

CHAPTER-I

INTRODUCTION

Critical care is a form of interdisciplinary care that treats people who have or are expected to have a life-threatening illness.¹ Compared to other hospital areas, Intensive Care Units (ICU) have different treatment strategies, technical equipment applications, external appearance, format of the treatment, and surrounding environment. As a result, patients and their loved ones go through a lot of stress during this phase.²

The severity of patient health conditions and the specific treatment methods used in Intensive Care Units (ICU) distinguish them from other hospital settings. The ICU environment is mostly technical, noisy, and creates anxiety for patients.³ Increased life expectancy worldwide leads to a high rate of chronic illness and “severe disease” among patients.⁴ Each year, up to 20 million people are hospitalized in the critical care unit (CCU) and placed on ventilators.⁵

An estimated 1.5–1.7 million people in India experience neurological disabilities every year following head trauma. Of these, 0.45–0.6 million people experience stroke-related impairment each year.⁶ The morbidity and mortality rates among patients in a state of coma are still high despite the use of several medicinal and surgical procedures. If patients are not treated properly, they may experience long-term disabilities, which would put a financial strain on them and lead to a poor standard of living not only on them, their families, and communities.⁷

Most patients who are referred to the ICU have emergency conditions. These serious conditions require the assistance of technology, the latest medical facilities, invasive and noninvasive procedures; and technological help in order to gauge, monitor, and regulate physiological activity. It has been observed and reported that critical care nurses use a variety of manual procedures in the ICU in an effort to immediately restore patients' physiological states. Due to their involvement in intense work, poor communication abilities have been observed in such situations.⁸

Coping mechanisms for adverse events completely vanished in comatose patients because these patients lost the capacity to cope with unpleasant stimuli and they were unable to analyze the circumstances or control events.⁹ Although it is important for the ICU health care workers to utilize advanced technological developments, patients may experience sensory alterations such as sensory deprivation and sensory overload due to increased invasive procedures, surplus of environmental stimuli, inadequate social networks, and unfamiliar surroundings, leading to high morbidity and mortality rates, and other disabilities.¹⁰

Background of the study

Wakefulness and awareness of oneself and one's surroundings are two different states of consciousness.¹¹ When someone is unconscious, they are not aware of their surroundings, similar to when they are asleep, and they are not responsive to stimuli.¹² Patients frequently report a lower quality of life due to pathological conditions like trauma, seizures, strokes, brain tumours, infections, respiratory failure or shock that cause hypoxia, chemical or metabolic brain

depressants like medications, toxins, ketones, or electrolyte imbalances, as well as lack of response to sensory and motor stimuli.¹³

There are three stages of consciousness: coma, vegetative state, and minimally conscious state.¹⁴ Unconsciousness has a variety of outcomes. A total span from healing to death can last from a few days / weeks. Afterward, some patients may be roused from their coma state, however, some patients might become vegetative where they remain for years or even decades, and some patients may pass away. Depending on the origin, location, degree, and extent of neurological injury, coma and vegetative state outcomes can vary.¹⁰ Not all patients make an entire healing, a few may die and others could be left with various bodily and cognitive disabilities.¹⁵

When people are in coma, they seem to be sleeping. They are unable to speak and their eyes are closed. However, their brain can still function. Even though they cannot communicate with others around them, they may still sense noises around them such as footsteps and voices of people.¹⁶

Coma is characterized as an apathetic state where the patient is not alert and unable to communicate with their surroundings, even after intense stimulation. It varies from diminished responsiveness (drowsiness) to coma. This spectrum represents a depression in the degree of consciousness. Being in ICU with coma are two painful experiences that can have lasting effects on comatose patients.¹⁷

Coma can occur as a result of serious accident such as brain injury or from a medical condition like certain infections. A particularly harmful complication of head trauma is “coma”. Intensive care unit patients with coma are affected by

sensory scarcity and overload. About 5% of emergency department patients have altered states of consciousness, and 1% of them are hospitalized due to coma.¹⁸ Patients who are comatose are at greater risk of sensory deprivation.¹⁹ Patients in coma with intense and recurrent auditory stimuli may recover from the coma and improve their state of consciousness.²⁰

A person is more likely to experience long-term cognitive, behavioural and emotional impairment. The longer they are unconscious, prevents them from living a productive and responsible lives after brain injury. The comatose patients absolutely depend on the nurses to control and manipulate all their daily activities and to monitor their essential functions. Although emergency services, diagnostic equipment, scientific research, and nursing care have improved, survival rates in people with brain injuries, however, arousal and cognitive healing are not guaranteed.¹²

Communication is an essential part of nursing practice to provide holistic and integrated care to patients.²¹ Considering that nurses interact with patients the most, ensuring that their communication desires are completely met. One of the most critical nursing abilities and nursing competencies is an effective communication which enable nurses to evaluate, plan, carry out, or compare care.²²

Communication with critically ill patients is crucial, especially when the patient is under sedation, on mechanical ventilation, and unable to communicate, As a result, in this life-or-death circumstance, verbal communication and contact is a quantifiable method of communicating messages.²³

Effective communication is essential in nurse-patient interaction. It can take numerous forms and is considerably more than simply speaking and hearing. Communication is a technique that allows the nurse to establish an interpersonal relationship and thus satisfying the motive of nursing. Healthcare professionals communicates with comatose patients who wants or requires care, which may be achieved with the aid of effective conversation.²⁴

There are two approaches to conversation: verbal communication and nonverbal communication. Verbal communication stimulates the reticular activating system of the brain and keeps a person awake.²⁵ Patients who are not conscious can listen and show emotional reaction to verbal conversation after neurological evaluation. Some patients said that they were aware of the nurses' demand to compress her hand, but they were immobile and unable to do so.⁴ Comatose patients might also respond to auditory stimuli on a daily basis. If not, this might reduce their probability of early recovery. On the contrary, nonverbal conversation including eye contact, facial expression, posture, and touch, is essential while interacting with an affected person. Touch with comforting phrases may be a great way of imparting reassurance. It is critical that nurses speak gently to subconscious patients and maintain dignity even if the patients' own circle of relatives are not present.¹⁹

Factors facilitating verbal communication with comatose patients

Communication with patients who are in coma state is affected by many factors. It is mandatory to tell comatose patients about their identity and help them to become aware of where they are, time of the day and people interacting with them. Additionally, patients should be informed about current events, diagnoses, therapies,

interventions by doctors and nurses, and significant events that they may be going through. Making them privy to the environment is essential on ethical and moral grounds. Despite difficult everyday practical situations in the ICU, another facilitating factor is the nurses speaking with subconscious patients offering sturdy verbal stimulation. This has been found to boost their chances of recovery.¹³

When nurses individualized their care by addressing each patient by name, utilizing a variety of communication techniques, and attending to the patients' specific needs, these patients experienced lesser stress and psychological problems. Nurses can analyze a patient's consciousness level, thinking, language skills, and fine gross motor abilities with the help of a variety of communication techniques.¹⁶

There was evidence to support the idea that comfort, familiarity, and touch, induce an ideal balance to meet patients' physical and psychological requirements. It reduces unnecessary stress, which eventually leads to a remarkable comeback of the patients. On the contrary, parameters that limit communication are workload, unsteady condition of the patient, individual issues, and health care-related issues.¹⁶

Most of the time, nurses' focus too much on their technical tasks rather than interacting with their patients. This action would have an impact on patients' ability to interact and express their thoughts, feelings, aspirations, and needs.⁴

Unique challenges arise for critical care nurses when communicating with seriously ill patients in the ICU. These challenges demand refined skills. There are several barriers in communicating with comatose patients, including altered consciousness, sedation, and the presence of articulated airways.²⁶

Communication can be easily missed when caring for such patients. Insufficient nurse-patient interaction leads to high levels of anxiety and stress. Hence, interaction within the ICU environment is difficult, but effective communication is a crucial component of nursing care.⁷

Many patients in critical care units are comatose with little flexibility due to illness processes and medications.²⁷ The unconscious patients are unable to control themselves or their environment, are disoriented to their surroundings, time, and people, and therefore they are highly dependent on the nurse.²¹

It is clear that many patients became conscious and they are able to provide precise information about what occurred to them while they were unconscious, despite the fact that they are unable to react to external stimuli. Sisson asserts that, when a person is unconscious, the last sense to go is hearing.²⁸ A study recorded that a large number of comatose patients have normal hearing responses in the brainstem and can hear.²⁹ A study examined 100 former patients' perspectives on communication in intensive care units while they were unconscious. The majority of the patients stated that they heard, interpreted, and emotionally reverted to what they were told.³⁰ Furthermore, Acoustic stimulation by a known voice could lead to an increase in consciousness (LOC) in comatose patients.³¹ All of these studies emphasize the significance of communicating with a comatose or patient under sedation, as well as the relevance of the content of such a context.

Verbal communication is usually perceived as an interactive phenomenon. It is important to know that comatose patients have a major requirement for information and assistance. As comatose patients are under the influence of severe stress, they

lack proper understanding and are unaware of what is going on around them. Verbal communication with comatose patients helps to relieve stress by allowing them to use adaptive coping mechanisms.²¹

NEED FOR THE STUDY

Communication is the foundation of all nursing care, particularly with the comatose patient having varying levels of consciousness, who basically relying on speech and hearing channels for stimulating the senses. When other sensory impulses are damaged and only hearing is intact, a comatose patient can listen to what is being said, even though he/she does not seem to react. Communication is a tool that allows nurses to maintain human-to-human relationships while carrying out nursing objectives. Communicating with unconscious or comatose patients has always been a difficult task for medical professionals. As a result, communication is found to be the most important component of health care services that needs attention.³²

In contrast, on the ethical ground, the patient has the right to be informed about any medical treatment and nursing procedure on a timely basis. Specifically, in the critical care area, nurses and doctors tend to forget to communicate with their patients since they are engaged in serving a large number of patients who are undergoing lifesaving treatments. As a result, it is the primary roles and responsibilities of healthcare providers, as the first point of contact, to communicate with patients who are on ventilators.³³

It has been mostly seen that medical and nursing personnel do interact with conscious patients in context to their diagnosis, treatment, discharge education and aspects related to care. Furthermore, when healthcare professionals need to interact with comatose patients, they perceive that patients lack the mental capacity to comprehend. Hence, they do not interact with them.³⁴ Sedatives and analgesics are commonly used to treat severely ill patients who require mechanical ventilation because pain and discomfort are the most common problems experienced by them in ICU. They are unaware and unresponsive for an extended period of time while recovering from their respective disease conditions.³⁵

According to study, healthcare professionals performed 90% of the care for unconscious patients in silence, and conversing with coma patients was extremely rare. Although medical personnel presume that a patient is not able to listen, this does not necessarily mean that they cannot understand. Comatose patients do not have any self- control, so they are highly dependent. Most of the time, it has been noticed that doctors and nurses communicate when assessing the neurological status of patients, but they do not interact while providing care.³⁶

In their report, Alasad & Ahmad have reviewed communication with critically ill patients. They found that most of the studies have shown that structured nurse-patient communication aids in improving the condition of patient health. They also reviewed studies done by Patricia Ashworth, who was a renowned nurse, and a great researcher, who investigated several factors pertaining to nurses' interactions with patients having cardiac disorders, and her study results were released in the book "Care to Communicate." The study by Ashworth shows the character and

composition of conversations between 39 patients and 112 nurses. In 71% of the cases studied, conversation between nurse and patient was very brief (1 minute) and concentrated mainly on the aspect of physiological care for the patient. Challenges in communication may worsen the potentially critical situation of comatose patients.⁸

Urhenjaphol et al. claimed that the programme for sensory stimulation can improve brain recovery in patients with brain trauma.³⁷ Numerous researches have shown that after regaining awareness, a small number of patients claim that they listened to and comprehended multiple interactions that occurred while they were unresponsive.¹⁹

Asbury and Dyer draw attention to the adverse effects of strange surroundings, including the use of on-going monitoring technology on distressed patients. The author, MacKellaig claims that critically ill patients may experience severe feelings of insecurity, tension, and isolation in the absence of orientation and reassurance, combined with hallucinations, delusions, and fluctuating states of consciousness.¹⁹

Green emphasizes the importance of strong communication at some point in which staff nurses customize their care by calling patients by name and meeting their specific needs. According to Podurgiel, if nurses use names of patients in informative and other concerned conditions, the extended levels of verbal exchange may improve patients' awareness levels and increase their survival chances.¹⁹

Nurses can provide individualized care by calling comatose patients by their name, praising and requesting support from patients' family members and friends to

add to the atmosphere of recognizable and known voices, and conversing about topics of the patient's interest.¹⁹ Patricia Ashworth has also claimed that this type of verbal exchange should enhance the patient's sensory stimulation.

Treloar et al. stated that staff nurses should motivate the family members of patients to converse with them in order to establish social normalcy and meet the patient's overall requirements. Families must participate in the orientation process by communicating with the patient about social family events and providing information such as the time of day and so on.¹⁹

As Ashworth had recognized, nurses frequently encounter difficulties when speaking with comatose patients, usually because the affected person is unable to respond. On the other hand, it has been indicated by other researchers that comatose patients can be reassured with communication techniques and this enabled them to fulfil their mental wishes and minimize distress, thereby assisting their recovery.²⁰

Information retrieved from a comatose patient may help to reduce stress, allow patients to maintain their consciousness, identity, and lessen their sense of isolation, as reported by Simoes et al.³⁸

In about 25 articles from various studies related to health practitioners' communication with comatose or unconscious patients, it was discovered that "open communication" is exclusively linked with blood pressure reduction, maintaining normal blood sugar levels in the body, it also helps in pain reduction, and in enhancing the patients' emotional state, and increased their general activity.³⁹

In a quasi-experimental study, 40 comatose patients with brain injuries were given a visual, auditory, olfactory, tactile, and gustatory stimulation. The findings revealed that these stimulation helped in brain healing process.³⁷

It has been explained that sensory stimuli increased arousal and awareness by activating the reticulated activation system, whereas sensory deprivation causes physical brain deterioration. The brain has the capacity to store and reorganize information. When part of the brain is damaged, the free or inactive area takes over the function of the damaged area through the reorganization process.⁴⁰ Hashmi et al reported that the use of correct awakening habits improves recovery of consciousness.⁴¹ Another study, showed the effect of touch. They demonstrated that touch can boost the cytotoxic ability of immune system of our body.⁴²

Another study which included 15 patients with consciousness disorder, researched the neurophysiologic and neuro-behavioural effects connected to sensory stimulation. In this trial, the patient was given personalized audio tapes of stories told by family members or people he or she knew at least a year before the injury. The author discovered that family members had more impact on the coma state than unknown people because comatose patients responded better to family members voices.⁴³

A study on the use of voice and music stimulus given to 30 patients with consciousness disorders demonstrated that voice messages of family members at a volume of 60 to 70 decibel were beneficial to comatose patients in improving their consciousness than music.⁴⁴

Communication skills can be improved by receiving specialized training that emphasizes education. As a result, improved communication has been associated with higher quality healthcare. The duration of stay and mortality rate for patients in the ICU can be decreased as a result of communication interactions between ICU staff, patients, and their families' members.⁴⁵

Ogle claimed that nurses communicate poorly with patients despite having good knowledge and skills in communication. Possible explanations may be extreme level of stress and other factors and the attraction of nurses to specific types of patients in critical care areas are discussed.⁴⁶ Staff nurses gave less value to patient communication when dealing with patients who were comatose.⁴⁷

Twenty five percent of comatose patients can listen, understand and emotionally react to their surroundings.⁴⁸ One patient stated that when she was neurologically examined, she apprehended the nurses' request to grab her hand but was incapable of moving. Another one reported that he could think and hear, but could not move, talk, or open his eyes.¹⁹ One more patient, Ann, who had spent two months in the ICU in a critical condition, recovered successfully. She started crying while sharing her ICU experience and said that she felt that her dignity had been compromised. She claimed that without dignity, it would be very difficult to live.⁴⁹

Due to progressive evaluation of the ICU, the nurses working in these specialized areas acquire specific communication skills. Intensive care nurses focus more on technical information and fail in meeting patients' physiological and social requirements with ample and effective communication.²¹

A study was based on the personal experiences shared by an intensive care nurses' group, in which verbal communication was involved with people who were critically ill. It has been proven that communication in critical care settings is never fully integrated into practical aspects. Incomplete patient-nurse interaction leads to high levels of psychological distress and anxiety. Verbal communication by nurses can facilitate the patients' to keep their confidence up, which eventually helps to provide optimism and quality of life and may further help to recover their lives. Verbal communication and interaction with comatose patient was less as compared to conscious patients.⁴ The ability of health professionals to communicate effectively is critical for providing quality care, which can alleviate symptoms of anxiety, guilt, pain, and disease.⁵⁰

Communication is a vital part of care. If we resist communicating with the current trends of care models, care plans, and care objectives, one might be caught up thinking that care is a set of pictorial displays. It is much more than that. Care is a human trait inherited as a quality of showing respect among different human beings. This shows that communication skills are quite relevant while nursing comatose patients.⁵¹

It has been stated that staff nurses rarely interact with comatose patients. At times, nurses speak in a very harsh tone, which causes irritation among the patients. Hence, it is essential that nurses regulate the content and quality of communication in the ICU. They should be thoughtful of their interactions and their impact on their patients.⁵²

Giving care to unconscious patients in the ICU can be very tough and challenging. Over a period of time, a few nurses may face hindrances which prohibit them from providing a caring attitude by means of proper communication. Through a review of the literature, it was discovered that a nurse's behaviour, healthcare technology, and the workplace atmosphere are the main obstacles to therapeutic nurse- patient communication with patients who are ventilated while being unconscious or sedated.⁵³

Patients in coma have sensory deprivation. In comatose patients, the threshold of the brain stimulating system, may rise in order to speed up the process of recovery.⁵⁴ A form of communication has been developed that makes use of the concept that environmental or sensory and motor stimulation can have a healing effect on the brain. As a result, it can be used to improve brain function and reduce sensory deprivation.⁵⁵

Some coma patients gradually regain consciousness and start to react normally. Various techniques have been proposed, as a measure to improve recovery from coma, sensory and motor function. Nurses are encouraged to communicate with patients who are comatose by using all of their senses. Additionally, nurses who care for patients in coma would benefit from examining what they can provide for these patients and their families in their local communities.⁵⁶

It has been observed by the researcher that the communication between a nurse and a comatose patient is a bare minimum in the ICU. While nurses are

involved in the clinical procedures, they only interact with comatose patients to check their reflexes. A varying number of comatose patients admitted to ICU were devoid of any proper information by the nurses.

As per literature, communication with comatose patients is of prime importance in ICU. The researcher found that giving proper care to unconscious patients is a major challenge for nurses who are deployed in ICU. The nurses working in a critical care setting adopted different methods of communication while doing their clinical experience.

The organization and functional activity of the brain are improved by following a defined communication protocol for comatose patients. The goal of sensory stimulation is to increase arousal and recovery by systematically exposing a patient who is unconscious or comatose to numerous stimuli, namely visual, auditory, tactile, olfactory, and kinesthetic.⁵⁷

Patient communication has long been considered a priority for research in the field of critical care. Unfortunately, it is difficult to make assertive recommendations for clinical practice because the majority of researches on the subject of communication with comatose patients have design flaws, such as unclear procedures. There is no evidence that interaction with comatose patients can cause serious physiological adverse events or harm (PAE).⁵⁸ Soltysiak et al. claims that repeatedly directing the program on communication protocol implementation will improve sensory impairment. As a result, the preceding statement emphasizes the significance of the use of Individualized Communication Protocol, by nurses, with

comatose patients.⁵⁹

The nurse performs a pivotal function by running with the multidisciplinary crew to plan, put into effect, and compare unique remedy regimens, at the same time getting involved in imparting emotional help and reassurance to the affected person and their relatives. Because there are no formal evidence-based guidelines in present setting, an evidence-based protocol will help to improve the prognosis of critically ill patients. Therefore, the researcher planned to conduct the present study.

Numerous researches have been done to examine the health benefits of interacting with comatose patients. It is still unclear how well these interactions work clinically. A communication protocol that critical care nurses can use while speaking with comatose patients is urgently recommended. Hence, researcher planned to undertake a study to meet that aforesaid need as stated under:

RESEARCH STATEMENT

Effectiveness of an Individualized Communication Protocol on clinical outcomes of comatose patients in selected intensive care unit of tertiary care hospital, Dehradun, Uttarakhand

PURPOSE OF THE STUDY

The present study aimed to develop and implement an Individualized Communication Protocol and to evaluate its effect on clinical outcomes of comatose patients admitted in intensive care unit.

RESEARCH QUESTIONS

1. Does Individualized Communication Protocol have any effect on nurses' knowledge and practice?
2. Does Individualized Communication Protocol used by nurses on comatose patients have any effect on their clinical outcomes?

OBJECTIVES OF THE STUDY

Primary Objectives:

PHASE-I

1. To develop Individualized Communication Protocol for staff nurses to be used for comatose patients.
2. To evaluate effectiveness of training on Individualized Communication Protocol on knowledge of staff nurses working in ICU.
3. To evaluate effectiveness of training on Individualized Communication Protocol on practice of the staff nurses working in ICU.

PHASE-II

4. To evaluate effectiveness of Individualized Communication Protocol implemented by nurses working in ICU on clinical outcomes of comatose patients in terms of physiological adverse events, level of consciousness, level of agitation and sedation and pain level.

Secondary Objectives:

PHASE-I

5. To find correlation of pre-test knowledge and practice of nurses working in ICU.
6. To find association between level of knowledge and socio-demographical variables of nurses.
7. To find association between level of practice and socio-demographical variables of nurses.
8. To assess opinion of nurses on Individualized Communication Protocol.

HYPOTHESES

- H1 There would be significant improvement in knowledge of nurses after receiving training program on Individualized Communication Protocol
- H2 There would be significant improvement in practice of nurses after receiving training program on Individualized Communication Protocol.
- H3 Comatose patients in experimental group would have significantly lower incidence of Physiological adverse event as compared to control group.
- H4 Comatose patients in experimental group would have significant improvement in consciousness compared to Control group.
- H5 Comatose patients in experimental group would have lower sedation score as compared to control group.
- H6 Comatose patients in experimental group would have significant lesser pain level as compared to control group.

OPERATIONAL DEFINITIONS:

1. Knowledge:

It refers to the level of understanding of nurses working in ICU on communication with comatose patients as measured by a structured knowledge questionnaire.

2. Practice:

It refers to the communications skills demonstrated by nurses while caring for comatose patients as measured by a structured observational checklist.

3. Individualized Communication Protocol (ICP):

It refers to tailored communication approach implemented by ICU nurses with comatose patients, that involves components like environmental preparation before and during communication, use of verbal and non-verbal communication with comatose patients including orientation of self, to time, place and person, recovery status of the patient, explanation before carrying out nursing interventions, importance of patient in the family and about pleasant memories, use of verbal and non-verbal communication with patients relatives/attendants.

4. Effectiveness:

It refers to an effect of implementing an Individualized Communication Protocol on clinical outcomes in comatose patients in terms of incidence of physiological adverse events, consciousness, sedation, pain as measured by physiological adverse events tool, 'Full outline of unresponsiveness scale', 'Richmond agitation and sedation scale', and 'behavioral pain scale'.

5. Comatose patients:

It refers to patients admitted in ICU with 'Glasgow Coma Scale' $\leq 8/15$

6. Clinical outcomes:

It refers to the clinical parameters of the comatose patients which reflect the clinical condition of the patients such as:

- a) Physiological adverse events
- b) Level of consciousness
- c) Sedation level
- d) Pain level

a) Physiological adverse events

It refers to clinical parameters in terms of cardiovascular, respiratory, metabolic status of the comatose patient as measured by physiological clinical variable assessment tool.

b) Level of consciousness

It refers to the consciousness of comatose patients in terms eye response, motor response, brainstem reflex and respiratory pattern as measured by Four Outline of Unresponsiveness scale (FOUR).

c) Sedation level

It refers to the level of sedation of the comatose patient in term of combative to un-arousable as measured by Richmond agitation sedation scale (RASS).

d) Pain level

It refers to discomfort experienced by comatose patients in terms of facial expression, upper limb movements and compliance with the mechanical ventilation as measured by behavioural pain scale (BPS).

CONCEPTUAL FRAME WORK FOR THE STUDY

The researcher used modified Wiedenbach's 1960 "Perspective Theory" of Nursing by a nurse theorist, Ernestine Wiedenbach. According to this model, the nurse has a primary goal that influences how the treatment plan is tailored to the specifics of a particular circumstance. The professional nurse is motivated to learn new information and has a clear sense of purpose, command of necessary skills, relationship-keeping ability, and interest in doing so. Nursing involves determining the patient's need for assistance, providing that assistance, and confirming that the action was successful.⁶⁰

CENTRAL PURPOSE:

The purpose was to bring changes in nurses' knowledge and practice about communication with comatose patients thereby improving clinical outcomes in comatose patients. The agents were the researcher and intensive care nurses, and the recipients were the comatose patients.

GOAL OF THE STUDY:

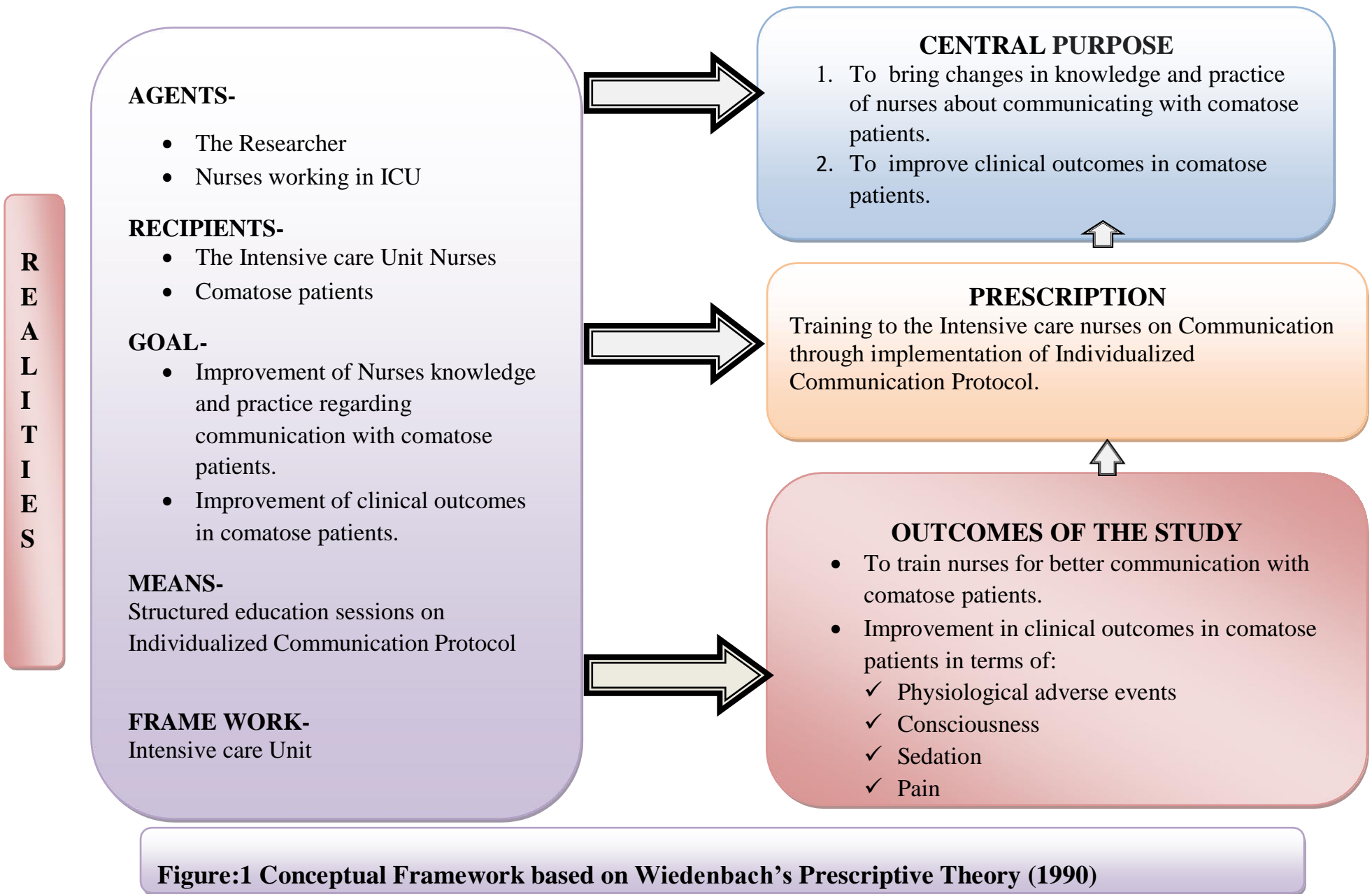
The goal was to improve clinical outcomes of comatose patients by training staff nurses.

MEANS:

The means refers to structured educational sessions on Individualized Communication Protocol.

CLINICAL OUTCOME:

The investigator assessed the clinical outcome in comatose patients. The experimental group was administered an Individualized Communication Protocol. The action was validated by collecting evidence of post intervention that shows the goal had been met as clinical outcomes improved.



ASSUMPTIONS

The study assumes that

1. The staff nurses may have some knowledge and practices regarding communication with comatose patients.
2. Sample (Staff nurses and comatose patients) would be true representative of population.
3. Respondents (Staff nurses) would give free and frank responses

DELIMITATIONS

The study was delimited to

1. Comatose patients admitted in a selected ICU.
2. Observation of clinical outcomes of comatose patients in Intensive care till 14 days/transfer out of patients from ICU/Death/LAMA, whichever was earlier.
3. Observation of communication protocol followed by staff nurses while performing any one nursing procedure on comatose patients .

SUMMARY

This chapter included introduction, background, need for the study research statements, objectives, variables, hypotheses, delimitations, and conceptual framework.