://doi.org/10.1111/nicc.12141 PMID: 25583405.
- Adika, V. O. (2020). Unconscious Patients Related Therapeutic Communication of Nurses: A Concept Analysis.
- Agarwal, P., Warner, M. B., Reichner, C., & Lazarous, D. G. (2014). Marino's the ICU book. Annals of the American Thoracic Society, 11(6), 999-999.
- Ahmadi A, Ahmadi M, Elyasi F, Ahmadi A, Ahmadi N (2013) The relationship of occupational burnout and communication skills in nurses. J Mazandaran Univ Med Sci 23(106):130–139.

- Alaparthi, G. K., Gatty, A., Samuel, S. R., & Amaravadi, S. K. (2020). Effectiveness, safety, and barriers to early mobilization in the intensive care unit. *Critical Care Research and Practice*, *2020*.
- Alashram, A. R., Annino, G., Aldajah, S., Bani Hamad, S., Aliswed, B., & Padua, E. (2020). Effects of sensory stimulation on level of consciousness in comatose patients after traumatic brain injury: a systematic review. *Physiotherapy Practice and Research*, *41*(2), 143-153.
- Albagawi, B. S., & Jones, L. K. (2017). Quantitative exploration of the barriers and facilitators to nurse-patient communication in Saudia Arabia. *Journal of Hospital Administration*, *6*(1), 16.
- Alexander, M. F., Fawcett, J. N., & Runciman, P. J. (2006). Nursing practice: hospital and home. Churchill Livingstone.the Adult 3rd Ed; p.p.965-83.
- Ali, b. (2016). *Assessment of Nurses Knowledge Regarding Care of Unconsciousness Patients in El-mak Nimer University Hospital* (Doctoral dissertation, جامعة شندي).
- Ali, M. (2018). Communication skills 3: non-verbal communication. *Nursing times*, *114*(2), 41-42.
- Alligood, M. R. (2017). *Nursing theorists and their work-e-book*. Elsevier Health Sciences..
- Amiri, H., Sadeghi Sharme, M., Karimi Zarchi, A., Bahari, F., & Binesh, A. (2013). Effectiveness of Solution-Focused Communication Training (SFCT) in nurses' communication skills. *Journal Mil Med*, *14*(4), 271-278.
- Amoah, V. M. K., Anokye, R., Boakye, D. S., Acheampong, E., Budu-Ainooson, A., Okyere, E., ... & Afriyie, J. O. (2019). A qualitative assessment of perceived barriers to effective

therapeutic communication among nurses and patients. *BMC nursing*, *18*(1), 1-8.

- Arslan, S., & Nadiye, Ö. Zer (2010). Complementary Treatments For Sensory Input Problems Of Icu Patients. *Anatolian Journal of Nursing and Health Sciences* , *13* (2), 68-75.
- Asadi-Noghabi, A. A., Gholizadeh, M., Zolfaghari, M., Mehran, A., & Sohrabi, M. (2015). Nurses use of critical care pain observational tool in patients with low consciousness. *Oman Medical Journal*, *30*(4), 276.
- Ayuso-Murillo, D., Colomer-Sanchez, A., & Herrera-Peco, I. (2017). Communication skills in ICU and adult hospitalisation unit nursing staff. *Enfermería Intensiva (English ed.)*, *28*(3), 105-113.
- Badiyepeymaiejahromi, Z., Ramezanli, S., Farzaneh, M., & Torabizadeh, C. (2018). Quality of Communication skills of nurses worked at the Hospitals Affiliated to Jahrom University of Medical Sciences, Iran. *Bangladesh Journal of Medical Science*, *17*(2), 275-281.
- Baer, L., & Weinstein, E., (2018): Improving Oncology Nurses' Communication Skills for Difficult Conversations. Oncology Nursing Society. Unauthorized reproduction, in part or in whole, is strictly prohibited.. Clinical Journal of Oncology Nursing • Volume 17, Number 3.
- Bani Younis, M., Hayajneh, F., & Alshraideh, J. A. (2021). Effect of noise and light levels on sleep of intensive care unit patients. *Nursing in Critical Care*, *26*(2), 73-78.
- Barati, M., Afsar, A., & Ahmadpanah, M. (2012). Assessment of communication skills level among healthcare

practitioners. *Avicenna Journal of Clinical Medicine*, *19*(1), 62-69.

- Barr J, Fraser GL, Puntillo K, Ely EW, Gélinas C, Dasta JF, et al; Barr, J., Fraser, G. L., Puntillo, K., Ely, E. W., Gélinas, C., Dasta, J. F., ... & Jaeschke, R. (2013). American College of Critical Care Medicine Clinical practice guidelines for the management of pain, agitation, and delirium in adult patients in the intensive care unit. *Crit Care Med*, *41*(1), 263-306.
- Bartuševičienė, I., & Šakalytė, E. (2013). Organizational assessment: effectiveness vs. efficiency. *Social Transformations in Contemporary Society*, *1*(1), 45-53.
- Bauer, Z. A., De Jesus, O., & Bunin, J. L. (2019). Unconscious Patient.
- Baumgarten, M., & Poulsen, I. (2015). Patients' experiences of being mechanically ventilated in an ICU: a qualitative metasynthesis. Scandinavian journal of caring sciences, 29(2), 205-214.
- Bello, O. (2017). Effective communication in nursing practice: A literature review.
- Berman, A. T., Snyder, S., & Frandsen, G. (2015). *Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice (10th) Edition*.
- Bersten, A. D., & Handy, J. (2013). *Oh's Intensive Care Manual E-Book*. Elsevier Health Sciences.p-525.
- Bickmore, T. W., Fernando, R., Ring, L., & Schulman, D. (2010). Empathic touch by relational agents. *IEEE Transactions on Affective Computing*, *1*(1), 60-71.
- Borg, J. (2012). *Body Language: How to know what's REALLY being said*. Pearson UK.

- Börner, K., Boyack, K. W., Milojević, S., & Morris, S. (2012). An introduction to modeling science: Basic model types, key definitions, and a general framework for the comparison of process models. In *Models of science dynamics* (pp. 3-22). Springer, Berlin, Heidelberg.
- Boukje DM, Gamel C, Van Der Bijl JJ, Bots ML, Kesecioglu J. The effects of music on physiological responses and sedation scores in sedated, mechanically ventilated patients. Journal of clinical nursing. 2010;19(7-8):1030- 9.
- Brunero, S., Lamont, S., & Coates, M. (2010). A review of empathy education in nursing. *Nursing inquiry*, *17*(1), 65-74.
- Buhler-Wilkerson, K., & D'Antonio, P. (2020). Nursing. Encyclopædia Britannica.
- Burton, M. A., & Ludwig, L. J. M. (2014). *Fundamentals of nursing care: concepts, connections & skills*. FA Davis.
- Cherry, K, (2021). Types of Nonverbal Communication.
- CHO, G. Y., Ha, M. N., & Seo, M. K. (2020). Effects of Communication Skills and Humanistic Knowledge on Professional Quality of Life in Intensive Care Unit Nurses. *Journal of Korean Critical Care Nursing*, *13*(2), 45-59.
- College of Nurses of Ontario (2008). Therapeutic nurse-client relationship. The standard of care; 3-17.
- Credland, N. (2021). Essential critical care skills 1: what is critical care nursing. Nursing Times, 18-21.
- Dawood, H. A., & Hassan, H. S. (2018). Effectiveness of Structured Educational Program on Nurses' Knowledge Concerning Therapeutic Communication at Cardiac Care Units in Holy Karbala Governorate Hospitals. *Indian Journal of Public Health Research & Development*, *9*(8).

- Dithole K, Phil D, Sibanda S, Tshweneagae T. Nurses' communication with patients who are mechanically ventilated in intensive care: the Botswana experience. International Nursing Review. 2016;63(3):415-21.
- Dithole K, Sibanda S, Moleki MM, Thupayagale-Tshweneagae G. Exploring communication challenges between nurses and mechanically ventilated patients in the Intensive Care Unit: A structured review. Worldviews Evid Based Nurs. 2016; 13(3): 197-206. https://doi.org/10.1111/wvn.12146.
- Edlow JA, Rabinstein A, Traub SJ, Wijdicks EF. Diagnosis of reversible causes of coma. Lancet. 2014 Dec 06;384(9959):2064-76. [Abstract].
- Espinoza-Caifil M, Baeza-Daza P, Rivera-Rojas F, Ceballos-Vázquez P. Communication between the user critically ill adult and the nursing professional: an integrative review. *Enfermería*: *Cuidados Humanizados*. 2021; 10(1): 30-43. Doi: https://doi.org/10.22235/ech.v10i1.2412.
- Faozi, E., Fadlilah, S., Dwiyanto, Y., Retnaningsih, L. N., & Krisnanto, P. D. (2021). Effects of a Multimodal Sensory Stimulation Intervention on Glasgow Coma Scale Scores in Stroke Patients with Unconsciousness. Korean Journal of Adult Nursing, 33(6), 649-656.
- Farmanbar, R., & Hosseinzadeh, T. (2018). Need to teaching communication skills of nursing students from the viewpoint of the faculty members of Guilan University of Medical Sciences.
- Finke, E. H., Light, J., & Kitko, L. (2008). A systematic review of the effectiveness of nurse communication with patients with complex communication needs with a focus on the use of

augmentative and alternative communication. *Journal of clinical nursing*, *17*(16), 2102-2115.

- Foà, C., Cavalli, L., Maltoni, A., Tosello, N., Sangilles, C., Maron, I., ... & Artioli, G. (2016). Communications and relationships between patient and nurse in Intensive Care Unit: knowledge, knowledge of the work, knowledge of the emotional state. Acta bio-medica: Atenei Parmensis, 87(4-S), 71-82.
- Gélinas, C., Fillion, L., Puntillo, K. A., Viens, C., & Fortier, M. (2006). Validation of the critical-care pain observation tool in adult patients. American Journal of Critical Care, 15(4), 420-427.
- Gélinas, C., Ross, M., Boitor, M., Desjardins, S., Vaillant, F., & Michaud, C. (2014). Nurses' evaluations of the CPOT use at 12-month post-implementation in the intensive care unit. *Nursing in critical care*, *19*(6), 272-280.
- Gholami H, Sarhangi F, Mokhtari Nouri J, Javadi M (2015) Nurses' communication skills in military hospitals. J Nurs Mid Sci 2(1): 40–45
- Giacino, J. T., Ashwal, S., Childs, N., Cranford, R., Jennett, B., Katz, D. I., ... & Zasler, N. D. (2002). The minimally conscious state: definition and diagnostic criteria. *Neurology*, *58*(3), 349-353.
- Gomarverdi, S., Sedighie, L., Seifrabiei, M. A., & Nikooseresht, M. (2019). Comparison of two pain scales: Behavioral pain scale and critical-care pain observation tool during invasive and noninvasive procedures in intensive care unit-admitted patients. Iranian journal of nursing and midwifery research, 24(2), 151.
- Gorji MAH, Araghiyansc F, Jafari H, Gorgi AMH, Yazdani J. Effect of auditory stimulation on traumatic coma duration in

intensive care unit of Medical Sciences University of Mazandarn, Iran. Saudi Journal of Anesthesia. 2014;8(1):69-72. https://doi.org/10.4103/1658-354X.125940

- Gorzin K, Sanagoo A, Jouybari L, Pahlavanzadeh B, Jesmi AA. The effect of education on function and communication skill of nurse with intubated patient in intensive care unit. J Nurs Midwifery Sci 2020;7:84-7.
- Goudarzi F, Basampoor S, Zakeri-Moghadam M, et al. Changes in level of consciousness during auditory stimulation by familiar voice in comatose patients. Iran Journal of Nursing. 2010; 23(63): 43-50.
- Grap MJ, Munro CL, Wetzel PA, Ketchum JM, Ketchum JS, Anderson WL, et al. Stimulation of critically ill patients: relationship to sedation. Am J Crit Care. 2016; 25(3):e48-e55. DOI: 10.4037/AJCC2016269
- Greenberg D, Aminoff M, Simon R. Clinical Neurology. New York, N.Y.: McGraw Hill Medical; 2012.
- Hagerty, T. A., Samuels, W., Norcini-Pala, A., & Gigliotti, E. (2017). Peplau's Theory of Interpersonal Relations: An Alternate Factor Structure for Patient Experience Data?. *Nursing science quarterly*, *30*(2),160167.https://doi.org/10.1177/0894318417693286.
- Han L, Li JP, Sit JW, Chung L, Jiao ZY, Ma WG. Effects of music intervention on physiological stress response and anxiety level of mechanically ventilated patients in China: a randomised controlled trial. Journal of clinical nursing. 2010;19(7-8):978-87.
- Happ MB, Garrett K, Thomas DD, Tate J, George E, Houze M, Radtke J, Sereika S. Nurse-patient communication interactions in the intensive care unit. Am J Crit Care. 2011 Mar;20(2):e28-40.

doi: 10.4037/ajcc2011433. PMID: 21362711; PMCID: PMC3222584.

- Happ, M. B., Garrett, K. L., Tate, J. A., DiVirgilio, D., Houze, M. P., Demirci, J. R., ... & Sereika, S. M. (2014). Effect of a multi-level intervention on nurse–patient communication in the intensive care unit: results of the SPEACS trial. *Heart & lung*, *43*(2), 89-98.
- Hemsley B, B. S., Worrall L. (2012). Nursing the patient with complex communicat ion needs: time as a barrier and a facilitator to successful communication in hospital. J. Adv. Nurs. 68(1), 116–126
- Henricson, M. (2008). Tactile touch in intensive care: Nurses' preparation, patients' experiences and the effect on stress parameters (Doctoral dissertation, Högskolan i Borås och Karlstads universitet).
- Hinkle, J. L., & Cheever, K. H. (2018). Brunner and Suddarth's textbook of medical-surgical nursing. Wolters kluwer india Pvt Ltd.
- Horsting, M. W., Franken, M. D., Meulenbelt, J., van Klei, W. A., & de Lange, D. W. (2015). The etiology and outcome of non-traumatic coma in critical care: a systematic review. *BMC anesthesiology*, *15*(1), 1-8.
- Hoseinzadeh, E., Shan, G. R. M., Vakili, M. A., & Kazemnejad, K. (2017). Effect of auditory stimulation on consciousness in coma patients with head injury: A randomized clinical trial. Journal of Nursing and Midwifery Sciences, 4(3), 82.
- Hsiung, N. H., Yang, Y., Lee, M. S., Dalal, K., & Smith, G. D. (2016). Translation, adaptation, and validation of the behavioral pain scale and the critical-care pain observational tools in Taiwan. Journal of pain research, 9, 661.

- Huff JS, Tadi P. Coma. [Updated 2021 Sep 29]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2021 Jan-.
- Indeed Editorial Team, (2021). Steps and Components of the Communication Process, https://www.indeed.com/career-advice/career-development/communication-process.
- Irwin, R. S., & Rippe, J. M. (Eds.). (2008). *Irwin and Rippe's intensive care medicine*. Lippincott Williams & Wilkins.; p1959.
- ISCED 2011", in OECD Handbook for Internationally Comparative Education Statistics: Concepts,
- Jackson, M., & Cairns, T. (2021). Care of the critically ill patient. Surgery (Oxford, Oxfordshire), 39(1), 29–36. https://doi.org/10.1016/j.mpsur.2020.11.002
- Jaddoue, B. (2011). Assessment of Nurses' Practices for Neurological Unconscious Patients in Intensive Care Units. Iraqi National Journal of Nursing Specialties, 1(24), 1-11.
- Jesus, L. M. T. D., Simões, J. F. F. L., & Voegeli, D. (2013). Verbal communication with unconscious patients. *Acta Paulista de Enfermagem*, *26*, 506-513.
- Jim Keogh , Aurora L., & Weaver, A. L. (2021). Critical care nursing demystified. second edition. p 31-32.
- Kashyap, M, 2017, Assess the Effectiveness of Self Instructional Module on Knowledge Regarding Communication to Unconscious Patient among Staff Nurses Working in ICU at Selected Hospitals in Maharashtra Volume 6 Issue 6, June 2017.
- Kawagoe, C. K., Matuoka, J. Y., & Salvetti, M. D. G. (2017). Pain assessment tools in critical patients with oral communication difficulties: a scope review. Revista Dor, 18, 161-165.

- Khatib Zanjani, N., Moharreri, M. (2012). Assessing the Nurses' Knowledge and Awareness of Effective Verbal Communication Skills. *Interdisciplinary Journal of Virtual Learning in Medical Sciences*, 3(1), 11-20.
- Kozier, B., Erb, G., Snyder, S. J., Frandsen, G., & Buck, M. (2018). Fundamentals of Canadian Nursing. Concepts, Process, and Practice-Pearson.
- Kynoch K, Chang A, Coyer F, McArdle A (2016) The effectiveness of interventions to meet family needs of critically ill patients in an adult intensive care unit: a systematic review update. JBI Database System Rev Implement Rep 14(3): 181-234.
- Langlume, S., Labro, G., Puyraveau, M., Capellier, G., & Piton, G. (2017). Estimation of critically ill patients' complaints by the nurse, the physician and the patient's family: A prospective comparative study. *Intensive and Critical Care Nursing*, *43*, 55-60.
- Laureys, S., & Schiff, N. D. (2012). Coma and consciousness: paradigms (re) framed by neuroimaging. Neuroimage, 61(2), 478-491.
- Lee, U., Choi, H., & Jeon, Y. (2021). Nursing students' experiences with computer simulation-based communication education. International Journal of Environmental Research and Public Health, 18(6), 3108.
- Leonard, K. E., & Kalman, M. A. (2015, September). The meaning of touch to patients undergoing chemotherapy. In Oncology Nursing Forum (Vol. 42, No. 5, pp. 517-526). Oncology Nursing Society.

- Lester, P. M. (2005). Visual communication with infotrac: Images with Messages. *Thomson Wadsworth*.
- Lillis, C., LeMone, P., LeBon, M., & Lynn, P. (2010). *Study guide for fundamentals of nursing: The art and science of nursing care*. Lippincott Williams & Wilkins.
- Loghmani, L., Borhani, F., & Abbaszadeh, A. (2014). Factors affecting the nurse-patients' family communication in intensive care unit of kerman: a qualitative study. Journal of caring sciences, 3(1), 67.
- Mahmoud S., & Hassan M., (2018): Effectiveness of Communication Skills Training Program on Empathetic Skill and Communication Self Efficacy of Pediatric Oncology Nurses. IOSR Journal of Nursing and Health Science (IOSRJNHS) e-ISSN: 2320–1959.p- ISSN: 2320–1940 Volume 7, Issue 2 Ver. 1 (March .2018), PP 75-85.
- Mandal, Ananya. (2021, January 21). What is the Nervous System?. News-Medical. Retrieved on November 29, 2021 from https://www.news-medical.net/health/What-is-the-Nervous-System.aspx.
- Marshall, J. C., Bosco, L., Adhikari, N. K., Connolly, B., Diaz, J. V., Dorman, T., ... & Zimmerman, J. (2017). What is an intensive care unit? A report of the task force of the World Federation of Societies of Intensive and Critical Care Medicine. *Journal of critical care*, *37*, 270-276.
- Mirhaghi, A., Sharafi, S., Bazzi, A., & Hasanzadeh, F. (2017). Therapeutic relationship: Is it still heart of nursing?. Nursing Reports, 7(1), 4-9.
- Miyagawa, Shigeru; Ojima, Shiro; Berwick, Robert C.; Okanoya, Kazuo (2014). "The integration hypothesis of human language

evolution and the nature of contemporary languages". Frontiers in Psychology. 5: 564. doi:10.3389/fpsyg.2014.00564. ISSN 1664-1078. PMC 4048833. PMID 24936195

- Moattari, M., Shirazi, F. A., Sharifi, N., & Zareh, N. (2016). Effects of a sensory stimulation by nurses and families on level of cognitive function, and basic cognitive sensory recovery of comatose patients with severe traumatic brain injury: a randomized control trial. Trauma monthly, 21(4).
- Mohammadi, M. K., Yeganeh Rasteh Kenari, M. R., Khaleghdoost Mohammadi, T., Atrkare Roshan, Z., & Mohammad Ebrahimzadeh, A. (2017). Effects of organized auditory stimulation by familiar voice on blood pressure and body temperature in comatose patients. Journal of Holistic Nursing And Midwifery, 27(1), 95-102.
- Mohammadi, M. K., Yeganeh, M. R., Ebrahimzadeh, A. M., Roshan, Z. A., Soodmand, M., & Pouralizadeh, M. (2019). The effects of familiar voices on the level of consciousness among comatose patients: a single-blind randomized controlled trial. J Pharm Res Int, 27(2), 1-8.
- Mohammed, H. M., & Hassane, A. E. S. (2017) Nursing Interventions: Effects of Coma Arousal Technique on the Clinical Outcomes of Unconscious Patients.
- MokhtarAbdallah, H., Elcokany, N. M., Eid, H., & Mohamed, N. T (2018). Responses of Unconscious Patients to Painful Procedures in Intensive Care Units. management, 8, 10.
- Momennasab, M., Ardakani, M. S., Rad, F. D., Dokoohaki, R., Dakhesh, R., & Jaberi, A. (2019). Quality of Nurses' Communication with Mechanically Ventilated Patients in a Cardiac Surgery Intensive Care Unit. *Investigacion y educacion en*

enfermeria, *37*(2), e02. https://doi.org/10.17533/udea.iee.v37n2e02

- Na'el K, A., & Mohammed, W. K. (2019). Nurses' Knowledge toward Care of Unconscious Adult Patients at Teaching Hospitals in Al-Hilla City. *Iraqi National Journal of Nursing Specialties*, *32*(1).
- Neese, B. (2015). Effective communication in nursing: Theory and best practices. *Document posted in Southeastern University Archived at http://online. seu. edu/effective-communication-in-nursing*.
- Nguyen, and Tuan C. (2021). The Early History of Communication. Retrieved from https://www.thoughtco.com/early-history-of-communication-4067897.
- Nugent, P. M., & Vitale, B. A. (2013). *Fundamentals of nursing: Content review plus practice questions*. FA Davis.
- OECD (2017), "Definition and classification of educational programmes: The practical implementation of
- Ofori, B. S. (2009). *Pain Assessment and Management in the Critically Ill Unconscious Patient in the Adult Intensive Care Unit* (Doctoral dissertation, University of the Witwatersrand).
- Ohana, M., Moser, T., Moussaouï, A., Kremer, S., Carlier, R. Y., Liverneaux, P., & Dietemann, J. L. (2014). Current and future imaging of the peripheral nervous system. Diagnostic and interventional imaging, 95(1), 17-26.
- Osgood-Schramm model of communication Sources: Kisspng, 2018; Web Editor 4, 2017

- Osmun, W. E., Brown, J. B., Stewart, M., & Graham, S. (2000). Patients' attitudes to comforting touch in family practice. Canadian Family Physician, 46(12), 2411-2416.
- Othman, S. Y., & El-Hady, M. M. (2015). Effect of implementing structured communication messages on the clinical outcomes of unconscious patients. Journal of Nursing Education and Practice, 5(9), 117.
- Otuzoğlu, M., & Karahan, A. (2014). Determining the effectiveness of illustrated communication material for communication with intubated patients at an intensive care unit. International Journal of Nursing Practice, 20(5), 490-498.
- Padmavathi, M. P., & Rajasankar, D. N. K. (2013). Assess the Effectiveness of Self Instructional Module on Knowledge of Premenstrual Syndrome among Adolescent Girls in Selected Area, Erode. *Signs*, *100*, 50.
- Parsons, L. C., & Walters, M. A. (2019). Management strategies in the intensive care unit to improve psychosocial outcomes. *Critical Care Nursing Clinics*, *31*(4), 537-545.
- Phutela, D. (2015). The importance of non-verbal communication. *IUP Journal of Soft Skills*, *9*(4), 43.
- Prasad, V., & George, S. (2014). Effectiveness of structured teaching module on therapeutic communication among staff nurses. *Journal of Nursing and Health Science*, *3*(2), 7-31.
- Raciti, L., Corallo, F., Calabrò, R. S., & Manuli, A. (2021). Nursing, Caregiving and Psychological support in Chronic Disorders of Consciousness: a scoping review. *Acta Bio Medica: Atenei Parmensis*, *92*(Suppl 2).

- Radtke, J. V., Tate, J. A., & Happ, M. B. (2012). Nurses' perceptions of communication training in the ICU. *Intensive and Critical Care Nursing*, *28*(1), 16-25.
- Reviewed by Nancy Choi, M.D. — Written by Yvette Brazier on November 20, 2017, What you need to know about coma. https://www.medicalnewstoday.com/articles/173655.
- Rosdahl, C. B. (2012). *Textbook of basic nursing*. Wolters Kluwer Health| Lippincott Williams & Wilkins.pp 521- 531.
- Rothman, A. A., Park, H., Hays, R. D., Edwards, C., Dudley, R. A. (2008). Can additional patient experience items improve the reliability of and add new domains to the CAHPS® Hospital Survey? Health Research and Educational Trust, 43, 2201-2222.
- Safavi, M., Fesharaki, M., & Esmaeilpour Bandboni, M. (2016). Communication skills and its related factors in Guilans teaching hospitals' nurses 94. *Avicenna Journal of Nursing and Midwifery Care*, *24*(1), 50-57.
- Saleh, N. M., & Ragab, O. H. G. (2021). Effect of Communication Competence Program on Nurses' Self-Advocacy. *Assiut Scientific Nursing Journal*, *9*(25), 107-114.
- Sanchez, N. (2002). Communication process. Hyperlink [http://www.stfrancis.edu/ba/ghkickul/stuwebs/btopics/works/com proc. html], 17.
- Shaffer J. Neuroplasticity and clinical practice: Building brain power for health. Front Psychol. 2016;7:1118. DOI: 10.3389/FPSYG. 2016.01118.
- Sherko, E., Sotiri, E., & Lika, E. (2013). Therapeutic communication. Jahr: Europski časopis za bioetiku, 4(1), 457-466.
- Sibiya, M. N. (2018). Effective communication in nursing. Nursing, 19, 20-34.

- Simões, J., Jesus, L., Voegeli, D., Martins, C., Hall, A., & Simpson, D. (2012). The effects of acoustic stimulation on comatose patients. Comas and Syncope: Causes, Prevention and Treatment. New York: Nova Science, 1-31.
- Smith, M. C., & Parker, M. E. (2015). Nursing theory and the discipline of nursing. *Nursing theories and nursing practice*, 3-18.
- Standards, Definitions and Classifications, OECD Publishing, Paris.
- Stöckigt, B., Suhr, R., Sulmann, D., Teut, M., & Brinkhaus, B. (2019). Implementation of intentional touch for geriatric patients with chronic pain: a qualitative pilot study. Complementary medicine research, 26(3), 195-205.
- Tapson K, Sierotowicz W, Maran DM, Thompson TM. 'It's the hearing that is last to go': a case of traumatic head injury. British Journal of Nursing. 2015;24(5).
- Thakur, P., Venkateshan, M., Sharma, R., & Prakash, K. (2016). Nurses Communication with Altered Level of Consciousness Patients. *International journal of nursing education*, *8*(3), 51-56.
- Thau, L., Reddy, V., & Singh, P. (2019). Anatomy, Central Nervous System.
- Thomas L. , Ratcliff, Graham , Nathan, Peter W. , Noback, Charles R. , Haines, Duane E. , Loewy, Arthur D. , Rudge, Peter and Matthews, Peter B.C.(2021). "human nervous system". Encyclopedia Britannica, Invalid Date, https://www.britannica.com/science/human-nervous-system. Accessed 29 November 2021.
- Thomas, D. (2006). *A study to assess the effectiveness of planned teaching program for nurses working in icu of st. John's medical*

college hospital, bangalore on communication to unconscious patients (Doctoral dissertation).

- Tiwary, A., Rimal, A., Paudyal, B., Sigdel, K. R., & Basnyat, B. (2019). Poor communication by health care professionals may lead to life-threatening complications: examples from two case reports. *Wellcome open research*, *4*, 7. https://doi.org/10.12688/wellcomeopenres.15042.1
- Tomaszewska, K., & Gronowska, K. (2020). Unconscious patient-role and tasks of the therapeutic team. *Journal of Education, Health and Sport*, *10*(1), 16-24.
- Urden, L. D., Stacy, K. M., & Lough, M. E. (2013). *Critical Care Nursing, Diagnosis and Management, 7: Critical Care Nursing*. Elsevier Health Sciences.
- Vermeir, P., Vandijck, D., Degroote, S., Peleman, R., Verhaeghe, R., Mortier, E., Hallaert, G., Van Daele, S., Buylaert, W., & Vogelaers, D. (2015). Communication in healthcare: a narrative review of the literature and practical recommendations. *International journal of clinical practice*, *69*(11), 1257–1267. https://doi.org/10.1111/ijcp.12686
- Vertino, K. A. (2014). Effective interpersonal communication: A practical guide to improve your life. The Online Journal of Issues in Nursing, 19(3).
- Videbeck, S. L. (2020). Psychiatric-Mental Health Nursing 8th Edition (Lippincott Williams and Wilkins).
- Walker, B. R., & Colledge, N. R. (2013). Davidson's principles and practice of medicine e-book. Elsevier Health Sciences.
- Weil, M. H., & Tang, W. (2011). From intensive care to critical care medicine: a historical perspective. *American journal of respiratory and critical care medicine*, *183*(11), 1451-1453.

- Wertheim, E. G. (2008). The importance of effective communication. *Retrieved April*, *19*, 2011.
- White J, Giacino J (2013). Disorders Of Consciousness. Arlington, VA: American Psychiatric Publishing; pp. 103-130.
- Wright, R. (2012). Effective communication skills for the 'caring'nurse. *The Great Teachers: Tertiary Place*..
- Wune, G., Ayalew, Y., Hailu, A., & Gebretensaye, T. (2020). Nurses to patients communication and barriers perceived by nurses at Tikur Anbessa Specilized Hospital, Addis Ababa, Ethiopia 2018. *International Journal of Africa Nursing Sciences*, *12*, 100197.
- Yaghoubinia, F., Navidian, A., Sheikh, S., Safarzai, E., & Tabatabaei, S. (2016). Effect of music therapy and reflexology on pain in unconscious patients: A randomized clinical trial. International Journal of Medical Research & Health Sciences, 5(9), 288-295.
- Yoo HJ, Lim OB, Shim JL (2020) Critical care nurses' communication experiences with patients and families in an intensive care unit: A qualitative study. PLoS ONE 15(7): e0235694. https://doi.org/10.1371/journal.pone.0235694
- Younis, J. R., Mabrouk, S. M., & Kamal, F. F. (2015). Effect of the planned therapeutic communication program on therapeutic communication skills of pediatric nurses. *Journal of Nursing Education and Practice*, *5*(8), 109.
- Zakaria, Z., Abdullah, M. M., Halim, S. A., Ghani, A. R. I., Idris, Z., & Abdullah, J. M. (2020). The neurological exam of a comatose patient: an essential practical guide. *The Malaysian Journal of Medical Sciences: MJMS*, *27*(5), 108.

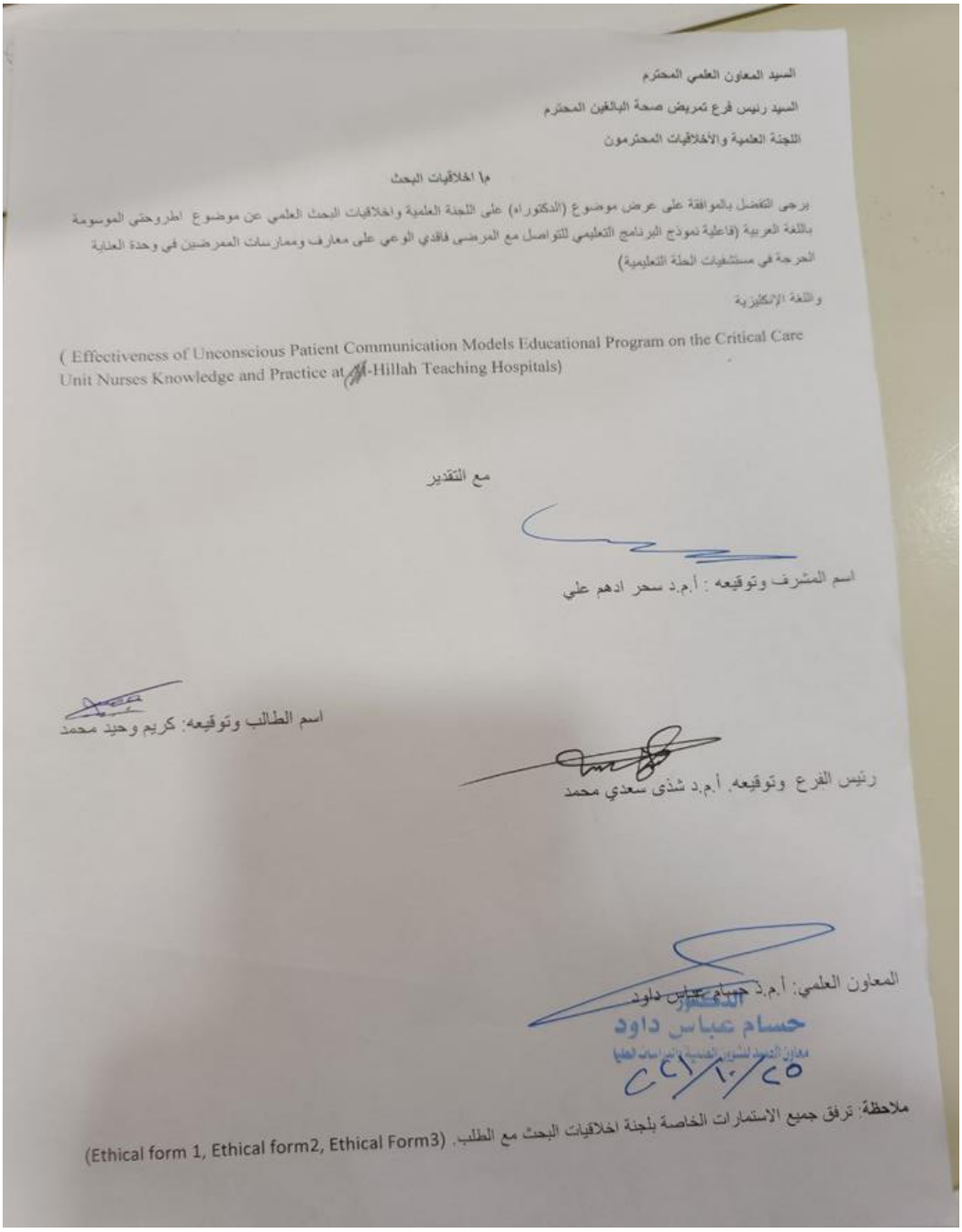
- Zangeneh, A., Lebni, J. Y., Azar, F. E. F., Sharma, M., Kianipour, N., Azizi, S. A., ... & Ziapour, A. (2021). A study of the communication skills in health care and the role of demographic variables (a case study of the nurses at the Educational, Therapeutic and Research Center of Imam Reza Hospital, Kermanshah, Iran in 2018). *Journal of Public Health*, *29*, 361-367.
- Zare, F., Farokhzadian, J., Nematollahi, M., Miri, S., & Foroughameri, G. (2020). Therapeutic Communication Skills Training: An Effective Tool to Improve the Caring Behaviors of ICU Nurses. *BioRxiv*.
- Zasler N, Katz D, Zafonte R**.** Brain Injury Medicine: Principles and Practice.NewYork, Demos. Com; 2007; 937-38.
- Zuo, J., Tao, Y., Liu, M., Feng, L., Yang, Y., & Liao, L. (2021). The effect of family-centered sensory and affective stimulation on comatose patients with traumatic brain injury: a systematic review and meta-analysis. *International Journal of Nursing Studies*, *115*, 103846.

Appendices

Appendices

Administrative Agreements

Appendix: 1



السيد المعاون العلمي المحترم

السيد رئيس فرع تمريض صحة البالغين المحترم

اللجنة العلمية والأخلاقيات المحترمون

م/ اخلاقيات البحث

يرجى التفضل بالموافقة على عرض موضوع (الدكتوراه) على اللجنة العلمية واخلاقيات البحث العلمي عن موضوع اطروحتي الموسومة باللغة العربية (فاعلية نموذج البرنامج التعليمي للتواصل مع المرضى فاقدي الوعي على معارف وممارسات الممرضين في وحدة العناية الحرجة في مستشفيات الحلة التعليمية)

واللغة الإنكليزية

(Effectiveness of Unconscious Patient Communication Models Educational Program on the Critical Care Unit Nurses Knowledge and Practice at Al-Hillah Teaching Hospitals)

مع التقدير

اسم المشرف وتوقيعه : أ.م.د سحر ادهم علي

اسم الطالب وتوقيعه: كريم وحيد محمد

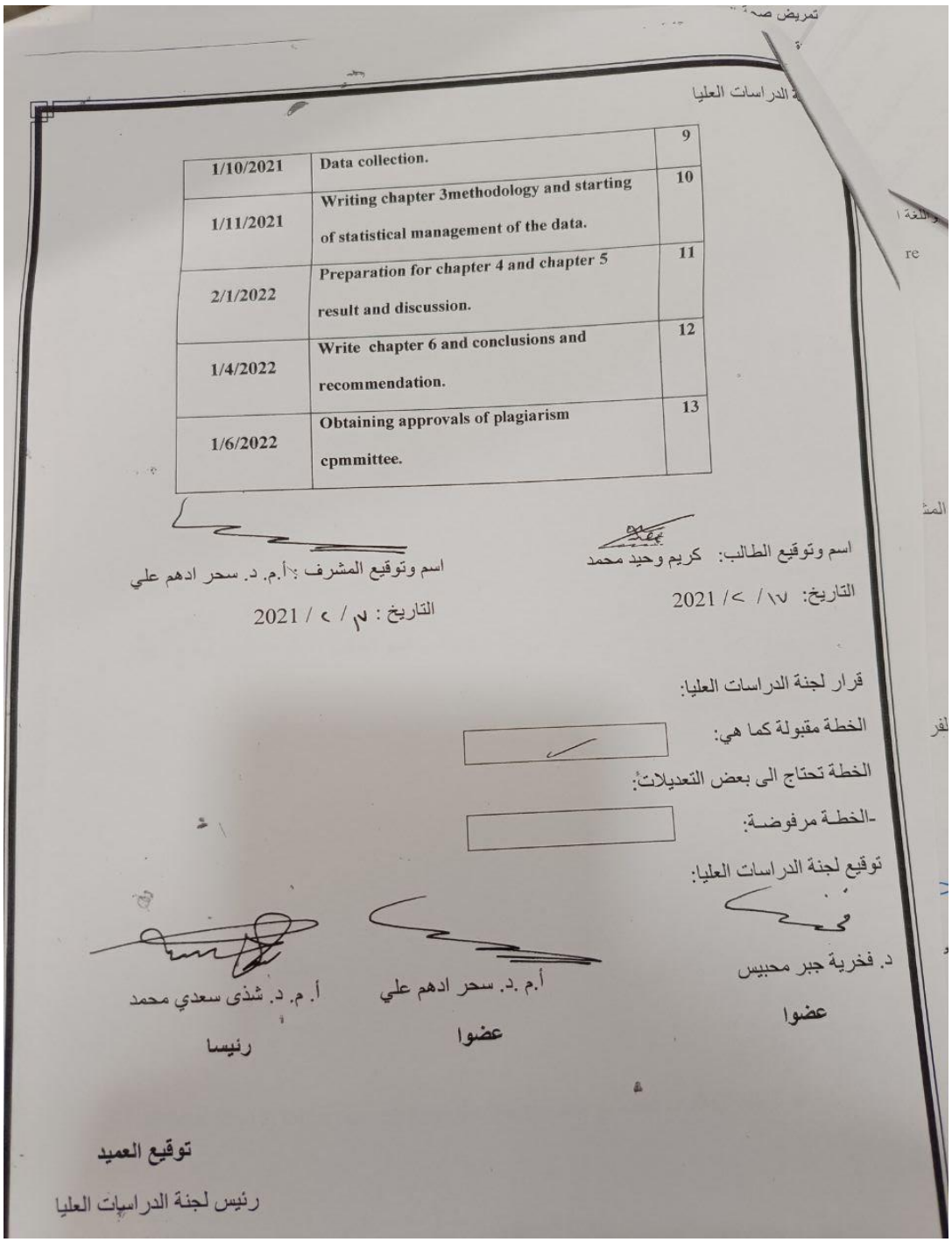
رئيس الفرع وتوقيعه أ.م.د شذى سعدي محمد

المعاون العلمي: أ.م.د حسام عباس داود

حسام عباس داود

٢٠٢١/١٠/٢٥

ملاحظة: ترفق جميع الاستمارات الخاصة بلجنة اخلاقيات البحث مع الطلب. (Ethical form 1, Ethical form2, Ethical Form3)



1/10/2021	Data collection.	9
1/11/2021	Writing chapter 3methodology and starting of statistical management of the data.	10
2/1/2022	Preparation for chapter 4 and chapter 5 result and discussion.	11
1/4/2022	Write chapter 6 and conclusions and recommendation.	12
1/6/2022	Obtaining approvals of plagiarism cpmmittee.	13

اسم وتوقيع الطالب: كريم وحيد محمد

التاريخ: ١٧ / ٧ / 2021

اسم وتوقيع المشرف :أ.م. د. سحر ادهم علي

التاريخ : ٢٩ / ٧ / 2021

قرار لجنة الدراسات العليا:

الخطة مقبولة كما هي:

الخطة تحتاج الى بعض التعديلات:

-الخطة مرفوضة:

توقيع لجنة الدراسات العليا:

د. فخرية جبر محبيس

عضوا

أ.م .د. سحر ادهم علي

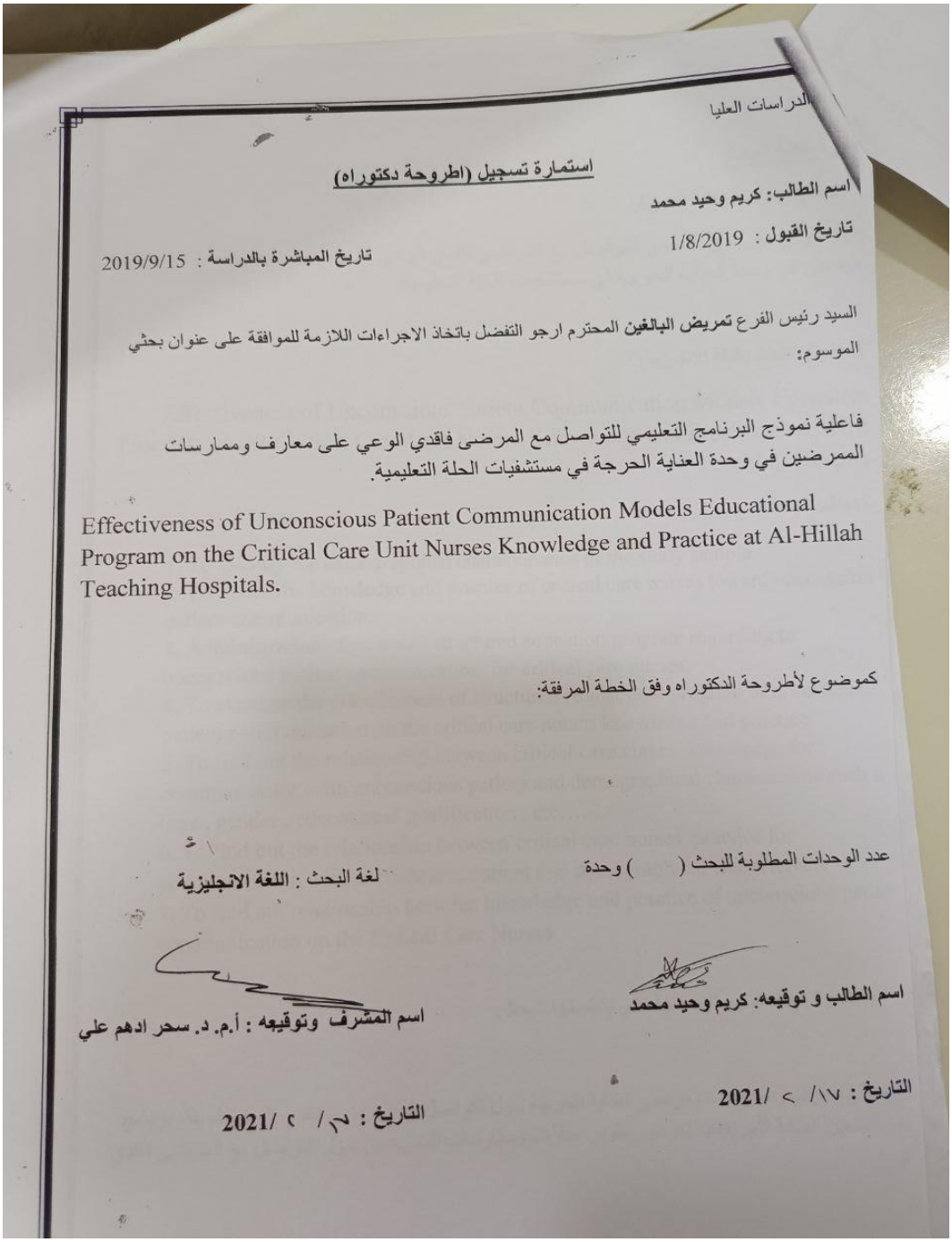
عضوا

أ. م. د. شذى سعدي محمد

رئيسا

توقيع العميد

رئيس لجنة الدراسات العليا



الدراسات العليا

استمارة تسجيل (اطروحة دكتوراه)

اسم الطالب: كريم وحيد محمد

تاريخ القبول : 1/8/2019

تاريخ المباشرة بالدراسة : 2019/9/15

السيد رئيس الفرع **تمريض البالغين** المحترم ارجو التفضل باتخاذ الاجراءات اللازمة للموافقة على عنوان بحثي الموسوم:

فاعلية نموذج البرنامج التعليمي للتواصل مع المرضى فاقدي الوعي على معارف وممارسات الممرضين في وحدة العناية الحرجة في مستشفيات الحلة التعليمية.

Effectiveness of Unconscious Patient Communication Models Educational Program on the Critical Care Unit Nurses Knowledge and Practice at Al-Hillah Teaching Hospitals.

كموضوع لأطروحة الدكتوراه وفق الخطة المرفقة.

عدد الوحدات المطلوبة للبحث ( ) وحدة

لغة البحث : اللغة الانجليزية

اسم الطالب و توقيعه: كريم وحيد محمد

التاريخ : ١٧/ ٧ /2021

اسم المشرف وتوقيعه : أ.م. د. سحر ادهم علي

التاريخ : ٢٧/ ٩ /2021

Appendix: 2

Ministry of Health Babylon Health Directorate Imam Sadiq General Hospital	جمهورية العراق	وزارة الصحة دائرة صحة بابل مستشفى الامام الصادق (ع) شعبة الموارد المالية والادارية وحدة الموارد البشرية العدد: ٣٩٠ التاريخ: ٥ / ١ /2022

إلى/ دائرة صحة بابل/ مكتب المدير العام / مركز التدريب والتنمية البشرية

م/ تسهيل مهمة

تحية طيبة

أشاره الى كتابكم المرقم ١١٦٢ بتاريخ ٣٠ /١١/ ٢٠٢١ لا مانع لدينا من تسهيل مهمة طالب الدراسات العليا (كريم وحيد محمد كاظم) لا تمام بحثه في مستشفانا في قدر تعلق الامر بنا وحسب الضوابط على أن لا تتحمل مستشفانا أي تبعات مالية أو قانونية.

للتفضل بالاطلاع .... مع الاحترام

الدكتور
ماجد ياسر خضير الشمري
مدير مستشفى الإمام الصادق (ع) التعليمي
٢٠٢٢/ ١١ /٥

نسخة منه الى

- مكتب مدير المستشفى
- المعاون الاداري
- الموارد البشرية /الارشيف
- وحدة RCU

جمهورية العراق

وزارة الصحة والبيئة
دائرة صحة محافظة بابـــل
المديـــر العـــام
مركـــز التدريب والتنمية البشرية
وحدة أدارة البحوث

العدد : ١١٦٢
التاريخ: ٢٠ / ١١ / ٢٠٢١

Ministry Of Health
Babylon Health Directorate
Email:-
Babel_Healthmoh@yahoo.com
Tel:282628 or 282621

وزارة الصحة
دائرة صحة بابل
مركز التدريب والتنمية البشرية

إلى / مستشفى الأمام الصادق (ع)
مستشفى الحلة التعليمي
م/ تسهيل مهمة

تحية طيبة ...

أشارة إلى كتاب جامعة بابل / كلية التمريض / لجنة الدراسات العليا ذي العدد ٣٦٣٨ في ٢٠٢١/١١/٢٥

نـــرفق لـكم ربطا استمارات الموافقة المبدئية لمشروع البحث العائد للباحث طالب الدراسات العليا الدكتوراه (كريم وحيد محمد كاظم).

للتفضل بالاطلاع وتسهيل مهمة المومأ أليه من خلال توقيع وختم استمارات اجراء البحث المرفقة في مؤسساتكم وحسب الضوابط والإمكانات لاستحصال الموافقة المبدئية ليتسنى لنا أجراء اللازم على أن لا تتحمل مؤسساتكم أية تبعات مادية وقانونية .... مع الاحترام

المرفقات :
استمارة عدد /٢

الدكتور
محمد عبد الله عجرش
مدير مركز التدريب والتنمية البشرية
/ / ٢٠٢١

نسخة منه إلى :
- مركز التدريب والتنمية البشرية / وحدة أدارة البحوث مع الأوليات

Appendix: 3

جمهورية العـــراق

وزارة الصحة والبيئة
دائرة صحة محافظة بابـــل
المديـــر العـــام
مركـــز التدريب والتنمية البشرية
لجنة البحوث

Ministry Of Health
Babylon Health Directorate
Email:-
Babel_Healthmoh@yahoo.com
Tel:282628 or 282621

استمارة رقم :-٠٣ /٢٠٢١

رقم القرار :- ١٩
تاريخ القرار :- ١/٢/٢٠٢٢

قرار لجنة البحوث

تحية طيبة ...

درست لجنة البحوث في دائرة صحة بابل مشروع البحث ذي الرقم (١٢ /٢٠٢٢/٠ بابل) المعنـــون (فاعلية نموذج البرنامج التعليمي للتواصل مع المرضى فاقدي الوعي على معارف وممارسات الممرضين في وحدة العناية الحرجة في مستشفيات الحلة التعليمية) والمقـدم من الباحث(كريم وحيد محمد) إلى وحدة أدارة البحوث والمعرفي مركز التدريب والتنمية البشرية في دائرة صحة بابل بتاريخ ٢٠٢٢/١/٢٣ وقررت :

قبول مشروع البحث أعلاه كونه مستوفيا للمعايير المعتمدة في وزارة الصحة والخاصة بتنفيذ البحوث ولا مانع من تنفيذه في مؤسسات الدائرة .

مـــــع الاحتـــــرام

وزارة الصحة
دائرة صحة بابل
مركز التدريب والتنمية البشرية
لجنة البحوث

الدكتور / محمد عبد الله عجرش
رئيس لجنة البحوث
/ /٢٠٢٢

نسخة منه إلى :
- مكتب المدير العام / مركز التدريب والتنمية البشرية / وحدة إدارة البحوث ... مع الأوليات.

سوزان

دائرة صحة محافظة بابل / مركز التدريب والتنمية البشرية // ايميل المركز babiltrainning@gmail.com

Appendix: 4

درجات الممرضين حسب استبيان ((تقييم الحاجه للبرنامج)):

ت	الدرجة الحاصل عليها	النتيجة
1-المشارك الاول	27	راسب
2-المشارك الثاني	27	راسب
3-المشارك الثالث	36	راسب
4-المشارك الرابع	46	راسب
5-المشارك الخامس	50	راسب
6-المشارك السادس	30	راسب
7-المشارك السابع	40	راسب
8-المشارك الثامن	20	راسب
9-المشارك التاسع	46	راسب
10- المشارك العاشر	55	راسب
11-المشارك الحادي عشر	18	راسب

Appendix: 5

Panel of Expert

Appendix: 5 A

بِسْمِ ٱللَّهِ ٱلرَّحْمَٰنِ ٱلرَّحِيمِ

حضرة ..... المحترم

نظرا للمكانة العلمية المرموقة لديكم يرجى التفضل بالمساهمة في تقييم الاستبيان

دراسة شبه تجريبيه :

(فاعلية البرنامج التعليمي على معارف وممارسات التمريضيين في التواصل مع المرضى فاقدي الوعي في وحدات العناية الحرجة).

ولكم فائق الشكر والاحترام.....

المرفقات:-

استبيان

الملاحظات:

التوقيع:-

الاسم :-

اللقب العلمي:-

الجامعة :-

الكلية:-

عدد سنوات الخبرة :-

التاريخ:-

Appendix: 5 Appendix: 5 B

Panel of expert

ت	اسم الخبير	الشهادة	اللقب العلمي	الاختصاص	مكان العمل	سنوات الخبرة
-1	راجحه عبد الحسن حمزه	دكتوراه	استاذ	تمريض بالغين	كلية التمريض / جامعة الكوفة	39 سنه
-2	امين عجيل الياسري	دكتوراه	استاذ	تمريض صحة مجمع	كلية التمريض/جامعة بابل	37 سنة
-3	هدى باقر حسن	دكتوراه	استاذ	تمريض بالغين	كلية التمريض/ جامعة بغداد	35 سنه
-4	صباح عباس احمد	دكتوراه	استاذ	تمريض بالغين	كلية التمريض\ جامعة بغداد	34 سنة
-5	حكيمه شاكر حسن	دكتوراه	استاذ	تمريض بالغين	كلية التمريض/ جامعة بغداد	32 سنة
-6	الدكتورة شذى سعدي	دكتوراه	استاذ	تمريض بالغين	كلية التمريض\ جامعة بابل	22
7	حسين هادي عطية	دكتوراه	استاذ	تمريض بالغين	كلية التمريض /جامعة بغداد	20 سنه
-8	الدكتورة خالدة محمد خضر	دكتوراه	استاذ	تمريض بالغين	كلية التمريض/ جامعة بغداد	20 سنه
9	حسن علوان بيعي	دكتوراه	أستاذ	طب صحة المجتمع	كلية الحلة الجامعة	40 سنة
10	حسام عباس	دكتوراه	استاذ مساعد	تمريض بالغين	كلية التمريض\ جامعة كربلاء	20
11	ضياء كريم عبد علي	دكتوراه	استاذ مساعد	تمريض بالغين	كلية التمريض/جامعة العميد	15 سنوات
12	صادق عبد الحسين	دكتوراه	استاذ مساعد	تمريض بالغين	كلية التمريض/ جامعة بغداد	12 سنه
13	حيدر ابراهيم	دكتوراه	م. جامعي اختصاص	تمريض بالغين	معهد الصحة العالي\ النجف الاشرف	12

Appendix: 6

Questionnaire

Appendix:6 A

وزارة التعليم العالي والبحث العلمي

جامعة بابل- كلية التمريض

عزيزي الممرض / عزيزتي الممرضة

بين يديك استبانة لدراسة

فاعلية البرنامج التعليمي على معارف وممارسات التمريضيين في التواصل مع المرضى فاقدي الوعي في وحدات العناية الحرجة.

Effectiveness of Unconscious Patient Communication Educational Program on the Critical Care Unit Nurses Knowledge and Practices

يروم الباحث الى دراسة فاعلية نموذج البرنامج التعليمي للتواصل مع المرضى فاقدي الوعي على معارف وممارسات الممرضين في وحدة العناية الحرجة في مستشفيات الحلة التعليمية.) ، وبما أن مشاركتكم في هذه الدراسة ذات قيمة كبيرة، فالرجاء اختيار الإجابة التي تحدد ما تشعر به بالفعل، علما أنه لا توجد إجابة صحيحة وأخرى خاطئة، وانما اجاباتكم تعد صحيحة فقط - طالما تعبر عن حقيقة شعورك تجاه المعنى الذي تحمله العبارة.

لاتضع أكثر من علامة أمام عبارة واحدة مع التأكد من عدم ترك أي عبارة بدون إجابة، علما ان الاستبانة بدون اسم وسوف تحضَ أجابتك بخصوصية وسرية مطلقة وتستعمل الاستبانة لغرض البحث العلمي فقط

. يرجى التحقق من أنك أجبت على كافة الأسئلة .

مع خالص الشكر والامتنان لتعاونكم معنا خدمة لأهداف الدراسة

الباحث / طالب الدكتوراه

كريم وحيد محمد

Appendix : 6 B

Part One: Demographical Data:

1- Gender: Male ☐ **Female** ☐

2- Age: ☐ **years old**

3- Educational level:

Nursing school graduate ☐

Graduate Diploma in Nursing ☐

Bachelor of Nursing graduate ☐

Postgraduate graduate ☐

4. Marital status: single ☐ **married** ☐ **separated** ☐ **widow** ☐ **divorced** ☐

Part two: Employment information

1. years of experience in nursing ☐

2. Duration of experience in the critical care unit ☐

3- Participated in courses on communication with the unconscious patient. Yes ☐ **No** ☐

Part Three:

First domain: Anatomy and physiology of nervous system

1- The functional work of the nervous system which include receipt of information, integration, and transmission of nerve impulses to recipient cells is performed by.

a- neurons b- cell c- fibers

2- Most activities of the nervous system originate from sensory receptors such as visual, auditory, or tactile receptors and are transmitted to the central nervous system by:

a- afferent fibers (sensory fibers) b- neurons c- body of cell.

3- The primary functions include sensory, motor, and cognitive is performed by:

a- cerebral cortex b- The cerebellum c- cerebrum

4- The largest lobes of the brain which control voluntary function such as, motor, cognitive (orientation, memory, insight, judgment, arithmetic, and abstraction extended to expressive language verbal and written is.

a- **Frontal lobes** b- occipital lobe c- temporal lobe

5- The lobe that primarily concerned with sensory functions which including integration of sensory information; awareness of body parts; interpretation of touch, pressure, and pain is:

a- **Parietal lobes** b- frontal lobe c- occipital lobe

6- Visual memory, verbal memory (such as understanding language), and interpreting the emotions and reactions of others are coordinate by the:

a- **Temporal lobes** b- Parietal lobes c- frontal lobe

7- Located in the back of the brain, just below the occipital lobes involved with motor skills, which refers to the coordination of smaller, or finer, movements, especially those involving the hands and feet is referred to

a- **cerebellum** b- brainstem c- occipital lobe

8- The immediate coma caused by destruction of the:

a- central reticular nuclei b- Cortex c- Intra Laminar Nuclei Region .

9- Deep Coma my due to small lesions developed in the:

a. Cerebrum b. Midbrain **c. Intra Laminar Nuclei Region**

Second domain: Basic communication principals.

1- Verbal communication is essential part of:

a. Healing process

b. Disease process

c. Nursing process

2- The nurse should be maintain communication with the unconscious patient during:

a. During change of shift

b. Only during procedure

c. Whenever possible

3- Master of all senses is:

a. Seeing b. Hearing **c. touch**

4- The nurse used task touch during caring out their work with the patients such kind of touch mean:

a. Comforting touch

b. caring touch

c. Reassuring touch

5- One of the following actions will promote recovery of the unconscious patient:

a. unfamiliar voice

b. familiar situations

c. familiar voice

6- The dynamic process which used to gather data, teach and persuade, express caring and comfort is:

a- communication b- assessment c- physical examination.

7- When the nurses provide care for patients during direct contact which made there be close with 0 to 1 1/2 feet from the patient, this distance referred to :

a- **Intimate distance** b- Public distance c- Personal distance

8- The nurse may receive information about the patient before the first face-to-face meeting such as name, address, age, medical history, and/or social history, which consider as the…….. communication phase

a- Pre interaction b- Introductory Phase c- working phase

9- Interaction between a health care professional and patient which related to enhance the patient's comfort, safety, trust, and well-being is known as

a- Therapeutic communication c- nursing process b- non therapeutic communication

10- The essential core of the patient care is:

a- **Successful communication** b- nursing practice c- nursing education .

11- Two- way process in communication may used as an essential part to reduce the patient anxiety and emotional stimulation, through sending message understanding and feedback this referrers to:

a- **Verbal communication** b- nonverbal communication c- nursing care

12- Body language which includes gestures, postures, touch and physical appearance referred to

a- **Nonverbal communication** b- verbal communication

c- body position.

Third domain: Therapeutic and non-therapeutic communication:

1. Many factors contribute as barriers of therapeutic communication such as:

a- **Asking questions that can be answered with "yes" or "no":**

b- Ask open-ended questions

C - Asking relevant questions

2. One of the goals of therapeutic communication is**:**

a - Helping patients to know their thoughts

b - Establishing barriers to communication

c- Providing treatment to patients

3. Non-therapeutic communication techniques include the following:

a- **Giving personal opinions** b- Asking for clarifications

C - Sharing feelings

4. Is it considered as one strategy of a therapeutic communication?

a – silence b- automatic responses c – arguing

Domain four: Communicating with unconscious patients

1- Touch should be used cautiously with patients who are:

a- **Aggressive** b- unconscious c- patient with pain

2- communication with unconscious patients causes harm or serious physiological adverse events for patient.

a- actually yes **b- actually no**

3- The communication barriers includes the following :

a- Impaired consciousness

b- Patient with pain

c- psychologically patient

4- The most common aftermaths of coma and hospitalization in ICU for patient is:

a-Sensory deprivation b- palpitation c- immobilization

5- The information received by unconscious patients contributes to

a- It helps reduce stress b - increases tension c - It has no effect on the patient.

6- Intensive care unit syndrome, which includes the following

a- fear from others **b - memory disorders** c - inability to speak

7- The nurse must introduce himself to the unconscious patient when providing care

a- not necessary **b- acutely needed** c- no need

8- The nurse should communicate with the unconscious patient as she/ he communicate with other alert patients.

a- no necessary

b- acutely needed

c- c- no need

9- It is not necessary to inform unconscious patients of current events, such as diagnosis, treatment, medical and nursing interventions

a- not always

b- it his right to know

c- c- no need he cannot take discussion

10- When the nurse provided nursing care of the patient, such as withdrawing fluids or changing the patient's position, she/he should:

a- Explain all procedures before implementation

b- It is not necessary to inform the patient

c- Explain the procedures to the patient's family only

11- The nurse directs the unconscious patient to the time and place at least once every-------- hours

a - 8

b- 24

c- c- she/he don't have to tell him anything

12- Lack of communication or insufficient communication between the nurse and the unconscious patient leads to:

a - Increased levels of stress and anxiety for the patient

b - Increased stress and anxiety levels for the nurse

c - It has no effect

Five domain: Communication with patients under artificial ventilation

1- There are several ways to enhance communication with ventilated patients such as:
   a- nursing care
   b- Acoustic therapies
   c- medical treatments
2- The most appropriate method of communication which preferred to use is for a patient on short-term ventilation who is alert and can move at least one hand
   a – gestures
   b- writing
   c- pronunciation techniques
3- Which of the following are alternative methods of communication for ventilator-dependent patients except:
   a- Translator and interpreter
   b- Communication board
   c-Pen and paper.
4- It is necessary to encourage the family of the unconscious patient to participate in patient care
   a- right
   b- wrong
   c- Certainly sometimes
5- Visiting concept for dying patients in the critical care unit should be

a- restricted

b- encouraged

c- c- not helpful

6- As the patient approaches death, it is important to continue care by the same nurse even after the shift is over.

a- It is very necessary

b- not necessary

c - There is no need to insist on care during this period

7- Families must be allowed to be present during Cardiopulmonary resuscitation and all respiratory procedures

a- It is very necessary

b- not necessary

c - There is no need to stress care during this period

8- Unconscious patients have a great need for information and support

a- always at all times

b - It is not necessary to provide them with information to prevent confusion of ideas

c- At times it is possible to provide them with the necessary information

9- is the unconscious patients hear and understand conversations around him

a - completely separated from the external environment

b. They receive and understand conversations

c - They hear voices and do not distinguish

10- Nurses should speak in a normal conversational tone while providing care to unconscious patients.

a- no need

b- it is necessary

c- in some event only

Six domain: :Educating the patient's family

1- The nurse should advise the families of unconscious patients to:

a - Not talking to the patient

b- Talking to the patient about general and social news

d- Speak carefully with the patient

2- It is important to encourage the patient's family and friends to remain positive when visiting their unconscious patient because:

a- It is very necessary

b- not necessary he can't feel

c- It has no significance effect

3- Visiting the family of the unconscious patient my stimulated (auditory, emotional and tactile) senses as:

a - increase the level of awareness of the patient

b - it has negative consequences for the patient

c - it has no effect

Seventh domain: Nurses Communication Practice with unconscious patient

No.	Item	First observation		Second observation		Third observation	
		Yes	No	Yes	No	Yes	No
1-	Calling the patient by name						
2-	Greeting the patient						
3-	Introducing herself/himself to the patient						
4-	Providing privacy						
5-	Giving Therapeutic touch while calling/caring						
6-	Orienting the patient about day and time/place						
7-	Explaining the procedure to the patient						
8	Uses appropriate non-technical language.						
9	Communicating with the patient while performing procedures						
10	Informing the patient about his/her near and dear ones						
11	Uses verbal and non-verbal communication free of abuse with patients and their families						
12	Communicates with a word of hope about the progress of the case						
13	Maintains an environment suitable for						

	effective communication - a noise-free environment						
14	Communicates respectfully and professionally with family members						
15	Communicates according to stages of development						
16	Communicates according to cultural background						
17	Use short, simple words and sentences						

Appendix : 6 C

الجزء الأول: الخصائص الديموغرافية للتمريضيين

1. العمر:

2. الجنس:

ذكر ☐

أنثى ☐

3. المستوى التعليمي:

خريج إعدادية تمريض ☐

خريج دبلوم في التمريض ☐

خريج بكالوريوس في التمريض ☐

خريج دراسات عليا ☐

4. الحالة الاجتماعية: أعزب/ باكر ☐ متزوج/ متزوجة ☐ منفصل/ منفصلة ☐

ارمل/ ارملة ☐ مطلق/ مطلقة ☐

الجزء الثاني: المعلومات الوظيفية

1. سنوات الخدمة في التمريض ☐

2. مدة خدمتك في وحدة العناية الحرجة ☐

3- شاركت في دورات حول التواصل مع المريض الفاقد للوعي نعم ☐ **كلا** ☐

الجزء الثالث: معارف الممرضين في التواصل مع المرضى فاقدي الوعي

المحور الأول: تشريح وفسلجة الجهاز العصبي

1. **وظيفة الجهاز العصبي تشمل تلقي المعلومات والتكامل ونقل النبضات العصبية إلى الخلايا المتلقية والتي تنجز بواسطة:**

أ- الخلية

ب- الخلايا العصبية

ت- الألياف

2. **تنبع معظم أنشطة الجهاز العصبي من المستقبلات الحسية مثل المستقبلات البصرية أو السمعية أو اللمسية وتنتقل إلى الجهاز العصبي المركزي عن طريق:**

أ- الخلايا العصبية

ب- جسم الخلية

ت- ألياف واردة (ألياف حسية)

3. **الوظائف الاساسية التي تشمل كل من الحسية والحركية والمعرفية تنجز بواسطة:**

أ- القشرة الدماغية

ب- المخيخ

ت- المخ

4. **أكبر فصوص الدماغ تتحكم في الوظائف الإرادية مثل ، الحركية ، المعرفية (التوجه ، الذاكرة، البصيرة، الحكم، الحساب، والتجريد الممتد إلى اللغة التعبيرية الشفوية والمكتوبة هو:**

أ- الفص القذالي(occipital lobe)

ب- الفص الجبهي(frontal lobe)

ت- الفص الصدغي(temporal lobe)

5. **الفص الذي يهتم بالدرجة الأولى بالوظائف الحسية التي تشمل تكامل المعلومات الحسية، الوعي بأجزاء الجسم، تفسير اللمس والضغط والألم هو:**

أ- الفص الجبهي (frontal lobe)

ب- الفص القذالي(occipital lobe)

ت- الفص الجداري(parietal lobes)

6. **الذاكرة البصرية والذاكرة اللفظية (مثل فهم اللغة) وتفسير مشاعر الآخرين وردود أفعالهم تنسق بواسطة:**

أ- الفصوص الجدارية (parietal lobes)

ب- الفص الجبهي(frontal lobe)

ت- الفص الصدغي(temporal lobe)

7. **تقع في الجزء الخلفي من الدماغ ، أسفل الفصوص القذالية**(occipital lobe) **مباشرة والتي تشارك في المهارات الحركية ، والتي تشير إلى تنسيق الحركات الصغيرة ، أو الدقيقة ، وخاصة تلك التي تشمل اليدين والقدمين يشار إليها:**

أ- المخيخ

ب- جذع الدماغ

ت- الفص القذالي (occipital lobe)

8. **الغيبوبة الفورية ناتجة عن تدمير:**

أ- قشرة الدماغ

ب- النوى المركزية الشبكية

ت- منطقة النوى الصفيحية الداخلية.

9. **الغيبوبة العميقة ناتجة عن اضرار صغيرة في:**

أ- المخ

ب. الدماغ المتوسط

ت. منطقة النوى الصفيحية الداخلية

المحور الثاني: مبادئ التواصل الأساسية.

1- **التواصل اللفظي جزء أساسي من:**

أ- عملية الشفاء

ب- مراحل المرض

ت- العملية التمريضية

2- **يجب أن يحافظ التمريضي على التواصل مع المريض الفاقد للوعي:**

أ- أثناء تغيير المناوبة

ب- فقط في أثناء الإجراءات

ت- متى أمكن

3. يعتبر من الحواس الرئيسية وهو وسيلة غير لفضية اساسية في عملية التواصل:

أ- النظر

ب- السمع

ت- اللمس

4- **عندما يحدث تماس مباشر بين التمريضي والمريض اثناء تقديم الرعاية التمريضية هذا النوع من التماس المباشر يطلق علية بتماس:**

أ. راحة

ب. عناية

ت. اطمئنان

5- أحد الإجراءات الاتية سيعزز شفاء المريض الفاقد للوعي:

أ. صوت غير مألوف

ب. مواقف مألوفة

ج. صوت مألوف

6- **العملية الديناميكية المستخدمة في جمع البيانات والتعليم والإقناع والتعبير عن العناية والراحة هي:**

أ- التقييم

ب- التواصل

ت- الفحص البدني.

7- **عندما يقوم التمريضيين بتقديم الرعاية للمرضى في أثناء الاتصال المباشر مما يجعل هناك مسافة قريبة من 0 إلى 1 2/1 قدم من المريض ، فإن هذه المسافة تشير إلى:**

أ- المسافة العامة

ب- المسافة الشخصية

ت- المسافة الحميمة

8- **قد يتلقى التمريضي معلومات عن المريض قبل لقائه وجهاً لوجه مثل(الاسم ،العنوان ،العمر، التاريخ الطبي و / أو التاريخ الاجتماعي) والتي تعتبر ..... مرحلة التواصل**:

أ- مرحلة ما قبل التفاعل

ب- المرحلة التمهيدية

ت- مرحلة العمل

9- **التفاعل بين اختصاصي الرعاية الصحية والمريض الذي يتعلق بتعزيز راحة المريض وسلامته وثقته ورفاهيته يعرف باسم:**

أ- التواصل العلاجي

ب- العملية التمريضية

ت- التواصل غير العلاجي

10- **اثناء رعاية المرضى فاقدي الوعي علينا الاخذ بنظر الاعتبار قضية اساسية وهي:**

أ- علاج التواصل

ب- العلاج الطبيعي

ت- العلاج الارشادي.

11- **عملية ثنائية الاتجاه في التواصل ربما تستعمل كجزء أساس لتقليل قلق المريض والتحفيز العاطفي ، من خلال إرسال رسالة مفهومة وردود الفعل تشير إلى:**

أ- التواصل اللفظي

ب- التواصل غير اللفظي

ت- الرعاية التمريضية

12- **لغة الجسد تشمل الإيماءات والمواقف واللمس والمظهر الجسدي تشير إلى:**

أ- التواصل غير اللفظي

ب- التواصل اللفظي

ت- وضعية الجسم.

المحور الثالث: التواصل العلاجي وغير العلاجي

1. **العديد من العوامل تساهم كعوائق في التواصل العلاجي مثل:**

أ. طرح أسئلة مفتوحة

ب. طرح الأسئلة ذات صلة بالموضوع

ت. طرح الأسئلة التي يمكن الإجابة عليها بنعم أو لا

2. **أحد أهداف التواصل العلاجي هو**

أ. تقديم العلاج للمرضى

ب. وضع عوائق أمام التواصل

ت. مساعدة المرضى على معرفة أفكارهم

3. **تقنيات التواصل غير العلاجية تشمل على ما يلي:**

أ- إبداء الرأي الشخصي

ب- طلب الإيضاحات

ت- مشاركة المشاعر

4. **تعتبر واحدة من استراتيجيات التواصل العلاجي؟**

أ. الصمت

ب. الجدال

ت. الردود التلقائية

المحور الرابع: التواصل مع المرضى فاقدي الوعي

1. **يجب توخي الحذر عند استعمال التماس مع المرضى:**

أ- فاقدي الوعي

ب- الذين لديهم سلوك عدائي

ت- الذين يعانون من ألم شديد

2. **التواصل مع المرضى فاقدي الوعي يسبب أذى أو تأثيرات جانبية فسيولوجية خطيرة للمريض:**

أ- في الواقع نعم

ب- في الواقع لا

3. عوائق التواصل تشمل ما يلي:

أ- الخلل في الوعي

ب- مريض مع الم شديد

ت- مريض نفسيا

4. **أكثر مضاعفات الغيبوبة والاستشفاء شيوعًا للمريض في وحدة العناية المركزة هي:**

أ- الشلل

ب- الخفقان

ت- الحرمان الحسي

5. المعلومات التي يتلقاها المرضى فاقدو الوعي تساهم في:

أ- تزيد من التوتر

ب- تساعد على تقليل التوتر

ت- ليس لها تأثير على المريض

6. **متلازمة وحدة العناية المركزة تشمل الآتي:**

أ- الخوف من الآخرين

ت- اضطرابات الذاكرة

ث- ج- عدم القدرة على الكلام

7. **يجب على الممرضة تقديم نفسها للمريض فاقد الوعي عند تقديم الرعاية:**

أ- ليست ضرورية

ب- ضرورية

ت- لا حاجة لها

8. يجب على التمريضي التواصل مع المريض الفاقد للوعي مثل تواصله مع المرضى الواعيين:

أ- غير ضرورية

ب- ضرورية

ت- لا حاجة لها

9. ليس من الضروري إبلاغ المرضى الفاقدين للوعي بالأحداث الجارية ، مثل التشخيص والعلاج والتدخلات الطبية والتمريضية

أ- ليس دائما

ب- من حقه

ت- لا داعي لا يمكنه المناقشة

10. **عندما تقدم الممرضة الرعاية التمريضية للمريض ، مثل سحب السوائل أو تغيير وضع المريض ، يجب عليه:**

أ. شرح جميع الإجراءات قبل التنفيذ

ب. ليس من الضروري ابلاغ المريض

ت. اشرح الإجراءات لأسرة المريض فقط

11. الممرض يوجه المريض الفاقد للوعي إلى الزمان والمكان مرة واحدة على الأقل كل ---- ---- ساعة

أ- 8

ب- 24

ت- ليس عليه أن يخبره بأي شيء

12. **يؤدي عدم التواصل أو عدم كفاية التواصل بين الممرضة والمريض فاقد الوعي إلى:**

أ - زيادة مستويات التوتر والقلق لدى المريض

ب - زيادة مستويات التوتر والقلق لدى الممرضة

ت - ليس لها تأثير

<u>المحور الخامس: التواصل مع المرضى تحت التهوية الصناعية</u>

1. **هناك طرائق عدة لتعزيز التواصل مع المرضى الخاضعين للتهوية مثل:**

أ- الرعاية التمريضية

ب- العلاجات الصوتية

ت- العلاجات الطبية

2. أنسب طريقة للتواصل والتي يفضل استعمالها للمريض الذي يخضع لتهوية صناعية قصيرة الأجل ويكون واعيا ويمكنه تحريك يد واحدة على الأقل:

أ- الإيماءات

ب- الكتابة

ت- تقنيات النطق

3. - أي مما يلي يعد طرق تواصل بديلة للمرضى المعتمدين على جهاز التنفس الصناعي باستثناء:

أ- مترجم ومترجم فوري

ب- لوحة التواصل

ت- القلم والورق

4. من الضروري تشجيع أسرة المريض الفاقد للوعي على المشاركة في رعاية المريض:

أ- صح

ب- خطأ

ت- بالتأكيد أحياناً

5. زيارة المرضى المحتضرين في وحدة العناية المركزة يجب أن:

أ- تقييد

ب- تشجع

ت- غير مفيدة

6. مع اقتراب المريض من الموت ، من المهم مواصلة الرعاية من قبل نفس التمريضي حتى بعد انتهاء المناوبة:

أ- ليس ضرورياً

ب- من الضروري جداً

ب- لا داعي للإصرار على الرعاية خلال هذه الفترة

7. يجب السماح للعائلات بالحضور أثناء الإنعاش القلبي الرئوي وجميع الإجراءات التنفسية:

أ- غير ضروري

ب- إنه ضروري للغاية

ت- لا داعي للتأكيد على الرعاية خلال هذه الفترة

8. المرضى الفاقدون للوعي لديهم حاجة كبيرة للمعلومات والدعم

أ- دائما في جميع الأوقات

ب - ليس من الضروري تزويدهم بالمعلومات لمنع الخلط في الأفكار

ج- من الممكن في بعض الأحيان تزويدهم بالمعلومات اللازمة

9. المريض فاقد الوعي يسمع ويفهم الأحاديث من حوله؟

أ - منفصل تماما عن البيئة الخارجية

ب. يستلمون ويفهمون المحادثات

ت- يسمعون الاصوات ولا يميزون

10. يجب على التمريضيين التحدث بنبرة محادثة عادية مع توفير الرعاية للمرضى الفاقدين للوعي.

أ- غير ضرورية

ت- ضرورية

ث- في بعض الحالات فقط

<u>المحور السادس: نصائح لأسر المرضى الفاقدين للوعي حول التواصل مع مريضهم</u>

1. **يجب أن ينصح التمريضي أسر المرضى فاقدي الوعي بما يأتي:**

أ- عدم التحدث مع المريض

ب- التحدث مع المريض عن الأخبار العامة والاجتماعية

ت- تحدث بعناية مع المريض

2. **من المهم تشجيع أسرة المريض وأصدقائه على البقاء إيجابيين عند زيارة المريض الفاقد للوعي:**

أ- ليس من الضروري أنه لا يشعر

ب- إنه ضروري للغاية

ت- ليس له تأثير معنوي

3. **زيارة أسرة المريض الفاقد للوعي له في وحدة العناية المركزة تسبب:**

أ- لها عواقب سلبية على المريض

ب - زيادة مستوى وعي المريض

ت - ليس لها تأثير

المحور السابع: ممارسة الممرضين خلال التواصل مع المريض الفاقد للوعي

ت	الفقرة: يقوم التمريضي بالإجراءات التالية	المشاهدة الاولى		المشاهدة الثانية		المشاهدة الثالثة	
		نعم	كلا	نعم	كلا	نعم	كلا
-1	ينادي المريض بأسمة						
2	يحيي المريض						
3	يقدم نفسه للمريض						
4	توفر الخصوصية للمريض						
5	يلمس المريض لمسة علاجية اثناء التواصل/العناية						
6	يرشد المريض إلى اليوم والزمان والمكان						
7	يشرح الإجراءات للمريض						
8	يستخدم لغة مناسبة غير فنية						
9	تتواصل مع المريض أثناء القيام بالإجراءات						
10	تخبر المريض بأقاربه وأعزاءه						
11	يستعمل التواصل اللفظي وغير اللفظي خالي من الإساءة مع المرضى وأسرهم						
12	يتواصل بكلمة مفعمة بالأمل حول تقدم الحالة						
13	يحافظ على بيئة مناسبة للتواصل الفعال - بيئة خالية من الضوضاء						
14	يتواصل باحترام ومهنية مع أفراد الأسرة						
15	يتواصل وفقًا لعمر المريض						
16	يتواصل وفقًا للخلفية الثقافية للمريض						
17	تستخدم كلمات وجمل قصيرة وبسيطة						

Appendix: 7

برنامج الدراسة

فاعلية البرنامج التعليمي على معارف وممارسات التمريضيين في التواصل مع المرضى فاقدي الوعي في وحدات العناية الحرجة.

التواصل مهم للغاية ، لأنه يحدد تحسنًا ملحوظًا في النتائج الصحية للمرضى ويزيد من وعي الممرضات بعوامل الإجهاد للمرضى. فيما يتعلق بآثار التواصل اللفظي مع المرضى فاقد الوعي ، يتفق العديد من المؤلفين على أن التواصل عنصر أساسي في الرعاية.

الأهداف العامة للبرنامج: -

1- تحديد تغير مستوى الوعي ،علم وظائف الأعضاء والفيزيولوجيا المرضية للجهاز العصبي.

2- التعرف على تشريح الدماغ.

3- التعرف على العنصر الأساسي للتواصل

4- التعرف على التواصل التمريضي مع المريض الفاقد للوعي

5- التعرف على طريقة التواصل مع مريض التنفس الصناعي

6- وصف أهمية التواصل الأسري مع مريضهم

الجلسة الأولى

العنوان: الجهاز العصبي وفقدان الوعي

المكان: مستشفى الحلة التعليمي

طريقة التدريس: محاضرة

وسائل تعليمية: عرض شرائح و صور.

الاهداف الخاصة:

1- وصف تشريح ووظائف الدماغ والتغيير الفسيولوجي للدماغ للمرضى فاقدي الوعي.

2- التعرف على التغيرات في مستوى الوعي والفيزيولوجيا المرضية التي تحدث في الجهاز العصبي.

3- معرفة فقدان الوعي ومراحل التغيير في الوعي.

ما هو الدماغ؟

الدماغ هو عضو يتكون من كتلة كبيرة من الأنسجة العصبية المحمية داخل الجمجمة. له دورًا في كل نظام الجسم الرئيسي تقريبًا. تشمل بعض وظائفه الرئيسية ما يلي:

1- معالجة المعلومات الحسية

2- تنظيم ضغط الدم والتنفس

3- إفراز الهرمونات

يتكون الدماغ من:

أ- المخ: المخ هو أكبر جزء من الدماغ. مقسم إلى نصفين يسميان نصفي الكرة. ينقسم كل نصف من المخ إلى مناطق واسعة تسمى الفصوص والتي تشمل:

1- الفص الجبهي: وهو أكبر الفصوص الموجودة في الجزء الأمامي من الدماغ. الوظائف الرئيسية للفص الجبهي هي :الحركية الإرادية ، والوظيفة المعرفية (التوجيه ، والذاكرة ، والبصيرة ، والحكم ، والحساب) ، واللغة التعبيرية (الشفوية والمكتوبة).

2- الفص الجداري: يقع خلف الفص الجبهي. يهتم بشكل أساسي بالوظائف الحسية ، بما في ذلك تكامل المعلومات الحسية ؛ الوعي بأجزاء الجسم. تفسير اللمس والضغط والألم ؛ والتعرف على حجم الجسم وشكله وملمسه.

3- الفص الصدغي: يقع على جانبي الرأس على نفس مستوى الأذنين. يقوم بتنسيق وظائف محددة ، بما في ذلك الذاكرة البصرية (مثل التعرف على الوجه) ، والذاكرة اللفظية (مثل فهم اللغة) ، وتفسير مشاعر الآخرين وردود أفعالهم.

4- الفص القذالي: يقع في مؤخرة الدماغ. له القدرة على قراءة الكلمات المطبوعة والتعرف عليها ، مع جوانب أخرى من الرؤية.

ب- المخيخ: يقع المخيخ في الجزء الخلفي من الدماغ ، أسفل الفصوص القذالية. حيث إنها مرتبطة بالمهارات الحركية الدقيقة ، والتي تنسق الحركات الصغيرة أو الدقيقة ، خاصة حركة اليدين والقدمين.

ج- الدماغ البيني: يقع الدماغ البيني في قاعدة الدماغ. يحتوي على:

1- المهاد: يعمل المهاد كمحطة ترحيل للإشارات الواردة إلى الدماغ. كما أنها تشارك في الوعي والنوم والذاكرة.

2- فوق المهاد: يعمل المهاد كحلقة وصل بين الجهاز الحوفي وأجزاء أخرى من الدماغ. الجهاز الحوفي هو جزء من الدماغ يشارك في العاطفة والذاكرة طويلة المدى والسلوك.

3- تحت المهاد: يساعد ما تحت المهاد في الحفاظ على التوازن. حيث يؤدي إلى توازن جميع وظائف الجسم.

د- جذع الدماغ: يقع جذع الدماغ أمام المخيخ ويتصل بالحبل الشوكي. يتكون من ثلاثة أجزاء رئيسية:

• **الدماغ المتوسط:** يساعد الدماغ المتوسط على التحكم في حركة العين ومعالجة المعلومات المرئية والسمعية.

• **الجسور:** إنها مجموعة من الأعصاب التي تساعد على توصيل أجزاء مختلفة من الدماغ. يحتوي الجسر أيضًا على بداية بعض الأعصاب القحفية. تساهم هذه الأعصاب في حركات الوجه ونقل المعلومات الحسية.

• **النخاع المستطيل:** يعمل كمركز تحكم لوظائف القلب والرئتين. يساعد في تنظيم العديد من الوظائف المهمة ، كالتنفس والعطاس والبلع.

فسيولوجيا الجهاز العصبي

• الخلايا العصبية تنفذ العمل الوظيفي للجهاز العصبي ، بما في ذلك تلقي المعلومات ، دمج ، ونقل النبضات العصبية إلى الخلايا المتلقية.

• تنشأ معظم أنشطة الجهاز العصبي من المستقبلات الحسية مثل المستقبلات البصرية أو السمعية أو اللمسية وتنتقل إلى الجهاز العصبي المركزي عن طريق الألياف الواردة (الألياف الحسية).

• الألياف الفعالة (الألياف الحركية) تنقل استجابة الجهاز العصبي المركزي إلى الأطراف لإنتاج استجابة حركية مثل تقلص العضلات الهيكلية ، أو تقلص العضلات الملساء للأعضاء ، أو إفراز الغدد الصماء.

• تشمل الوظائف الأساسية للقشرة الدماغية الوظائف الحسية والحركية والمعرفية.

• تشمل الوظائف الأساسية للمخيخ التوازن والتنسيق الحركي.

• الوظيفة الأساسية لجذع الدماغ (الدماغ المتوسط ، الجسر ، النخاع) هي تنظيم الوظائف الحيوية مثل التنفس.

تشريح الجهاز العصبي وفسيولوجيا الوعي

يلعب التكوين الشبكي الذي يبدأ في النخاع ويمتد إلى الدماغ المتوسط دورًا رئيسيًا في دورات النوم واليقظة عند الحيوانات والبشر. يحتل جزءًا كبيرًا من جذع الدماغ الظهري ويشكل شبكة من الألياف الشبكية التي تتشابك مع العديد من مسارات الألياف الصاعدة والهابطة وتعدلها. يعتبر تكوين الشبكية ضروريًا للوظيفة الذهنية والعاطفية اليومية ، وللتناسق الحركي وتعديل المسار الحسي.

المجموعة المركزية من النوى تُعرف بنظام النشاط الشبكي. تتلقى هذه المجموعة مدخلات حسية متقاربة كبيرة من جميع الطرائق والمشاريع الحسية إلى المهاد (أي النوى داخل الصفيحة) القاعدية الكولينية لنواة الدماغ والقشرة الدماغية بأكملها. تنتج الغيبوبة الفورية عن تدمير النواة

الشبكية المركزية عند مستوى الجزء العلوي أو فوقه. يؤدي الاذى الصغير جدًا في منطقة النواة داخل الصفيحة إلى غيبوبة عميقة ، على الرغم من سلامة جذع الدماغ والقشرة.

ما هو اللاوعي؟

كلمة واعي مشتق من الكلمة اللاتينية "conscius" التي تعني "معرفة". الوعي هو حالة اليقظة التي يمكن للشخص أن يتفاعل بشكل مناسب مع المواقف وتذكر الاحداث. اللاوعي يعني موت الوعي أو هو حالة من عدم الإحساس تتميز بفقدان البيئة الخارجية وعدم القدرة على الاستجابة للمنبهات الحسية.

مراحل التغيير في الوعي:

1- التشوش: وهو فقدان القدرة على التفكير بسرعة ووضوح. ضعف في الحكم واتخاذ القرار.

2- الارتباك: وهو بداية فقدان الوعي. الارتباك في الوقت والأماكن والأشخاص.

3- الخمول: وهو قلة الحركة أو الكلام العفوي. يُثار المريض بسهولة بالكلام أو اللمس ولكن لا يتم توجيهه إلى المكان أو الأشخاص أو الوقت.

4- الاستغراق: وهو ضعف القدرة على الاستثارة والاستجابة المحدودة للبيئة. ينام المريض ما لم يتم تحفيزه بالكلام أو اللمس. الرد اللفظي على الأسئلة قليل.

5- الخدر: حالة من النوم العميق أو عدم الاستجابة قد لا يثار منها المريض إلا بمحاكاة قوية وأحيانًا مؤلمة. يستجيب المرضى بالارتداد من عند مصدر الألم.

6- الغيبوبة: لا توجد استجابة حركية أو لفظية للبيئة أو أي منبهات حتى الألم العميق أو الشفط ، الغيبوبة تعتبر حالة طويلة من فقدان الوعي.

الخرس الحركي: عدم الاستجابة للبيئة ؛ لا يقوم المريض بأي حركة أو صوت ولكنه يفتح عينيه أحيانًا. بينما الموت الدماغي: هو فقدان لجميع وظائف الدماغ بأكمله لا رجعة فيه ، بما في ذلك جذع الدماغ.

الفيزيولوجيا المرضية لمستوى التغير في الوعي

التغير في الوعي ليس خلل في حد ذاته ؛ بل هو نتيجة لظواهر فيزيولوجية مرضية متعددة. قد يكون السبب عصبيًا (إصابة في الرأس ، سكتة دماغية) ، سموم (جرعة زائدة من المخدرات ، تسمم بالكحول) ، أو ايضي (إصابة كبدية أو كلوية ، الحماض الكيتوني السكري). السبب الكامن وراء الخلل الوظيفي العصبي هو اضطراب في خلايا الجهاز العصبي أو الناقلات العصبية أو تشريح الدماغ. تنجم الاضطرابات عن الوذمة الخلوية أو آليات أخرى ، مثل تعطيل انتقال المواد الكيميائية في مواقع المستقبلات بواسطة الأجسام المضادة. يحتوي المخيخ على كل من الإجراءات الاستثارية والمثبطة وهو مسؤول إلى حد كبير عن تنسيق الحركة. يحتوي جذع الدماغ على مناطق تتحكم في معدل ضربات القلب والتنفس وضغط الدم. الاضطرابات في

الهياكل التشريحية ناتجة عن الصدمة ، أو الوذمة ، أو الضغط من الأورام ، أو آليات أخرى ، مثل زيادة أو نقصان الدورة الدموية أو السائل النخاعي.

الجلسة الثانية

العنوان: مهارات الاتصال الأساسية

المدة: 30 ساعة

المكان: مستشفى الحلة التعليمي

طريقة التدريس: محاضرة

الوسائل التعليمية: عرض شرائح

الاهداف الخاصة: -

1- معرفة التواصل وتحديد العناصر الأساسية للتواصل

2- التعرف على طرق التواصل والعوامل المؤثرة في عملية التواصل.

3- معرفة مراحل التواصل.

4- معرفة عملية التواصل.

5- معرفة التداخل بين التواصل و العملية التمريضية.

مقدمة

التواصل هو مهارة حاسمة للتمريض. إنها العملية التي يلبي بها البشر احتياجات البقاء على قيد الحياة ، وبناء العلاقات ، وتجربة العواطف. في التمريض ، يعد التواصل عملية ديناميكية تُستخدم لجمع بيانات التقييم ، وللتعليم والإقناع ، وللتعبير عن الرعاية والراحة.

العناصر الأساسية للتواصل

1. **المرسل:** الشخص أو المجموعة التي ترغب في إيصال رسالة إلى شخص آخر، حيث يعتبر مصدر الارسال.
2. **الرسالة:** الرسالة هي ما يقال أو يكتب بالفعل ، ولغة الجسد المصاحبة للكلمات ، وكيف يتم نقل الرسالة.
3. **المتلقي:** هو المستمع الذي يجب أن يسمع ويراقب ويحضر. هذا الشخص هو مفكك التشفير ، الذي يجب أن يدرك ما قصده المرسل (التفسير).

طرق التواصل

1- التواصل اللفظي

التواصل اللفظي هو الوعي إلى حد كبير لأن الناس يختارون الكلمات التي يستخدمونها. تختلف الكلمات المستخدمة بين الأفراد حسب الثقافة والخلفية الاجتماعية والاقتصادية والعمر والتعليم. يمكن أن تنتقل مجموعة متنوعة من المشاعر عندما يتحدث الناس.

2- التواصل غير اللفظي

الذي يُطلق عليه أحيانًا لغة الجسد ، الإيماءات، حركات الجسم، استخدام اللمس والمظهر الجسدي ، بما في ذلك الزينة. غالبًا ما يخبر التواصل غير اللفظي الآخرين عما يشعر به الشخص أكثر مما يُقال في الواقع ، لأن السلوك غير اللفظي يتم التحكم فيه بوعي أقل من السلوك اللفظي. التواصل غير اللفظي إما يعزز أو يتعارض مع ما يقال شفهيًا (.Eubanks et al، 2010).
التواصل غير اللفظي يشمل ما يلي:

1- المظهر الشخصي: يمكن أن تكون الملابس والزينة مصادر للمعلومات عن الشخص ، وقد تنقل الحالة الاجتماعية والمالية ، والدين الثقافي ، والارتباط الجماعي ، ومفهوم الذات.

2- الموقف والمشي: غالبًا ما تكون الطرق التي يمشي بها الناس ويحملون أنفسهم مؤشرات موثوقة لمفهوم الذات والمزاج الحالي والصحة.

3- تعابير الوجه: لا يوجد جزء من الجسم معبر مثل الوجه. مشاعر المفاجأة والخوف والغضب والاشمئزاز والسعادة والحزن يمكن أن تنقلها تعابير الوجه.

4- الإيماءات: قد تؤكد إيماءات اليد والجسد على الكلمة المنطوقة وتوضحها ، أو قد تحدث بدون كلمات للدلالة على شعور معين أو لإعطاء إشارة.

3- الاتصالات الإلكترونية

تتجه العديد من وكالات الرعاية الصحية نحو السجلات الطبية الإلكترونية حيث يوثق الممرضون تقييماتهم ورعايتهم التمريضية.

المزايا: يتمتع البريد الإلكتروني بالعديد من المزايا الإيجابية. إنها طريقة سريعة وفعالة للتواصل ومقروءة. يوفر سجلاً لتاريخ ووقت الرسالة التي تم إرسالها أو استلامها.

العيوب: أحد الجوانب السلبية أو السلبية للبريد الإلكتروني هو قلق كل من العملاء ومقدمي الرعاية الأولية فيما يتعلق بالخصوصية والسرية وإساءة الاستخدام المحتملة للمعلومات

العوامل المؤثرة في عملية التواصل

1- التطوير

2- الجنس

3- القيم والتصورات

4- المساحة الشخصية: المساحة الشخصية هي المسافة التي يفضلها الناس في التفاعل مع الآخرين. وبالتالي يتغير الاتصال وفقًا لأربع مسافات

1. الحميمة: 0-1 1⁄2 قدم

2. شخصي: 1 1⁄2 إلى 4 أقدام

3. الاجتماعية: من 4 إلى 12 قدمًا

4. العامة: 12 قدما وما بعدها.

يتميز التواصل الحميم عن بعد بالتلامس الجسدي ، والإحساس المتزايد بحرارة الجسم والرائحة ، والأصوات المنخفضة. كثيرا ما تستخدم الممرضات المسافة الحميمة. تشمل الأمثلة احتضان طفل ، ولمس مريض كفيف ، وتقييد طفل صغير للحقن.

المسافة الشخصية أقل إرهاقًا من المسافة الحميمة. نغمات الصوت معتدلة ، وتقل ملاحظة حرارة الجسم والرائحة. من الممكن الاتصال الجسدي مثل المصافحة أو لمس الكتف.

تتطلب المسافة العامة أصواتًا عالية وواضحة مع نطق دقيق. على الرغم من أن وجوه الناس وأشكالهم تُرى على مسافة عامة ، إلا أن الفردية تضيع.

5- البيئة: عادة ما يتواصل الناس بشكل أكثر فاعلية في بيئة مريحة. يمكن أن تتداخل درجات الحرارة القصوى والضوضاء المفرطة والبيئة سيئة التهوية مع التواصل. أيضًا ، قد يتعارض نقص الخصوصية مع تواصل المريض بشأن الأمور التي يعتبرها المريض خاصة. يمكن أن يضعف الإلهاء البيئي التواصل ويشوهه.

مراحل التواصل

1- مرحلة ما قبل التفاعل

تشبه مرحلة ما قبل التفاعل مرحلة التخطيط قبل المقابلة. في معظم الحالات ، يكون لدى الممرضة معلومات حول المريض قبل الاجتماع الأول وجهًا لوجه. قد تتضمن هذه المعلومات اسم المريض و / أو العنوان و / أو العمر والتاريخ الطبي و / أو التاريخ الاجتماعي.

2- المرحلة التمهيدية

تعتبر المرحلة التمهيدية ، والتي يشار إليها أيضًا باسم مرحلة التوجيه أو مرحلة ما قبل التمكين ، مهمة لأنها تحدد بقية العلاقة. خلال هذا اللقاء الأولي ، يراقب المريض والممرض بعضهما البعض عن كثب ويصدران أحكامًا حول سلوك الآخر. هدف الممرض في هذه المرحلة هو تطوير الثقة والأمان ضمن علاقة الممرض بالمريض (Boyd، 2012).

3- مرحلة العمل

أثناء مرحلة عمل علاقة المساعدة ، يبدأ الممرض والمريض في النظر إلى بعضهما البعض كأفراد متفردين. تتكون مرحلة العمل من مرحلتين رئيسيتين: استكشاف وفهم الأفكار والمشاعر ، والتيسير واتخاذ الإجراءات.

4- مرحلة الإنهاء

غالبًا ما يُتوقع أن تكون مرحلة إنهاء العلاقة صعبة ومليئة بالتناقض. ومع ذلك ، إذا تطورت المراحل السابقة بشكل فعال ، فإن لدى المريض عمومًا نظرة إيجابية ويشعر بالقدرة على التعامل مع المشكلات بشكل مستقل.

التواصل والعمليات التمريضية

التواصل جزء لا يتجزأ من عملية التمريض. يستخدم الممرضين مهارات التواصل في كل مرحلة من مراحل عملية التمريض. التواصل مهم أيضًا عند رعاية المرضى الذين لديهم مشاكل في التواصل. تعتبر مهارات التواصل أكثر أهمية عندما يكون لدى المريض عجز في الحواس أو اللغة أو الإدراك.

الرعاية التمريضية تشمل:

1- التقييم

لتقييم قدرات الاتصال لدى المريض ، يحدد الممرض ضعف أو حواجز التواصل وأسلوب التواصل.

2- **التشخيص**

يمكن استخدام ضعف التواصل اللفظي كتشخيص تمريضي عندما يعاني الفرد من "انخفاض أو تأخير أو غياب القدرة على تلقي المعلومات (على سبيل المثال ، صعوبة في السمع أو صعوبة في التحدث).

3- **التخطيط**: عندما يتم إجراء تشخيص تمريضي متعلق بضعف التواصل اللفظي ، يحدد الممرض والمريض النتائج ويبدآن في التخطيط لطرق تعزيز التواصل الفعال.

4- **التنفيذ**: تشمل تدخلات التمريض لتسهيل التواصل مع المرضى الذين يعانون من مشاكل في الكلام أو اللغة ، التلاعب بالبيئة ، وتقديم الدعم ، واستخدام التدابير لتعزيز التواصل ، وتثقيف المريض.

5- **التقييم:** التقييم مفيد للتواصل بين المريض والممرض.

الجلسة الثالثة

العنوان: التواصل العلاجي

المدة: 30 دقيقة

المكان: مستشفى الحلة التعليمي

طريقة التدريس: عرض شرائح.

الأهداف الخاصة:

1-معرفة التواصل العلاجي.

2- معرفة اهداف التواصل العلاجي.

3- وصف معوقات التواصل العلاجي.

4- وصف تقنيات التواصل العلاجي.

مقدمة

يعرف التواصل العلاجي على أنه تبادل الأفكار والتعليمات الصحية والمعلومات واختيار الرعاية والمشاعر لتحقيق الأهداف المرغوبة وتقوية العلاقات الشخصية مع المرضى ومقدمي الرعاية الصحية. التواصل العلاجي يركز على المريض.

التفاعل بين أخصائي الرعاية الصحية والمريض يهدف إلى تعزيز راحة المريض، سلامته، ثقته أو صحته ورفاهه.

أهداف التواصل العلاجي

1- لتعزيز فهم أكبر لاحتياجات المريض واهتماماته ومشاعره.

2- عند ممارسة التواصل العلاجي ، يساعد الممرضين المرضى على استكشاف أفكارهم ومشاعرهم ، وتشجيع التعبير عنها ، وتجنب حواجز التواصل.

حواجز أو عوائق للتواصل العلاجي

يمكن أن تساهم العديد من العوامل في عدم نجاح التواصل التي تشمل:

1. قد يرسل المرسل رسالة محيرة أو غير كاملة.

2. قد تصبح الرسالة مشوهة أو يساء فهمها ، أو قد لا يتم استلامها على الإطلاق.

3- تشمل الحواجز غير اللفظية للتواصل النظرة المشتتة ، الابتعاد، تخويف المرضى بالوقوف فوقهم أثناء جلوسهم.

حواجز التواصل تشمل ما يلي:

• طرح الأسئلة التي يمكن الإجابة عليها بـ "نعم" أو "لا": "هل تشعر بتحسن بعد التحدث إلى الطبيب؟"

• إعطاء طمأنة كاذبة: "لا تقلق ، كل شيء سيكون على ما يرام."

• طرح الكثير من الأسئلة الاستقصائية الشخصية: "لماذا تعتقد ذلك؟"

• تقديم النصيحة: "أعتقد أنه يجب عليك ..." أو "إذا كنت مكانك ..."

• التقليل من شأن مشاعر المريض: "هناك مرضى آخرون يحتاجون إلى مساعدة أكثر منك".

• التعبير عن الرفض: "لن أقرر أبدًا عدم العلاج الكيميائي".

تقنيات التواصل العلاجي؟

1- الاستماع الفعال - الانتباه لما يقوله المريض بشكل لفظي وغير لفظي. اجلس في مواجهة المريض، وانحن نحو المريض ، والتركيز بالعين، والاسترخاء.

2- تبادل الملاحظات - إبداء الملاحظات بالتعليق على مظهر الشخص الآخر أو أصواته أو تصرفاته. مثال: "تبدو متعبًا" أو "لم أراك تأكل أي شيء اليوم".

3- مشاركة التعاطف- القدرة على فهم وقبول واقع الشخص الآخر ، وإدراك المشاعر بدقة ، وتوصيل الفهم.

4- مشاركة الأمل - إيصال "الإحساس بالإمكانية" للآخرين. التشجيع عند الاقتضاء والإيجابي. مثال "أعتقد أنك ستجد طريقة لمواجهة موقفك ، لأنني رأيت شجاعتك في الماضي".

5- مشاركة الفكاهة- يساهم في زيادة مشاعر التآزر والتقارب والود.

6- مشاركة المشاعر - يمكن للممرضين مساعدة المرضى على التعبير عن المشاعر من خلال تدوين الملاحظات ، والاعتراف بالمشاعر ، وتشجيع التواصل ، وإعطاء الإذن بالتعبير عن المشاعر "السلبية" .

7- استخدام اللمس - أقوى أشكال التواصل. تعتبر اللمسة المريحة مثل الإمساك باليد مهمة بشكل خاص للمرضى الضعفاء الذين يعانون من مرض شديد.

8- الصمت - يجب أن يسمح الممرض للمريض بقطع حاجز الصمت.

9- التوضيح - للتحقق مما إذا كان الفهم دقيقًا ، أو لفهم أفضل ، يعيد الممرض صياغة رسالة غير واضحة أو غامضة لتوضيح معنى المرسل. "لست متأكدًا من أنني أفهم ما تقصده بعبارة" أكثر سوءًا من المعتاد "، ما هو الاختلاف الآن؟"

10- التركيز- ملاحظة فكرة واحدة معبر عنها أو حتى كلمة واحدة. مثال على ذلك "على مقياس من 0 إلى 10 أخبرني بمستوى الألم الذي تعاني منه في إصبع قدمك الكبير الآن."

11- إعادة صياغة- إعادة صياغة رسالة شخص آخر بإيجاز باستخدام الكلمات الخاصة.

12- طرح الأسئلة ذات الصلة - تسمح الأسئلة المفتوحة بأخذ زمام المبادرة في المحادثة وتقديم المعلومات ذات الصلة بالموضوع.

13- توفير المعلومات - المعلومات ذات الصلة مهمة لاتخاذ القرارات.

14- التلخيص- يجمع المعلومات للتوثيق. يعطي- إنها مراجعة موجزة للجوانب الرئيسية للتفاعل.

15- الكشف عن الذات - يتم الكشف عن التجارب الشخصية الحقيقية الذاتية عن الذات عمدًا إلى شخص آخر بغرض التأكيد على أوجه التشابه والاختلاف في التجارب.

16- المواجهة - مساعدة المريض على إدراك التناقضات في مشاعره ومواقفه ومعتقداته وسلوكياته.

تقنيات التواصل غير العلاجي تشمل:

1- طرح أسئلة شخصية
2- إبداء الرأي الشخصي
3- تغيير الموضوع
4- الردود التلقائية
5- الاطمئنان الكاذب - "لا تقلق ، كل شيء سيكون على ما يرام
6- التعاطف
7- طلب توضيحات - "لماذا أنت مستاء للغاية؟"
8- الموافقة أو الرفض
9- الردود الدفاعية
10- الردود السلبية أو العدوانية
11- الجدال

الجلسة الرابعة

العنوان: التواصل مع المرضى فاقدي الوعي

المدة: 40 دقيقه

المكان: مستشفى الحلة التعليمي

طريقة التدريس: المحاضرة والممارسة

الأهداف الخاصة:

1-معرفة أهمية التواصل للمرضى فاقدين الوعي.

2- التعرف على أهمية تواصل الممرضين مع المرضى فاقدين الوعي.

3-وصف المبادئ التوجيهية في التواصل مع المريض فاقد للوعي.

مقدمة

إن التواصل مع المرضى المصابين بأمراض خطيرة له أهمية أساسية وهو يمثل تحديًا كبيرًا ، خاصةً عندما يكون المريض تحت تأثير التخدير والتهوية وعدم القدرة على الكلام. لذلك ، في هذا الموقف الصعب للغاية ، يعد التواصل اللفظي واللمس وسيلة قابلة للقياس لنقل الرسائل.

التواصل مهم للغاية ، لأنه يحدد تحسنًا ملحوظًا في النتائج الصحية للمرضى ويزيد من وعي الممرضين بعوامل الإجهاد للمرضى. فيما يتعلق بآثار التواصل اللفظي مع المرضى فاقدين الوعي ، يتفق العديد من المؤلفين على أن التواصل عنصر أساسي في الرعاية.

إن رعاية المرضى غير القادرين على التعبير عن أنفسهم لفظيًا تتطلب بشكل خاص اختصاصيي الرعاية الصحية لأنها تتطلب كفاءات محددة مثل التقييم السريري لمستوى الوعي ومستوى الألم والمهارات المصاحبة له ، باستخدام التواصل غير اللفظي لتحسين إمكانية تعافي المريض.

السمع هو آخر حاسة يتم الانتقال إليها عندما يصبح الشخص فاقدًا للوعي. أفاد عدد من الدراسات أنه بعد استعادة الوعي ، قال بعض المرضى إنهم سمعوا وفهموا المحادثات المختلفة التي حدثت أثناء فقدانهم للوعي.

أهمية التواصل مع المرضى فاقدي الوعي

1- المرضى الفاقدون للوعي لديهم حاجة كبيرة للمعلومات والدعم.

2- يمكن أن يوفر التواصل اللفظي مدخلات حسية موجهة وذات مغزى لهؤلاء المرضى.

3- تساعد المعلومات التي يتلقاها المرضى الفاقدون للوعي في تقليل التوتر ومساعدة المرضى على الحفاظ على الهوية الذاتية واحترام الذات وتقليل العزلة الاجتماعية.

4- أكد خبراء التواصل أن استخدام التواصل غير اللفظي في شكل تواصل حذر مع التواصل اللفظي له نتائج كبيرة بالنسبة للمرضى فاقدي الوعي.

5- يمكن أن تعزز الرسائل التي يتلقاها المريض وتساعد على تلبية احتياجات المريض النفسية ويمنع الانسحاب الذهاني والهذيان مما قد يساهم في الضغط النفسي والارتباك والقلق والعزلة.

6- على الرغم من أهميته ، إلا أن هناك أدلة على أن التواصل في وحدات العناية المركزة لا يتم تنفيذه بشكل كافٍ في الممارسة العملية.

7- لاحظ الباحثون أيضًا أن الممرضين لا يتحدثون كثيرًا مع المرضى الفاقدين للوعي أثناء القيام بأي إجراء. حتى لو تواصلوا ، فإن الأمر يتعلق بفحص ردود أفعال المريض فقط.

أهمية تواصل الممرضين مع المرضى الفاقدين للوعي:

1- مهارة التواصل مهمة للممرضين لأنها تساعدهم على تقديم رعاية تمريضية كفؤة.

2- التواصل يمكّن الممرضين من إقامة علاقة عمل مع المرضى ومساعدتهم على تلبية احتياجات الرعاية الصحية الخاصة بهم.

3- التواصل الفعال هو المحدد الرئيسي لرضا المريض والامتثال والتعافي.

4- التواصل الناجح هو قلب الرعاية للمرضى.

5- التواصل هو الوسيلة التي يستخدمها الممرضين لتقديم المساعدة للمرضى.

ذكريات المرضى فاقدي للوعي

تشير دراسات ذكريات المرضى عن حالتهم وهم فاقدي الوعي إلى أنهم سمعوا وفهموا المحادثات. وجد لورانس (1995) أن المرضى الفاقدين للوعي يمكنهم الاستماع والاستجابة عاطفياً للتواصل اللفظي. أحد المرضى ، عند تقييمه من الناحية العصبية ، فهم طلب الممرض للضغط على يده لكنه لم يكن قادرًا على الحركة. وقال آخر: "كان بإمكاني التفكير والسماع ، لكنني لم أستطع التحرك ولم أستطع التحدث أو فتح عيني.

المرضى الفاقدون للوعي مشوشون بشأن المكان والزمان والشخص ، وليس لديهم سيطرة على أنفسهم أو بيئتهم ويعتمدون بشكل كبير على الممرضين. على الرغم من أنهم غير قادرين على الاستجابة للمنبهات الخارجية ، إلا أنه تم توثيق أن العديد من المرضى قد استعادوا وعيهم وقدموا حسابات دقيقة لما حدث لهم في مرحلة اللاوعي. السمع هو آخر حاسة تفقد عندما يصبح الشخص فاقدًا للوعي. غالبية المرضى الفاقدون للوعي لديهم جذع دماغ سمعي طبيعي يستجيب وانهم قد يسمعون.

لا يوجد دليل على أن التواصل مع المرضى فاقدين الوعي يسبب أي ضرر أو أحداث عكسية فسيولوجية خطيرة. بالإضافة إلى ذلك ، أدت التطورات الأخيرة في مجال التصوير العصبي الوظيفي إلى أدلة مثيرة على أن المرضى الفاقدين للوعي يمكنهم سماع بعض القدرات المعرفية والاحتفاظ بها.

التواصل مع المرضى الفاقدين للوعي أثناء الرعاية

1- يمكن للأفراد الفاقدين للوعي في كثير من الأحيان سماع ما يتم التحدث به على الرغم من أنهم غير قادرين على الاستجابة.

2- من المهم أن يحذر الممرض مما يقال في وجود مريض فاقد للوعي.

3- يجب على الممرضين التحدث بنبرة محادثة عادية أثناء تقديم الرعاية. تذكر أيضًا قيمة التواصل غير اللفظي ، ولمس المريض الفاقد للوعي.

إرشادات للممرضين/الممرضات للتواصل مع المرضى فاقدي الوعي.

1- افترض دائمًا أن المريض يمكنه السماع.

2- قدم نفسك للمريض.

3- توجيه المريض نحو الذات.

4- صف ما يمكن أن يتوقعه المريض (البرد ، رطوبة الجو ، ضغط).

5- مخاطبة المريض بالاسم.

6- للمريض الحق في اطلاعه على الأمور الجارية ، والتشخيص ، والعلاج ، والتدخلات الطبية والتمريضية ، والأحداث المهمة التي يمرون بها.

7- شرح جميع الإجراءات قبل التنفيذ.

8- الحفاظ على الروتين لزيادة شعور المريض بالأمان.

9- استخدام اللمس بشكل متعمد.

10- معاملة المريض بنفس الاحترام والكرامة التي قد تظهر لكل مريض.

11- يقوم الممرض بتوجيه المريض إلى الوقت والمكان مرة واحدة على الأقل كل 8 ساعات.

وضع التواصل والمريض الفاقد الوعي:

1- التواصل اللفظي

يعد الاتصال اللفظي جزءًا أساسيًا من العملية التمريضية التي يمكن أن تقلل من القلق أو الضيق وتحفز المريض عاطفياً. عادة ما تكون العملية ذات اتجاهين يتم من خلالها إرسال الرسالة وفهمها وتقديم الملاحظات. عند التعامل مع المرضى الفاقدين للوعي ، غير قادرين على الاستجابة ، من المستحيل معرفة ما إذا كانوا قد فهموا ما قيل. ومع ذلك ، من المهم أن نتذكر أن الحاجة إلى التواصل لا تزال قائمة.

أن المرضى الفاقدين للوعي قد يكون لديهم استجابة سمعية طبيعية ، وأن عدم التحدث إليهم يشير إلى أنه من غير المحتمل أن يتعافوا ، مما يزيد من إحساسهم بالضعف.

مزايا التواصل اللفظي للمرضى فاقدي الوعي:

1- التواصل اللفظي هو جزء أساسي في العملية التمريضية يمكن أن يقلل من القلق والتوتر ويحفز المريض عاطفياً.

2- يُنظر إلى التواصل اللفظي في الغالب على أنه عملية تفاعلية ، ويمكن إدراك أهميته للمرضى الفاقدين للوعي لأن لديهم حاجة كبيرة للمعلومات والدعم.

3- قد تساعد المعلومات التي يتلقاها المرضى الفاقدون للوعي في تقليل التوتر ومساعدة المرضى على الحفاظ على الهوية الذاتية واحترام الذات وتقليل العزلة الاجتماعية.

4- قد تساعد المعلومات التي يتلقاها المرضى فاقدو الوعي في تقليل التوتر. ، لذلك يمكن أن يوفر التواصل اللفظي مدخلات حسية موجهة وذات مغزى لهؤلاء المرضى.

5- يمكن أن يعزز الرسائل التي يتلقاها المريض ويساعد على تلبية احتياجات المريض النفسية ويمنع الانسحاب الذهاني والهذيان مما قد يساهم في الضغط النفسي والارتباك والقلق والعزلة.

6- يمكن أن يقلل التواصل اللفظي من مضاعفات ما بعد الجراحة ويقلل من حدوث متلازمة وحدة العناية المركزة ، والتي تشمل الارتباك واضطرابات الذاكرة والهلوسة وجنون الشك.

7- التواصل اللفظي الجيد له سلوك علاجي ينتج عنه نتائج إيجابية للمرضى.

8- يمكن للتواصل اللفظي أن يحفز المركز السمعي. عندما تتحدث إلى المريض الفاقد للوعي سيتم تسجيله في الدماغ.

2- التواصل غير اللفظي: الذي يطلق عليه أحيانًا لغة الجسد ، يشمل الإيماءات وحركات الجسم واستخدام اللمس والمظهر الجسدي ، بما في ذلك الزينة.

ما هو اللمس؟

اللمس هو أكثر الأحاسيس شخصية، وهو أساسي في عملية الاتصال البشري. اللمس يسمى أم كل الحواس. قد يعمل اللمس أيضًا على تعزيز احترام الذات. اللمس هو وسيلة غير لفظية قوية للتواصل. يمكن استخدامه للتهدئة والراحة. يمكن أن ينقل اللمس إحساسًا بالرعاية - كما يحدث عندما يمسك الممرض يد شخص أثناء إجراء مؤلم - أو يمكن أن يُنظر إليه على أنه تدخلي أو عدائي.

اللمس هو شكل قوي من أشكال التواصل غير اللفظي. يمكن أن تعزز لمسة العناية الشعور بالراحة والتعافي المبكر والعلاقة بين الممرض والمريض في وقت قصير جدًا.

مكونات اللمس: هناك ثلاثة مكونات رئيسية للمس:

1- لمسة العناية: لمسة العناية مهمة جدا لأنها تمنح المريض الراحة والطمأنينة.

2- لمسة المهمة: تختص بأداء الإجراءات التمريضية. إذا لم تتم هذه اللمسة باهتمام ، فقد لا يشعر المريض بدفء الرعاية وقد لا تكون النتيجة مرضية.

3- اللمسة الوقائية: تهتم بحماية المريض من الحوادث أثناء رعاية المريض فاقداً للوعي ، ومن المهم جداً حماية المرضى لأنهم غير قادرين على الاستجابة لأي منبهات عكسية. مع "الفقاعة" الشخصية (التي تتراوح من 18 بوصة إلى 4 أقدام) يتم اختراقها. عندما يكون الشخص مريضًا ، قد يؤدي اللمس أحيانًا إلى تهيجه وإزعاجه. لتجنب هذا الانزعاج ، يجب أن نوفر لهم لمسة لطيفة وعاطفية تمنحهم الأمان والرفاهية. أكدت الدراسات أن التحفيز اللمسي ينقل الدعم العاطفي. اللمس لديه القدرة على تحفيز المرضى عندما تفشل طرق التفاعل الأخرى. ومع ذلك ، يجب أن يكون الممرضين أكثر اهتمامًا بلمسة الرعاية من لمسة المهمة.

يجب استخدام اللمس بحذر مع المرضى الذين هم:

- **مرتبكون:** قد يسيئون تفسير القصد من اللمس.
- **عدوانيون:** قد يرون أن اللمس يمثل تهديدًا وينفجرون بشدة.
- **مريبون:** قد يعتقدون أن اللمسة ضارة.
- **ضحايا الإساءة:** قد يخافون من اللمس.

يساعد استخدام اللمس والتواصل العلاجي المريض في التغلب على مشاعر العزلة ويعزز مفهوم الذات الإيجابي.

للمس عدة استخدامات مهمة في ممارسة التمريض من حيث:

- جزء لا يتجزأ من التقييم
- يعزز الترابط بين الممرض والمريض
- هي وسيلة تواصل مهمة ، خاصة عندما تضعف الحواس الأخرى
- يساعد في التهدئة والهدوء والراحة
- يساعد في الحفاظ على توجه المريض

حواجز التواصل مع المريض:

1- ضعف الوعي

2- التخدير

3- وجود جهاز تنفس اصطناعي.

يؤدي التواصل غير الكافي بين الممرض والمريض إلى زيادة مستويات التوتر والقلق. وبالتالي ، فإن التواصل داخل بيئة وحدة العناية المركزة له أهمية قصوى ، والتواصل الفعال هو جانب أساسي من جوانب رعاية الممرضين للمرضى.

تواصل الأسرة مع المريض فاقد الوعي في وحدة العناية المركزة

يمكن لممرضي الرعاية الحرجة دعم أسر المرضى بشكل أفضل من خلال توفير تواصل مباشر وصادق (بما في ذلك الاعتراف بصعوبة التنبؤ بالتشخيص) ومن خلال الاعتراف بحاجتهم إلى الوجود والمشاركة في الرعاية. يمكن لممرضين الرعاية الحرجة تقليل قلق أفراد الأسرة من خلال التعاون مع زملائهم في الرعاية التقدمية والحادة لتوفير استمرارية الرعاية والتعليم حول مراحل التعافي (، Burns, 2014).

احتياج أسر مرضى الرعاية الحرجة للتواصل:

1- يعاني أفراد أسرة المرضى في وحدة العناية المركزة من أزمات نفسية وضغوط واكتئاب نتيجة دخول أقاربهم إلى هذه الوحدة ، وهو عادة ما يكون حدثًا غير متوقع ومخصص للأفراد في حالة سريرية حرجة مع إمكانية لارتفاع معدل الوفيات.

2- أفراد الأسرة جزء لا يتجزأ من عملية الرعاية الصحية وإدارة رفاهية المرضى. من أجل خفض مستوى القلق والأزمة النفسية ، يجب معرفة وتلبية الاحتياجات الفورية لأفراد أسر المرضى.

3- أظهرت العديد من الدراسات أن وجود الأسرة ليس له تأثير سلبي على رعاية المريض أو مدة المرض.

كيف يتعامل أفراد الأسرة مع مريضهم في وحدة الرعاية الحرجة؟

1- تشجيع العائلات على التحدث مع المريض.

2- يمكن للأصوات المألوفة أن تريح المريض

3- أكد لهم أن المريض قد يتمكن من سماعها ، على الرغم من عدم وجود إشارة واضحة من المريض.

4-تكلم في محادثة منتظمة. تحدث عن الطقس ، وما يحدث مع أفراد الأسرة الآخرين ، والمناسبات الخاصة القادمة ، وما إلى ذلك.

5- شجع أهل المريض وأصدقائه على البقاء إيجابيين عند الزيارة. أفاد المرضى الذين كانوا في وحدة العناية المركزة أنهم يستطيعون إدراك ما إذا كان الزوار صادقين ومرتاحين.

6- يجب عدم السماح بالزوار السلبيين أو المسيئين.

7- العائلات تريد المشاركة. امنحهم "وظيفة" عند الاقتضاء. على سبيل المثال ، علمهم كيفية أداء النطاق السلبي للحركة.

تأثيرات الأصوات المألوفة والتحفيز الحسي لدى المرضى فاقدي الوعي

1- قد يكون للتنبيه السمعي بصوت مألوف تأثير على تعزيز مستوى الوعي لدى المرضى فاقدي الوعي.

2- الحرمان الحسي هو أحد أكثر عواقب الغيبوبة شيوعًا.

3- هناك حاجة إلى استراتيجيات لتزويد المرضى الفاقدين للوعي بالتحفيز الحسي للوقاية من الحرمان الحسي.

4- التحفيز الحسي طريقة علاجية تحفز جهاز تنشيط الشبكية في الدماغ وتسهل إعادة تنظيم أنشطة الدماغ من خلال خلق روابط عصبية جديدة.

5- التحفيز السمعي هو أحد المحفزات الحسية التي يمكن أن يقدمها للمرضى من قبل أفراد أسرهم أو الممرضين.

6- يمكن للممرضين اتخاذ قرار بشأن استخدام المنبهات الحسية المختلفة ، والتحفيز السمعي أمر بالغ الأهمية لأن السمع هو آخر حاسة يفقدها مرضى الغيبوبة وسيظلون بالتأكيد وظيفيين حتى في حالة فقدان جميع الحواس الأخرى.

7- التحفيز السمعي هو أبسط طريقة مستخدمة من خلال التواصل اللفظي مع المريض من قبل الممرضين أثناء أنشطة الرعاية الصحية الروتينية.

8- يمكن إجراء التحفيز السمعي باستخدام أصوات مختلفة بتأثيرات مختلفة ، مثل الصوت المألوف الذي يمكن للمريض أن يتذكره بسرعة أكبر.

9- المرضى الذين أصيبوا بالاضطراب أو فقدوا الوعي قد يصبحون فجأة واعين ومنتبهين عندما يكونون على وشك الموت. إذا كان ذلك ممكنًا ، فاتصل بأفراد العائلة في هذا الوقت حتى تتاح للجميع فرصة الوداع النهائي.

تأثير زيارة الأسرة على التحفيز السمعي واللمسي على مستوى وعي مرضى الغيبوبة المصابين بإصابة في الرأس.

1- زيارة الأسرة كتحفز حسي مختلط (سمعي ، وعاطفي ، ولمسي) يؤدى إلى زيادة مستوى الوعي للمرضى.

2- الزيارة العائلية المنتظمة ، كبرنامج تحفيز حسي (خاصة ، كتنبيه عاطفي) ، قد يكون لها تأثير إيجابي على مستوى وعي المرضى الفاقدين للوعي.

3- كما يوفر مشاركة فعالة للأسرة في الرعاية.

4- يجب أن تكون التدخلات التمريضية المصاحبة لتطبيق التحفيز الحسي المبرمج في المرحلة المبكرة من إصابة الدماغ.

ما هي آثار ضعف التواصل

1- التواصل الفعال يحمي المرضى من الضرر المحتمل الناجم عن سوء الفهم.

2- فشل التواصل يؤدي إلى ضرر جسيم ، حتى النواقص الطفيفة يمكن أن يكون لها عواقب وخيمة.

3- يمكن أن يؤدي ضعف التواصل في تسليم المهام في نهاية المناوبة إلى إلحاق الضرر بالمريض.

تأثير التواصل على الضيق النفسي

1- الوقاية من متلازمة العناية المركزة ، والتي تُعرف أيضًا باسم ذهان العناية المركزة ، تسبب ضغوطًا نفسية كبيرة لدى المرضى في مختلف حالات الوعي.

2- التواصل مع المرضى فاقدي الوعي حول بيئتهم بالإضافة إلى توفير الرعاية الشخصية ، يمكن للممرضين المساعدة في تلبية الاحتياجات النفسية لهؤلاء المرضى.

3- يمنع الانسحاب الذهاني والهذيان.

4- منع الضغط النفسي بما في ذلك الارتباك والقلق والعزلة.

استعادة الحالة الصحية للمرضى فاقدي الوعي:

يساعد الممرض المريض وعائلته على استعادة صحة المريض الفاقد للوعي من خلال:

1- استخدام الأنشطة السمعية والبصرية والشمية والذوقية واللمسية والحركية لتحفيز المريض على الخروج من الغيبوبة.

2- يتم بذل الجهود لاستعادة الشعور بالإيقاع اليومي من خلال الحفاظ على أنماط النهار والليل المعتادة للنشاط والنوم.

3- تلامس الممرضة المريض وتتحدث معه وتشجع أفراد الأسرة والأصدقاء على ذلك.

4- التواصل مهم للغاية ويتضمن لمس المريض وقضاء وقت كاف مع المريض حتى يصبح حساسًا لاحتياجاته.

5- من المهم أيضًا تجنب الإدلاء بأي تعليقات سلبية حول حالة المريض أو توقعات سير المرض في وجود المريض.

6- يقوم الممرض بتوجيه المريض إلى الوقت والمكان مرة واحدة على الأقل كل 8 ساعات.

7- يمكن إدخال أصوات من البيئة المعتادة للمريض باستخدام جهاز تسجيل.

8- يمكن لأفراد الأسرة القراءة للمريض من كتاب مفضل وقد يقترحون برامج إذاعية وتلفزيونية كان المريض يتمتع بها سابقاً كوسيلة لإثراء البيئة وتقديم مدخلات مألوفة. (ميغا وآخرون ، 2013).

الجلسة الخامسة

العنوان: التواصل مع المرضى الخاضعين للتهوية الميكانيكية

المدة:30 دقيقه

المكان: مستشفى الحلة التعليمي

طريقة التدريس: عرض شرائح

الاهداف الخاصة:

1- مقدمة عن المرضى الخاضعين للتهوية الميكانيكية

2- التعرف على طرق تعزيز التواصل مع المرضى الخاضعين للتهوية الميكانيكية

3- التعرف على أهمية دور الممرضات في شرح حالة المرضى لأفراد الأسرة (علاقة الممرضة مع عائلة المريض).

مقدمة

لا يستطيع المرضى الخاضعون للتهوية الميكانيكية التحدث والتواصل لفظيًا بسبب وجود أنبوب القصبة الهوائية أو أنبوب ثقب القصبة الهوائية. عدم القدرة على الكلام أمر محبط للمريض والممرضين وأعضاء فريق الرعاية الصحية. يؤدي ضعف التواصل إلى إصابة المرضى بالقلق والخوف ، وهي أعراض يمكن أن يكون لها تأثير ضار على حالتهم الجسدية والعاطفية. يكشف المرضى الذين تمت مقابلتهم بعد نزع الأنبوب عن مدى شعورهم بالعزلة والوحدة بسبب عدم قدرتهم على الكلام.

سيكون للتواصل مع المرضى الخاضعين للتهوية الميكانيكية تأثير مزدوج حيث سيكون كل من العائلات والمرضى راضين عن الرعاية المقدمة من خلال توفير المعلومات وشرح الإجراءات على الرغم من عدم وجود استجابة (كارول 2007).

طرق تعزيز التواصل مع المرضى الخاضعين للتهوية الميكانيكية

1- علاجات غير لفظية (إيماءات ، قراءة الشفاه ، كلمات شفهية ، ورق وقلم ، لوحات أبجدية / رقمية ، بطاقات تعليمية ، إلخ).

2- **العلاجات الصوتية** (أنابيب القصبة الهوائية الناطقة والصمامات الناطقة لأنابيب القصبة الهوائية فقط). لا تزال أفضل طريقة للتواصل مع المريض ، من لديه مجرى هوائي صناعي أو الذي يخضع للتهوية الميكانيكية ، غير معروفة حتى الآن.

لقاء الممرضين مع أسر المريض الفاقد للوعي

عائلة المريض الفاقد للوعي في حالة أزمة مفاجئة وتخوض عملية قلق شديد ، الإنكار ، الغضب ، الندم ، والحزن ، والمصالحة.

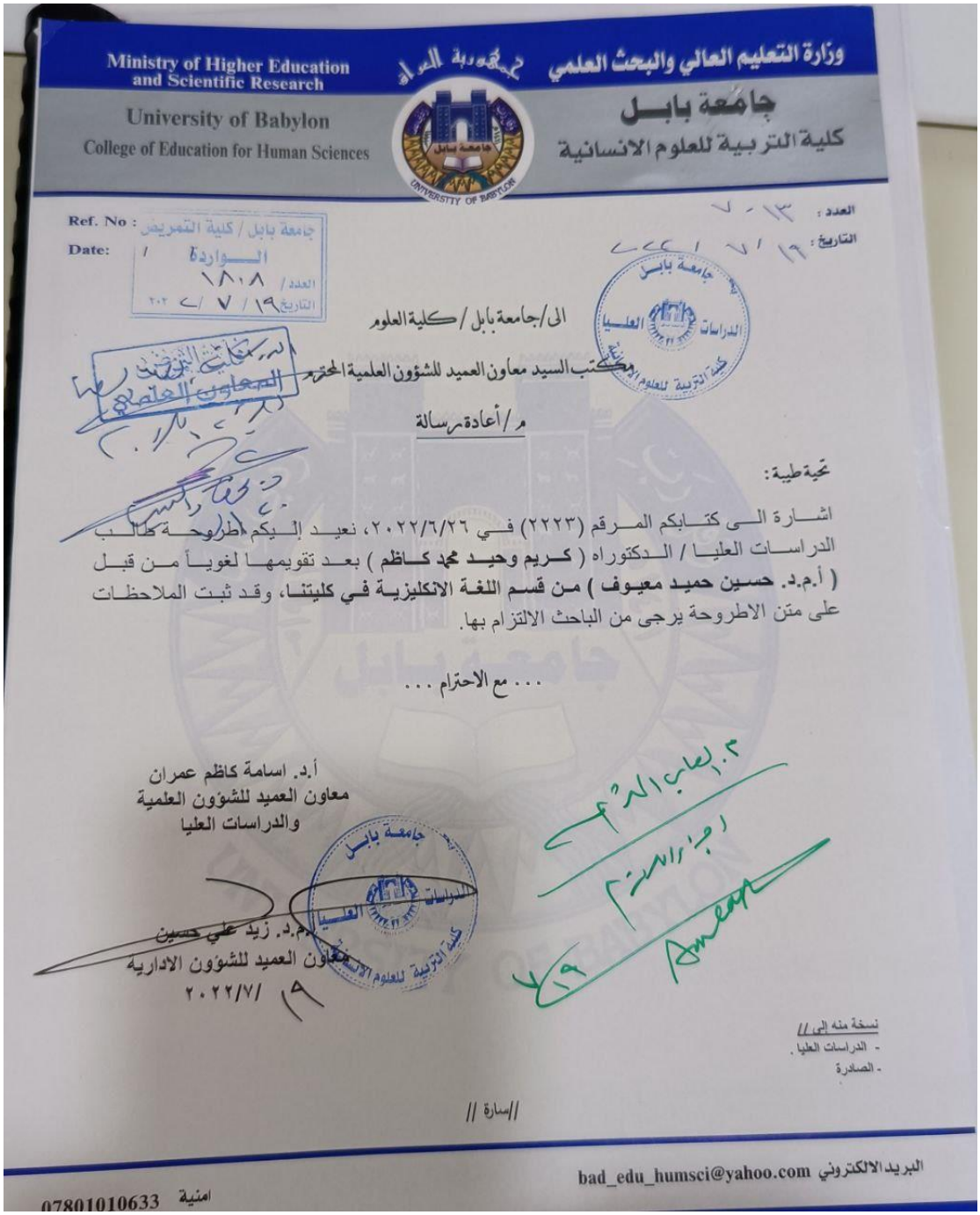
ساعات الزيارة الى الاماكن الحرجة

من غير المقبول تقييد زيارة المرضى المحتضرين في وحدة الرعاية الحرجة . توفير وقت الزيارة لمساعدة أفراد الأسرة على القول بأن الوداع وظيفة مهمة. يجب السماح للزوار إلى أقصى حد ممكن ، مع عدم التدخل في خصوصية المرضى الآخرين أو راحتهم. قد تقيم العائلات احتفالات دينية أو ثقافية مهمة بالنسبة لهم لأداءها قبل وفاة المريض أو تجربة انسحاب أجهزة دعم الحياة. يجب تشجيع هذه الممارسات وتسهيلها قدر الإمكان. من المهم استمرار الرعاية من قبل نفس الممرض مع اقتراب المريض من الموت ،يبقى الممرضين أحيانًا مع الأسرة بعد نهاية المناوبة عندما يكون الموت وشيكًا حتى لا يحتاجوا إلى التكيف مع شخص آخر في هذا الوقت الصعب.

التواجد العائلي أثناء عملية الإنعاش

تاريخيا ، يطُلب من أفراد الأسرة مغادرة الغرفة أثناء الإنعاش. أصدرت الجمعية الأمريكية لممرضات الرعاية الحرجة (AACN) وجمعية ممرضات الطوارئ (ENA) بيانات موقف توصي بالسماح للعائلات بالحضور أثناء إجراءات الإنعاش القلبي الرئوي والإجراءات التنفسية. يعد التواجد العائلي مصدرًا مهمًا لدعم المريض ، وقد يكون هناك فائدة للعائلة في مراقبة الإنعاش من خلال معرفة أن كل ما هو ممكن قد تم.

المقوم اللغوي



وزارة التعليم العالي والبحث العلمي
جمهورية العراق
Ministry of Higher Education and Scientific Research
جامعة بابل
University of Babylon
كلية التربية للعلوم الانسانية
College of Education for Human Sciences

العدد : ٧ - ١٣
التاريخ : ١٩ / ٧ / ٢٠٢٢

Ref. No : جامعة بابل / كلية التمريض
Date: الواردة / ١
العدد / ١٨٠٨
التاريخ ١٩ / ٧ / ٢٠٢٢

الى/جامعة بابل / كلية العلوم

م/مكتب السيد معاون العميد للشؤون العلمية المحترم

م/أعادة مرسالة

تحية طيبة:

اشارة الى كتابكم المرقم (٢٢٢٣) في ٢٠٢٢/٦/٢٦، نعيد إليكم اطروحة طالب الدراسات العليا / الدكتوراه (**كريم وحيد محمد كاظم**) بعد تقويمها لغوياً من قبل (**أ.م.د. حسين حميد معيوف**) **من قسم اللغة الانكليزية في كليتنا**، وقد ثبت الملاحظات على متن الاطروحة يرجى من الباحث الالتزام بها.

... مع الاحترام ...

أ.د. اسامة كاظم عمران
معاون العميد للشؤون العلمية
والدراسات العليا

أ.م.د. زيد علي حسين
معاون العميد للشؤون الادارية
٢٠٢٢/٧/١٩

نسخة منه إلى //
- الدراسات العليا .
- الصادرة

//سارة//

البريد الالكتروني bad_edu_humsci@yahoo.com
امنية 07801010633


طرق تعزيز التواصل مع المرضى الخاضعين للتهوية الميكانيكية
١. علاجات غير لفظية (إيماءات ، قراءة الشفاه ، كلمات شفهية ،
ورق وقلم ، لوحات أبجدية الخ)
الكتابة: عادة ما تكون الطريقة الأسهل والأكثر شيوعا للتواصل
الملتمة بسهولة هي الورق والقلم.
الإيماءات: الإيماءات هي الأنسب للمرضى
المدى القصير والذي يكون في حالة تا
على الأقل ، حتى لو كان ذلك قليل.
٢. العلاجات الصوتية (أنابيب القصبة
الشاملة لأنابيب القصبة الهوائية فقط)


15

المستخلص

أحد أساسيات ممارسة التمريض المهنية وفن رعاية المرضى الشاملة هو القدرة على التواصل الفعال مع المرضى. التواصل هو جوهر التمريض ، الفشل في التواصل يؤدي إلى عدم رضا المريض وعائلته والممرض الصحي المحترف، ويؤدي الى علاقة عمل مضطربة، وسوء النتائج الصحية.

تهدف هذه الدراسة لتقييم فعالية البرنامج التعليمي على معارف وممارسات الممرضين في التواصل مع المرضى فاقدي الوعي في وحدات الرعاية الحرجة

اجريت دراسة كمية شبه تجريبية من الفترة من ١٥ ايلول ٢٠٢٠ إلى ٢٣حزيران ٢٠٢٢ ونُفذ في مستشفى الحلة التعليمي ومستشفى الإمام الصادق التعليمي. تم اختيار عينة من الممرضين الذين يعملون في الوحدات الحرجة . تكونت عينة الدراسة من (٦٣) ممرض مقسمة إلى (٣٠) ممرض للمجموعة التجريبية ، و (٣٣) ممرض للمجموعة الضابطة معدة لجمع البيانات بطريقة المقابلة. يشتمل الاستبيان على أربعة أجزاء: الجزء الأول: الخصائص الديموغرافية للممرضين ، والجزء الثاني معلومات التوظيف ، والجزء الثالث معارف الممرضين حول التواصل مع المرضى فاقدي الوعي الذي يشمل ستة مجالات، الجزء الرابع: استخدام استمارة رصد ممارسات الممرضين فيما يتعلق بالتواصل مع المرضى فاقدي الوعي في وحدة العناية الحرجة تتضمن ١٧ فقره.

أظهرت نتائج الدراسة أن المعرفة الإجمالية للممرضين حول التواصل مع المرضى فاقدي الوعي في كلتا المجموعتين سجلت مستوى ضعيف من المعرفة بلغ (٦٨.٨٨) ، (٦٩.٧٣) في الاختبار القبلي ، وخلال الاختبار البعدي أظهرت مجموعة التحكم نفس المستوى الضعيف بشكل واضح ، بينما سجل الممرضين اللذين حضروا جلسات البرنامج التعليمي تحسناً ملحوظاً في الاختبارين البعديين (٨٩.٩٠) و (٨٥.٧٣) ، فيما يتعلق بالممارسات أظهرت النتائج أن الممرضين لا يتواصلون مع المرضى فاقدي الوعي في الاختبار القبلي لعينة الدراسة والمجموعة الضابطة، بينما لوحظ ان الممرضين يتواصلون مع المرضى فاقدي الوعي بعد أخذ البرنامج.

استنتجت الدراسة ان هناك تحسناً ملحوظاً يظهر بوضوح بين افراد مجموعة الدراسة من خلال نتيجة الاختبار القبلي والبعدي ، والتي توضح فعالية محتوى البرنامج التعليمي على معارف وممارسات الممرضين. اوصت الدراسة بأنشاء جلسات تثقيفية مستمرة لتعزيز معارف الممرضين تجاه عملية التواصل والاستراتيجيات كأداة لتوفير الرعاية المثلى للمرضى و أفراد أسرهم.

.

جمهورية العراق

وزارة التعليم العالي والبحث العلمي

جامعة بابل

كلية التمريض

فاعلية البرنامج التعليمي على معارف وممارسات التمريضيين في التواصل مع المرضى فاقدي الوعي في وحدات العناية الحرجة

اطروحة مقدمة

الى

مجلس كلية التمريض / جامعة بابل

من قبل

كريم وحيد محمد ابو خطه

وهي جزء من متطلبات نيل شهادة الدكتوراه فلسفة في التمريض

بأشراف

الاستاذة

الدكتورة سحر ادهم علي

ذو القعدة/١٤٤٣ هجرية

حزيران/٢٠٢٢ ميلادية