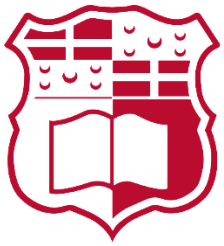

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ICU Nurses' Perceptions of Communication with Patients' Families: Roles, Facilitators, and Challenges

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A dissertation presented to the Faculty of Health Sciences in part-fulfilment of the requirements for the Degree of Master of Science in Nursing (Critical Care) at the University of Malta

November 2025

L-Università ta' Malta

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Abstract

Background: Effective communication between intensive care unit (ICU) nurses and patients' families is a central element of family-centred care. Families depend on nurses for information, reassurance, and emotional support when patients are critically ill or unable to communicate. Despite its significance, communication in the ICU remains complex and emotionally demanding. Organisational pressures, role ambiguity, and emotional strain often hinder the process. Within the Maltese context, research on nurses' perceptions remains limited.

Aim: This study aimed to explore ICU nurses' perceptions and experiences of communication with patients' families, focusing on their perceived roles, facilitators, challenges, and the strategies used to sustain effective and compassionate communication.

Design and Methods: A qualitative descriptive design was adopted. Semi-structured interviews were conducted with seven registered ICU nurses were recruited through purposive sampling from a general adult ICU (20 beds) in Malta. Data were analysed thematically using Braun and Clarke's (2021) framework, and Symbolic Interactionism was employed as an interpretive lens during data analysis to explore how meaning is created and negotiated through everyday communicative exchanges.

Findings: Five interconnected themes emerged. *Communication as a Strategic and Adaptive Practice* describes how nurses adjusted tone, timing, and delivery to meet families' needs. *Emotional Navigation in Clinical Communication* emphasises the emotional intensity and the importance of empathy, composure, and self-regulation. *Navigating Role Boundaries and Team Dynamics* addresses interprofessional overlap and the mediating role nurses take between families and physicians. *Structural and Organisational Barriers* include time constraints, staffing pressures, and restrictive visitation policies. Lastly, *Communication as a Professional and Humanising Practice* reflects nurses' views on compassionate, honest, person-centred communication as essential to preserving trust and connection in care relationships.

Conclusion: ICU nurses perceive communication with families as a dynamic, relational, and humanising process that lies at the heart of their professional role. While adaptability, empathy, and teamwork are perceived to enhance communication, organisational and emotional barriers continue to limit its consistency. Structured communication training, interdisciplinary collaboration, and supportive institutional policies are essential to strengthen family-centred care in intensive care settings.

Keywords: Intensive Care Unit, Nurse–Family Communication, Qualitative Research, Family-Centred Care, Symbolic Interactionism, Critical Care Nursing, Malta

Acknowledgements

I would like to express my deepest gratitude to all those who have guided, supported, and inspired me throughout this research journey. My sincerest appreciation goes to Dr. Josef Trapani, my supervisor, whose expertise, guidance, and encouragement have been invaluable from the earliest stages of this study to its completion. His insightful feedback and steady support have not only enriched the quality of this dissertation but have also deepened my understanding of research and reflective practice.

My heartfelt thanks are also extended to the intensive care nurses who generously shared their time, experiences, and perspectives. Their openness and commitment made this study possible and meaningful. This research is as much a reflection of their voices as it is of my academic journey.

I am profoundly grateful to my wife, whose unwavering love, patience, and belief in me have been my greatest motivation. Her support has been a constant source of strength throughout this process. My deepest appreciation also goes to my parents for their lifelong encouragement, sacrifices, and guidance, which have shaped both my personal and professional path.

To all who contributed in any way through encouragement, advice, or understanding. I extend my sincerest thanks. This achievement is shared with each of you.

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Chapter 1

Introduction

1.1 Background and Context

Communication between healthcare professionals, patients, and their relatives is a fundamental aspect of delivering high-quality healthcare. Beyond simply exchanging clinical information, it helps build trust, promote understanding, and provide emotional support to patients and their families. In intensive care settings, communication becomes even more critical due to the severity of patients' conditions. ICU nurses, who maintain close and ongoing contact with both patients and families, often serve as vital communicators and sources of emotional support. As noted by Adams et al. (2017), ICU nurses play a significant role in reducing distress and enhancing satisfaction among families through effective communication.

Among various aspects of healthcare communication, engaging with patients' families is especially important. Family members often speak on behalf of patients who are unable to communicate and are key figures in emotional support and decision-making. In these moments, family members take on an informal advocacy role, representing the patient's values, preferences, and best interests, especially when the patient cannot do so themselves (Gunnlaugsdóttir et al., 2024). The effectiveness of this advocacy is closely tied to the quality of communication they receive from nurses. Clear, empathetic, and timely communication empowers families to make informed decisions and feel supported in their involvement, while unclear or dismissive communication can hinder their confidence, increase distress, and compromise the advocacy

process. Research shows that good communication from nurses can improve transparency, reassure families, and ensure they remain well-informed (Loghmani & Beheshti, 2013). Additionally, poor communication may foster confusion, mistrust, and heightened emotional distress, particularly in end-of-life situations (Jo et al., 2019).

These dynamics are amplified in the ICU, where patients are frequently sedated, unconscious, or critically ill. Family members may find it challenging to interpret medical updates or cope with the emotional burden of the situation. ICU nurses are often tasked with breaking down complex information and offering empathy and reassurance (Sangala et al., 2015), an aspect many also consider a crucial part of their professional role. However, barriers, such as emotional exhaustion, limited training, and time constraints, can make this task difficult (Adams et al., 2017; Jin et al., 2022).

Understanding how ICU nurses perceive their communication role with families is therefore essential. Although nurses generally acknowledge its importance, many report feeling underprepared or unsupported, especially in high-pressure environments. Adams et al. (2017) suggest that providing communication training and peer support can enhance nurse-family communication, particularly in high-pressure environments. Additionally, structured approaches, such as scheduled updates and written materials, have been shown to improve overall care satisfaction (Medland & Ferrans, 1998). Therefore, this study seeks to explore ICU nurses' perceptions on these communication challenges and supports, particularly within the local healthcare context, to better understand how their experiences can inform future improvements in practice and policy.

1.2 The Researcher's Professional Background

As the researcher conducting this study, I am a senior registered nurse with seven years of continuous experience working in an adult-based intensive care unit (ICU). My clinical role involves caring for critically ill patients, often intubated and sedated, and engaging with their families who are frequently navigating highly stressful, uncertain circumstances. This professional background positions me as an "insider" within the context of the research. I have daily firsthand experience of the interpersonal, ethical, and communicative demands of ICU nursing, particularly in relation to family interactions.

Although I have not received formal or structured education in family-centred communication or care beyond limited content within my initial nursing training, I have acquired an intuitive understanding of its significance through clinical exposure. My engagement with families is largely informed by practice-based learning, interactions shaped by real-time emotional cues, institutional norms, time pressures, and the evolving clinical condition of patients. These lived experiences have made me acutely aware of the barriers and nuances inherent in nurse-family communication, such as inconsistent team messaging, emotional burden, or the absence of clear protocols for communication roles.

My positionality is deeply rooted in a commitment to compassionate, responsive care, and a belief that families are not peripheral but integral to the ICU experience. Choosing this research topic stemmed from both observation and personal frustration. I frequently witnessed variability in how communication was handled between nurses and families and noted the emotional impact it had on both parties. These reflections cultivated a desire to explore how ICU nurses perceive and

manage communication with families, and whether systemic or cultural factors either support or inhibit these interactions.

My position as both a practising ICU nurse and a researcher brings valuable insight but also necessitates ongoing reflexivity. I remained aware of how my background could shape data interpretation, and took steps, such as reflective journaling and maintaining a clear analytic process to limit bias and prioritise participants' voices.

While this dual role as insider and researcher offers strengths, it also presents challenges. These will be further discussed in the next section dedicated to exploring the influence of researcher positioning and managing subjectivity throughout the study.

1.3 Families' and Relatives' Perceptions regarding communication with ICU Nurses

An expanding body of literature focuses on how families and relatives perceive communication from healthcare professionals, especially in critical care settings. Consistent findings suggest that effective communication significantly contributes to family satisfaction and psychological well-being. Families value not only the technical competence of nurses but also their ability to provide honest, timely, and compassionate communication. This expectation for human connection becomes even more critical during times of heightened stress and restricted access, such as during the COVID-19 pandemic. During this period, the emotional burden of restricted visitation was particularly evident, with many families expressing distress over insufficient communication, even when digital methods like video calls were available (Digby et al., 2023).

Across various healthcare systems, families consistently prioritize being well-informed about patients' conditions and treatment plans. This trend is evident in both high- and low-resource settings. For example, in tertiary hospitals in Malawi, families ranked frequent and clear communication higher than physical comfort provisions (Kalolo et al., 2023). Being kept informed is often described by relatives as a coping mechanism during stressful and uncertain periods. Family participation in care discussions, such as during bedside handovers, further highlights the importance of communication. Inclusion in these moments is often perceived as a form of validation and respect for their role. Nonetheless, challenges such as time limitations, nurse hesitation, and relatives' fear of asking questions frequently reduce such engagement (Ghosh et al., 2025). Although many healthcare frameworks promote family-centred care, implementation remains inconsistent.

Cultural expectations also influence how families perceive communication. A Greek study found that relatives preferred two-way communication, where nurses encouraged questions and helped guide decision-making (Malliarou et al., 2014). Families reported greater satisfaction when nurses appeared approachable, respectful, and informative. In contrast, limited or dismissive communication often left them feeling excluded or frustrated. While these studies offer rich insight into the expectations and experiences of family members, there is comparatively less research exploring how ICU nurses themselves experience and perceive these communication dynamics. Bridging this gap is crucial for designing effective support strategies and communication interventions. Accordingly, this study examines ICU nurses' perceptions on communication, including how they navigate cultural expectations and relational dynamics with families in high dependency settings.

1.4 Literature on Nurses' Perceptions towards Family Communication and Research Gaps

Nurses generally view communication with patients' families as a core element of holistic, patient-centred care. However, their experiences reflect a complex interplay between recognition of its importance and the many challenges it presents. According to Hetland et al. (2018), involving family caregivers in ICU settings can positively influence patient and family outcomes, but requires careful judgment based on caregiver readiness, safety, and institutional policies. Nurses often assess factors like emotional stability, physical capability, and relational dynamics when deciding the level of family involvement.

Yoo et al. (2020), likewise observed that nurses see communication with families as essential for quality care and their own job satisfaction. Yet, they also face difficulties such as time constraints, emotionally distressed families, and the challenge of relaying sensitive information, particularly when patients are ventilated or unable to communicate.

Attitudes towards family involvement also appear to vary based on nurses' experience. Shibily et al. (2021) noted that more experienced nurses often expressed more cautious or reserved attitudes, possibly due to prolonged exposure to complex cases and concerns about safety or workload. Conversely, nursing students and less experienced staff were generally more open to engaging with families.

The idea of "balancing interests," as presented by Dijkstra et al. (2024), offers a helpful framework for understanding nurses' perceptions. Nurses must simultaneously address the needs of patients, relatives, and their own professional responsibilities. Although many report positive outcomes from involving families, concerns persist around workload, emotional strain, and potential disruptions to patient care. Taken together, these findings suggest that while ICU nurses support

the principle of family involvement, practical barriers often limit its execution. Institutional support, structured communication policies, and ongoing training are needed to help nurses translate their values into consistent and sustainable practices. Nevertheless, there remains a limited understanding of how ICU nurses themselves perceive and experience these communication challenges in practice, particularly within specific national or cultural contexts such as Malta. By exploring these perceptions in depth, this study aims to address that gap and contribute new insights to guide effective interventions.

Despite the relevance of this topic, especially in high dependency settings, there is limited research on ICU nurses' perceptions towards communication with patients' families and relatives, particularly no specific research regarding this, within the Maltese healthcare system. A review of Maltese literature revealed no recent studies on the specifics of this topic, with only two studies from over two decades ago examining other aspects of communication in ICU settings (which will be further elaborated in Chapter 2).

1.5 Research Question

This study aims to tackle that gap by examining how local ICU nurses view and experience communication with patients' families.

Therefore, this study attempts to address this Research Question: "How do ICU nurses perceive their role in communication with patients' families, and what facilitators, challenges, and strategies shape these interactions in ICU settings?"

1.6 Objectives of the Study

- To explore ICU nurses' perceptions of their communication role with patients' families.
- To identify factors that support effective communication in the ICU.
- To examine barriers and challenges nurses face during family interactions.
- To investigate the strategies nurses employ to improve communication.

1.7 Relevance and Significance of the Study

Nurse-family communication in the ICU plays a crucial role in supporting emotional well-being, promoting transparency, and facilitating decision-making during critical illness. However, these interactions are often more complex than they appear. By exploring ICU nurses' views and strategies, this study aims to enhance understanding of the realities and demands of communication in high-pressure care environments.

For current ICU nurses, the findings may offer validation and practical insights. For new staff, they may provide a useful introduction to the expectations and challenges they are likely to face. Senior nurses involved in mentorship or preceptorship may also find the findings valuable for guiding less experienced colleagues. From an management perspective, the study may inform training, workforce planning, and the development of communication protocols. Understanding communication barriers from the nurse's perspective can help institutions design better systems of support.

This research also contributes to the broader academic conversation by addressing a relatively underexplored area, particularly in Malta, and may serve as a foundation for future studies in critical care communication.

1.8 Definition of Terms

In the context of this study, the following key terms are defined as indicated below:

- "ICU nurses": Registered nurses working in Intensive Care Units, providing care for critically ill patients requiring close monitoring and complex interventions.
- "Communication": The sharing of information, emotional support, and collaborative dialogue between nurses and patients' families.
- "Patients' families": Immediate relatives or significant others involved in supporting, caring for, or making decisions on behalf of the patient. In this study, this term is also used interchangeably with "Patients' relatives".
- "Facilitators": Conditions or tools that enable or enhance communication between nurses and families.
- "Challenges": Obstacles or limitations that interfere with effective communication in ICU settings.
- "Strategies": Practical methods or approaches used by nurses to navigate communication with families.

1.9 Overview of the Methodology

This study employed a qualitative descriptive design to explore how ICU nurses perceive and experience communication with patients' families. This approach was chosen for its ability to provide a rich, practical description of real-world experiences and to identify communication factors such as roles, challenges, facilitators, and strategies that shape communication in the intensive care environment (Doyle et al., 2020; Baillie, 2019).

Data were gathered through individual semi-structured interviews with seven registered ICU nurses working in an adult intensive therapy unit at Malta's main public hospital. Participants were recruited using purposive sampling to ensure they had direct and sustained experience of nurse–family communication in the ICU setting. Interviews were audio-recorded, transcribed verbatim, and analysed thematically following Braun and Clarke's (2021) framework. Symbolic Interactionism (SI) was then incorporated during data analysis as an interpretive lens to explain how meanings and roles are constructed and negotiated through nurse–family interactions. Ethical approval was obtained from the institutional research ethics committee, and participants provided informed consent. A detailed overview of methodological details are presented in Chapter 3.

The next Chapter 2 provides a critical review of the existing literature on ICU nurse–family communication, outlining key findings, and gaps that informed this research. Chapter 3 discusses in detail the methodology and research design adopted in the study, including sampling, data collection, analysis procedures, and ethical considerations. Chapters 4 & 5 present the findings of the study and interprets them in relation to existing literature, highlighting the major themes that emerged from the analysis. Finally, Chapter 6 offers recommendations for practice, education, and future research, and concludes the dissertation by summarising the key contributions of the study.

1.10 Conclusion

This chapter has introduced the research focus and provided background on the significance of communication in ICU settings. It outlined the study's research question, objectives, and rationale, and defined key terms to ensure conceptual clarity. The next chapter will offer a detailed literature review, followed by methodology, findings, and discussion in the subsequent chapters, and final conclusions and recommendations in the final chapter.

Chapter 2

Literature Review

2.1 Introduction

This chapter builds upon the previous discussion of ICU nurse–family communication by critically examining how these interactions are understood and experienced through a theoretical and evidence-based lens. While Chapter 1 highlighted the significance of effective communication in critical care, the focus of this chapter is on how meanings are constructed and interpreted during nurse–family exchanges and how existing research has explored these dynamics.

The chapter begins by introducing the guiding theoretical perspective of Symbolic Interactionism, which offers a foundation for understanding how ICU nurses assign meaning to their communicative role with families. Following this, a systematic and transparent literature review is presented. This includes a detailed account of the search strategy, databases consulted, and the inclusion and exclusion criteria applied to ensure relevance and rigor.

The core of the chapter synthesises empirical studies that explore ICU nurses' perceptions of communication with patients' families. These studies are critically appraised to highlight recurring themes such as the roles assumed by nurses, the challenges and barriers related with efficient communication encountered, and the strategies employed to foster effective communication. The synthesis also identifies gaps in current knowledge, with particular attention to underexplored contexts such as the Maltese healthcare setting.

By structuring the chapter in this way, moving from theoretical framing, through methodological transparency, to a critical synthesis, the review not only illustrates the current state of knowledge but also establishes the rationale for the present study. It demonstrates why exploring ICU nurses' perceptions of communication is both timely and necessary, and how this study is positioned to address existing gaps and contribute new insights.

2.2 Importance of a Theoretical Framework

A theoretical framework can be a helpful tool in shaping how a study is designed, carried out, and understood. As Grant and Osanloo (2014) point out, it offers more than just structure; it helps explain why a study focuses on certain questions and how the findings are interpreted. In qualitative research, where the focus is often on lived experiences and meaning, a framework can guide how the data is viewed and understood.

In this study, Symbolic Interactionism provided an interpretive lens for understanding how ICU nurses make sense of their communication with patients' families. It was not used to guide the design of the interviews or data collection, but rather to inform how the data was analysed and interpreted. While SI focuses on how meaning is created through social interaction, the primary emphasis of this research remains on the data shared by participants themselves. The theory was therefore applied cautiously and reflexively, serving as a tool to enhance understanding rather than as a framework imposed on the findings. This approach ensured that interpretations stayed grounded in the nurses' own accounts, while SI helped frame the broader discussion in Chapter 5,

particularly regarding how nurses' communicative roles and behaviours are shaped by their environment, interactions, and lived experiences.

2.3 Core Concepts of Symbolic Interactionism

Symbolic Interactionism (SI) is a sociological perspective that examines how individuals create and interpret meanings through social interactions. While the foundational ideas of SI were developed by George Herbert Mead, it was his student, Herbert Blumer, who coined the term and systematically articulated its principles. Blumer (1969) outlined three fundamental premises that underpin SI as shown in the table below ***(Table 2.1).***

Table 2.1 - ***Three fundamental premises of Symbolic Interactionism adapted from Blumer (1969)***

Concept	**Description**
Meaning	Individuals act toward things based on the meanings those things have for them. These "things" encompass physical objects, other people, institutions, or abstract concepts. The significance assigned to these entities guides behaviour.

Language	The meanings of things arise from social interactions. Through communication, particularly language, individuals negotiate and construct shared meanings, facilitating a common understanding within society.
Thought	Individuals interpret and modify meanings through an internal process. This reflective activity enables people to adjust their behaviours based on their interpretation of interactions and experiences.

These premises highlight that meaning is not found in objects or actions but is constructed and reconstructed through social interaction and individual interpretation. This dynamic process is central to understanding human behaviour within any social context. By establishing this theoretical foundation, we can apply SI to specific contexts, such as healthcare communication in ICU settings, ensuring a clear and structured progression from theory to application.

In situations where patients are non-verbal, family members rely heavily on their interactions with nurses to interpret not only the clinical condition of their loved ones but also the emotional tone of care. These interactions are full of symbolic signals such as facial expressions, tone of voice, clinical attire, and even body posture. The process of communication, therefore, becomes an exchange of both verbal and non-verbal symbols through which roles, authority, and emotional safety are continuously negotiated.

2.4 Application of SI in Healthcare Communication

Cersosimo (2019) highlights how healthcare communication is shaped not only by language but by institutional roles and cultural expectations. In nurse-family exchanges, elements such as tone, language choice, and even uniforms convey meaning. Families often interpret compassion, professionalism, or confidence through these symbolic indicators.

Cleveland (2009) examined similar dynamics in the context of Neonatal Intensive Care Units (NICUs), where mothers' emotional responses were strongly influenced by how nurses communicated. The tone, language, and degree of engagement shaped mothers' perceptions of their role and inclusion in their infant's care. This supports the view that communication is not merely informational, but emotionally and socially loaded.

A broader synthesis by Husin et al. (2021) also affirms SI's relevance in healthcare, particularly in exploring identity and role negotiation. In ICU settings, where emotional stakes are high and routines are rigid, SI provides a lens to examine how interactions unfold and how meaning is continually redefined. For instance, a nurse's calm and composed manner may be interpreted by family members as a sign that the patient's condition is stable, whereas hurried movements or a tense tone may raise concerns and heighten anxiety. These perceptions significantly influence how families feel emotionally and how much confidence they place in the healthcare team. The choice of language also plays a crucial role; using complex medical terminology can confuse or overwhelm families, while adapting language to their level of understanding promotes clarity, reduces stress, and encourages engagement. In addition, consistent and empathetic communication helps build rapport and supports collaborative decision-making. Nurses often reflect on their interactions and adapt their communication based on the family's reactions and the evolving

situation. This reflective process ensures that communication remains centred on the needs of both the patient and the family. For example, in situations where a patient's prognosis is unclear, a nurse may choose to spend more time with the family, offering honest explanations and emotional reassurance, which can foster trust and strengthen the relationship. These kinds of interactions demonstrate how meaning is continuously shaped through communication, in line with the principles of Symbolic Interactionism.

While Symbolic Interactionism (SI) offers useful insight into how communication develops through social interaction, it has some important limitations. The theory mainly focuses on individual meaning-making and tends to overlook wider institutional and cultural influences on communication (Stryker, 1987). In intensive care units (ICUs), nurses' communication is often shaped by hospital policies, hierarchical decision-making, and technological systems that restrict personal autonomy and symbolic exchange (Alves et al., 2008). In addition, SI-based research relies heavily on researchers' interpretations, which can introduce subjectivity (Valencia Contrera-Avilés et al., 2025). For these reasons, SI was used cautiously in this study, to explore interpersonal communication while recognising that institutional and contextual factors also strongly influence how nurses communicate in the ICU.

2.5 Relevance of Symbolic Interactionism to This Study

Applying Symbolic Interactionism to this study enables a deeper exploration of how ICU nurses interpret their role in family communication and how they understand the reactions and expectations of family members. This approach moves beyond describing communication as a clinical task to analysing it as a socially constructed process shaped by roles, expectations, and symbolic behaviours.

This framework also supports the thematic analysis planned in later chapters, helping to interpret how meaning is co-created during nurse-family interactions. It will allow the study to capture not just what nurses say, but how they perceive their own behaviour and interpret the responses they receive from families. Symbolic Interactionism will serve as a guiding lens during the discussion of findings. Important concepts like making sense of experiences, using symbols in communication, and working out roles help illustrate how ICU nurses personally relate to families and navigate the emotional challenges they encounter in these intense moments. Symbolic Interactionism will be next be revisited in Chapter 5 to guide the interpretation of findings.

This chapter will now proceed by detailing the systematic search strategy undertaken, outlining the databases consulted, the inclusion and exclusion criteria applied, and the process of study selection, before presenting the key findings and outcomes of the literature review.

2.6 Inclusion/Exclusion Criteria

Before outlining the detailed eligibility criteria applied during the review process, it is important to first clarify that this section serves to delineate the boundaries of the literature review. Establishing these boundaries ensures that the included studies remain relevant, focused, and aligned with the research aim, to explore ICU nurses' perceptions of communication with patients' families. By defining what was considered within and outside the scope of this review, a clear framework was created for selecting and analysing evidence.

To ensure that the literature reviewed is relevant and academically sound, specific inclusion and exclusion criteria were applied when selecting studies. These criteria were developed in alignment with the research aim, which is to explore ICU nurses' perceptions of communication with patients' families.

Only studies involving registered nurses working in adult intensive care units (ICUs) or critical care settings were included, as these professionals possess direct and sustained experience in nurse-family communication during critical illness. Studies on Nurses working in neonatal or paediatric ICUs, as well as student nurses or other healthcare professionals, were excluded to maintain a focused scope on qualified ICU nurses' perceptions working in 'adult' settings. Focusing solely on adult ICUs also aligns with current adult ICU family-centred care guidelines, ensuring that the facilitators and barriers identified are interpreted within a consistent organisational and clinical model.

The phenomenon of interest was defined narrowly as communication with patients' families in ICU settings. Therefore, studies exploring nurse-patient communication, or communication within

interprofessional healthcare teams, were excluded unless they specifically addressed nurse-family interactions.

The review focused on primary research studies that used qualitative or mixed-methods designs, as these offer rich, in-depth insights into nurses' lived experiences and perceptions of communication with families in the ICU. Editorials, commentaries, and other non-empirical sources were excluded early in the screening process. Although systematic reviews and meta-syntheses are valuable and high in the evidence hierarchy, they were not selected for final synthesis, as the focus of this review was on analysing original, first-hand qualitative data. However, such reviews were still considered during the screening phase, as they occasionally led to the identification of relevant primary studies. The aim was to prioritise direct empirical evidence while maintaining transparency in the search process.

Only studies published in English were considered to ensure accessibility and accurate interpretation of findings. The review was limited to peer-reviewed journal articles, postgraduate dissertations, and reputable grey literature with full-text availability. Sources such as conference abstracts, blog posts, and newsletters were excluded due to limited methodological transparency and lack of peer review.

No publication date limit was applied during the search to capture a wide range of perceptions and developments in nurse-family communication. This approach was chosen because communication is a core human and professional process that remains relevant across time. Excluding older studies based solely on date may have led to the omission of valuable insights that continue to inform current practice.

The criteria determined for the search strategy were informed by both the research question and the guidance available in comparable academic work, and they served to ensure that the selected literature was both conceptually aligned and methodologically sound.

Table 2.2 - ***Inclusion & Exclusion Criteria For Literature Review***

Criterion	Inclusion	Exclusion	Rationale
Population	Studies involving nurses working in adult ICUs that reported **nurse-specific perceptions on communication** (either nurse-only samples or mixed samples **with nurse data analysed separately or predominating**).	Studies focusing on pediatric or neonatal ICU nurses, student nurses, or other healthcare professionals only. (Studies that combined roles **without nurse-specific analysis** were excluded.)	To ensure that the findings are specific to the roles and experiences of ICU nurses whose practice focuses on adult patients.
Phenomenon of Interest	Studies focusing on communication between ICU nurses and patients' families	Studies focusing solely on nurse-patient or interprofessional communication (unless family interactions are also explored)	To maintain focus on the specific communication dynamics between nurses and families, which differ from other

Criterion	Inclusion	Exclusion	Rationale
			types of communication
Study Design	Qualitative or mixed-methods primary research studies	Quantitative-only studies, systematic reviews, meta-syntheses, commentaries, and editorials	To capture in-depth, interpretive insights based on original field data, suitable for thematic synthesis using CASP
Empirical Status	Original empirical research	Non-empirical sources such as conceptual papers or theoretical discussions	To include only studies grounded in real-world data and avoid purely theoretical discussions
Language	English	Non-English publications	To ensure consistency in interpretation and accessibility of findings
Publication Type	Peer-reviewed articles, postgraduate dissertations, and reputable grey literature with full text	Abstracts, blog posts, newsletters, unpublished or non-peer-reviewed materials	To maintain academic credibility and ensure sources meet minimum scholarly standards
Timeframe	All studies regardless of publication year	No date restrictions applied	Older studies can still offer valuable insights;

Criterion	Inclusion	Exclusion	Rationale
			no date restriction allows a broader understanding of the topic
Full Text Access	Full-text articles available for review	Studies where only abstracts were available or full text could not be accessed	To ensure the complete context and findings of each study can be fully evaluated

2.7 The Literature Search Strategy

The search was conducted between May and June 2025 using the University of Malta Hybrid Discovery (HyDi) platform, and was supplemented with targeted searches in CINAHL Complete, MEDLINE Complete, Academic Search Ultimate, and PubMed via the EBSCOhost interface. In addition to free-text keyword searching, Medical Subject Headings (MeSH) were applied, particularly within PubMed, to increase specificity and enhance the retrieval of conceptually relevant literature. These included “Intensive Care Units” [MeSH], “Nursing Staff” [MeSH], “Communication” [MeSH], and “Nurse-Family Relations” [MeSH].

To identify relevant literature exploring ICU nurses’ perceptions of communication with patients’ families, a comprehensive and systematic search strategy was developed. Boolean operators, truncation, and phrase searching were used to ensure the retrieval of focused, high-quality results.

The main concepts derived from the research question, including intensive care, nurses, communication, perceptions, and families, were searched using combinations of terms such as ("intensive care" OR ICU OR "critical care"), nurs*, communication AND (perception* OR experience* OR perspective* OR view*). The truncation symbol (*) was applied to capture variations of keywords (for example, nurs* retrieved nurse, nurses, and nursing).

Initial exploratory searches without the use of the NOT operator and specific truncation techniques yielded thousands of results, many of which were irrelevant or outside the scope of the study. This volume made thorough screening impractical. Therefore, the NOT operator was introduced as a refined strategy which was applied to narrow the focus and improve the relevance of results.

Table 2.3 below provides a summary of the search strategy, showing how each concept was operationalised into search terms, the Boolean logic applied, and the purpose of each search element. The table is organised into rows representing the key search concepts, such as Setting, Profession, Phenomenon, and Perspective/Experience, followed by the exact search terms and logic used. The final row presents the combined search string, demonstrating how all terms were systematically integrated to ensure comprehensive retrieval across databases.

To broaden the scope and capture less formally published data, a grey literature search was conducted using the Google Scholar search engine. Grey literature, including theses and non-commercial reports, can reduce publication bias and provide insight into emerging evidence not yet available in peer-reviewed databases (Philips & Barker, 2021). Grey literature was searched using Google Scholar by combining key terms such as "ICU nurses," "family communication," "critical care," and "qualitative study." Boolean operators (e.g., AND, OR) were used where possible. The first 50 results for each search were screened by title and abstract, and full texts were

checked for relevance. After screening, none met the inclusion criteria and were therefore excluded from the final review.

A search for relevant local studies and conference contributions was also performed via HyDi and institutional repositories (OAR@UM). However, no research specifically addressing ICU nurse-family communication within the Maltese context was identified.

This search strategy was designed to ensure that the included literature was reliable, relevant to clinical practice, and reflective of the changing nature of nurse-family communication in intensive care settings. In addition to database searching, citation tracking was also used. This involved reviewing the reference lists of included studies (backward citation chasing) and identifying more recent studies that cited them (forward citation chasing), to help uncover any relevant literature that may not have been captured through database searches alone. However, no additional studies meeting the inclusion criteria were found through citation tracking, suggesting that the database search was comprehensive and adequately covered the available evidence on ICU nurses' communication with families.

Table 2.3 - ***Search Strategy: Keywords, Synonyms, Truncations used.***

Search Concept	Search Terms Used	Boolean Logic Applied	Purpose
Setting	intensive care OR ICU OR critical care	OR	To capture all variations of the ICU environment
Profession	nurs*	Truncation	To include nurse, nurses, nursing
Phenomenon	communication	–	Core concept: nurse-family communication
Perspective / Experience	perception* OR perspective* OR experience* OR view*	OR	To focus on insights, views, and experiences
General Family Terms	famil* OR relative*	OR	Ensures inclusion of articles mentioning family
Exclusion Criteria	"famil* perception*" OR "famil* perspective*" OR "famil* experience*" OR "famil* view*" OR "relative* perception*"	NOT with grouped OR	To exclude studies focused primarily on family views

	OR “relative* perspective*” OR “relative* experience*” OR “relative* view*”		
Combined Search Logic	(“intensive care” OR ICU OR “critical care”) AND nurs* AND communication AND (perception* OR perspective* OR experience* OR view*) AND (famil* OR relative*) NOT (“famil* perception*” OR “famil* perspective*” OR “famil* experience*” OR “famil* view*” OR “relative* perception*” OR “relative* perspective*” OR “relative* experience*” OR “relative* view*”)	AND / OR / NOT (grouped logic)	Final full search string

2.8 Study Selection and Results

The study selection process adhered to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines, which promote transparency and reproducibility through a structured 27-item checklist and flow diagram (Page et al., 2021). This systematic search aimed to identify empirical qualitative or mixed-methods studies that explored intensive care unit (ICU) nurses’ perceptions and experiences of communication with patients’ families.

The initial search yielded 293 records. After removing 144 duplicates using manual screening, 149

records remained. These records underwent title and abstract screening, during which 83 were excluded based on some predetermined inclusion and exclusion criteria (Population, Timeframe, Language & Accessibility). This left 66 articles to be assessed through full-text review.

During the eligibility assessment, a further 58 full-text articles were excluded secondary to further focused inclusion and exclusion criteria ***(Table 2.4).*** Specifically, eight were not empirical studies, such as literature reviews or opinion pieces; seven employed purely quantitative methodologies; sixteen did not focus on the exploration of ICU nurses' perceptions or experiences; nineteen did not specifically address communication with patients' families; and eight presented perceptions from multiple healthcare professionals without distinguishing those of nurses. Ultimately, eight studies fulfilled all inclusion criteria and were incorporated into the final synthesis.

The studies derived from this search consisted of four qualitative descriptive studies, two phenomenological studies, one qualitative cross-sectional study, and one exploratory qualitative analysis embedded within a cross-sectional survey. These studies offered rich, qualitative insights into ICU nurses' experiences and perceptions regarding communication with patients' families. A visual representation of the selection process is provided in the PRISMA 2020 flow diagram ***(Figure 2.1)***, and a detailed list of excluded full-text articles with reasons for focused exclusion is available in ***Table 2.4.***

This structured and transparent selection process strengthens the methodological rigour of the review and supports replicability and critical appraisal by other researchers.

Figure 2.1 – ***PRISMA (2020) Flowchart showing Audit Trail of Research Outcome***

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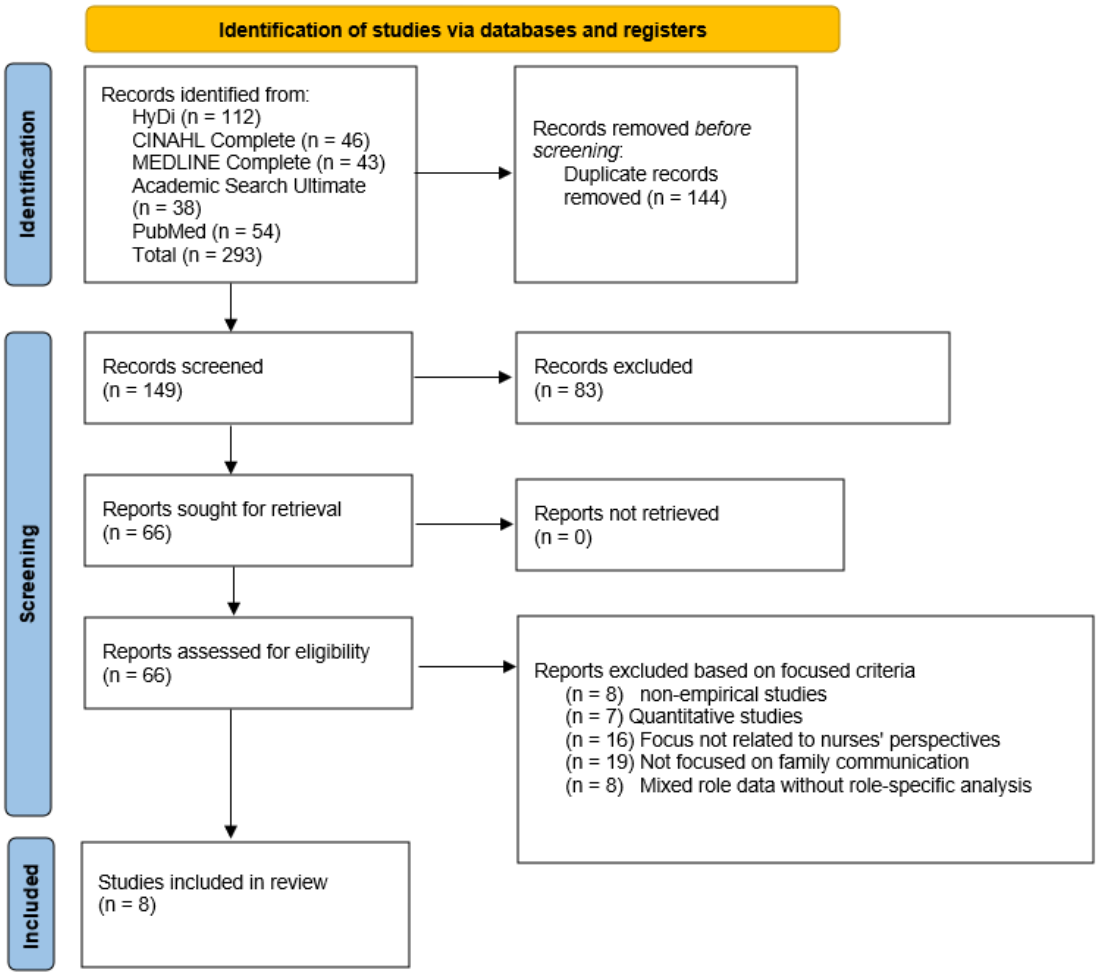


Table 2.4 - ***Focused Exclusion Criteria***

Category	Number Excluded	Examples of Reasoning
1. Non-empirical	8	Literature reviews, commentaries, and frameworks without original data could not provide firsthand insight into nurses' lived experiences.
2. Quantitative only	7	These studies used surveys or observational checklists, lacking the depth required to explore perceptions and interpretive processes.
3. Not focused on ICU nurses' perceptions	16	These studies either generalised across roles or prioritised physician, patient, or family narratives, with minimal input from ICU nurses themselves.
4. Not focused on communication with families	19	Some explored ICU stress, workload, or care delivery without directly addressing how nurses engage with families.
5. Mixed roles without role-specific analysis	8	Several studies presented blended data from multiple healthcare professionals but did not isolate or interpret the nurse-specific voice, making them unsuitable for this research focus.

2.9 Appraising Study Quality Using CASP Tools

Critical appraisal tools are important in evidence-based practice as they help systematically assess the reliability, relevance, and methodological quality of research studies (Burls, 2015). Among these, the Critical Appraisal Skills Programme (CASP) is one of the most widely used tools for evaluating qualitative research. Developed in 1993, CASP has continued to evolve to meet the needs of both academic and clinical users (CASP, 2018). This study used the CASP Qualitative Research Checklist (2018), which includes ten structured questions addressing key areas such as clarity of aims, appropriateness of methodology, ethical rigour, recruitment, data collection, and the value of findings. Its format, allowing responses of "yes," "no," or "can't tell," supports nuanced assessment and promotes reflective thinking (Long et al., 2020). The checklist highlights key aspects of credibility, transferability, dependability, and confirmability, which are essential for assessing the trustworthiness of qualitative research. By guiding users through a structured appraisal process, CASP enhances critical thinking and research literacy, supporting the integration of qualitative evidence into clinical decision-making and policy development.

A total of eight qualitative studies were appraised using the CASP tool. These studies, conducted across diverse geographical and clinical contexts, explored ICU nurses' perceptions and experiences of communication with patients' families. Each study varied in design, sample size, and data-collection methods but shared a focus on understanding communication processes within the emotionally charged ICU environment. The key characteristics of the included studies such as

author details, aims, design, data-collection methods, and participant information are summarised in ***Table 2.5*** below.

Table 2.5 - *Summary of the Research Studies included in the review*

Author(s)	Year	Country	Aim	Design	Data Collection Method	Participants
Yoo, Lim, & Shim	2020	South Korea	To explore ICU nurses' communication experiences with patients and families	Descriptive qualitative	2 focus groups and 4 individual interviews	16 ICU nurses (≥1 year experience)
Loghmani, Borhani, & Abbaszadeh	2014	Iran	To identify barriers and facilitators of nurse-family communication in ICU	Qualitative content analysis	Unstructured interviews	8 ICU nurses and 10 family members
Emaliyawati et al.	2020	Indonesia	To explore challenges and barriers in nurse-family communication	Qualitative phenomenology	In-depth interviews (60–90 minutes)	10 ICU nurses (≥3 years experience)

Author(s)	Year	Country	Aim	Design	Data Collection Method	Participants
Naef et al.	2021	Global (10 countries)	To examine ICU nurses' perceptions on family engagement globally	Qualitative descriptive	Semi-structured interviews	65 ICU nurses across 26 ICUs
Maharmeh et al.	2023	Jordan	To explore ICU nurses' communication experiences with families	Qualitative phenomenology	Semi-structured interviews (30–60 minutes)	18 ICU nurses from 3 hospitals in Amman
Bloomer et al.	2016	Australia & New Zealand	To explore nurses' communication strategies during withdrawal of life-sustaining treatment	Qualitative descriptive	Focus groups in 4 tertiary ICUs	21 registered nurses with EOLC experience
Ahluwalia et al.	2016	United States	To examine ICU nurses' roles and barriers in structured family meetings	Qualitative (cross-sectional)	6 focus groups	30 ICU nurses from a single VA hospital

Author(s)	Year	Country	Aim	Design	Data Collection Method	Participants
Cypress et al.	2024	United States	To identify facilitators and barriers to nurse-family communication in ICU	Qualitative Descriptive	Open - ended interviews	multidisciplinary ICU staff; 52 provided narrative data (27 RNs, 22 physicians, 1 pharmacist, 1 dietitian, 1 social worker)

2.10 Critical appraisal of the literature retrieved

This critical review presents each qualitative study individually rather than in a thematic manner, to ensure a detailed and refined analysis. This allows for a more precise examination of each study's unique design, contextual factors, and a clear identification of its specific strengths and limitations, providing a richer, more comprehensive understanding than a broad thematic overview. This critical appraisal also incorporates some key findings directly within each study's review to ensure adherence to the structure and comprehensive requirements of the critical appraisal tool. These findings will subsequently be elaborated upon and discussed in greater detail in a dedicated section of the literature review.

2.10.1 Critical Analysis of the Study by Yoo, Lim, & Shim (2020)

This qualitative study by Yoo et al. (2020), aimed to explore the experiences of critical care nurses in communicating with patient' families and patients themselves in the intensive care unit (ICU). The authors provided a clear and well-justified statement of purpose, focusing their research and emphasizing on therapeutic communication in critical care settings. A qualitative approach was appropriately selected, considering the study's aim to uncover personal experiences and meanings. The research employed a descriptive qualitative design, utilizing both focus groups and in-depth interviews, which were suitable methods to explore the phenomenon in depth.

The recruitment strategy was well thought out, involving purposive and snowball sampling to identify ICU nurses with at least one year of direct clinical experience. This ensured that participants had substantial engagement with ICU communication dynamics. Data collection was strong, using open-ended questions in two focus group discussions and four individual interviews, all of which were audio-recorded, transcribed, and analyzed using Colaizzi's phenomenological method. This method allowed the authors to identify and validate key themes grounded in participants' accounts.

While the study briefly described the researchers' backgrounds and efforts to build rapport with participants, it offered limited reflection on the influence of researcher-participant relationships and potential power dynamics during data collection, a common limitation in qualitative work. Ethical considerations were appropriately addressed, including ethics approval, informed consent, and participant confidentiality. The data analysis was rigorous and systematic, featuring multiple coders, clear theme development, and participant validation of themes. The authors presented their findings clearly, identifying three overarching themes, facing unexpected communication

difficulties, learning through trial and error, and recognizing communication as essential to nursing care. These were well supported by illustrative quotes.

Overall, the study offers significant value to nursing practice, shedding light on communication challenges ICU nurses face, such as family distress, lack of communication training, and situational complexity. It highlights the need for structured communication education and improved organizational support. The findings offered useful insights for both clinical practice and further studies in critical care communication.

2.10.2 Critical Analysis of the study by Loghmani, Borhani, & Abbaszadeh (2014)

The qualitative study by Loghmani et al. (2014) aimed to explore the factors that facilitate or hinder communication between ICU nurses and families of critically ill patients in Iran. The study had a clearly defined aim, and a qualitative design using content analysis was appropriately selected to address the complex, context-dependent nature of communication. Data were collected through non-structured interviews with eight registered ICU nurses and ten family members from two large university hospitals in Kerman. Participants were selected using purposive sampling, ensuring the inclusion of individuals with relevant and diverse experiences in nurse-family interaction.

Interviews lasted between 20 and 90 minutes and were conducted in private hospital rooms. The researchers transcribed and analysed the data using a conventional content analysis approach, involving inductive coding, categorisation, and constant comparison. Through this process, the authors identified five main facilitators for better communication, including spiritual care, emotional support, participation, notification, and consultation while several barriers included

misunderstandings, job-related and ethical challenges, and patient-related factors. The findings were supported by rich participant quotations, enhancing the study's credibility and depth.

Ethical considerations such as informed consent and confidentiality were appropriately addressed. However, the study provided limited discussion of researcher reflexivity, such as no mention of whether the researchers were previously acquainted with the participants or worked in the same institutions. Despite this limitation, the findings offer valuable insight into how cultural, religious, and institutional factors shape nurse-family communication in ICU settings. The study contributes meaningfully to improving practice, particularly in terms of culturally sensitive training and the removal of structural barriers to effective communication.

2.10.3 Critical Analysis of the study by Emaliyawati, Widiasih, Sutini, et al. (2020)

Emaliyawati et al. (2020) conducted a qualitative phenomenological study to explore ICU nurses' reflections on the challenges and barriers of communication with patients and their families in a high-acuity Indonesian hospital setting. The study had a clear aim, and a phenomenological methodology was appropriately chosen to assess the lived experiences of ten ICU nurses, each with over three years of clinical experience. Participants were recruited through purposive sampling, ensuring that insights were rooted in hands on clinical experience.

The researchers conducted in-depth, 60–90-minute interviews, which were digitally recorded, transcribed verbatim, and analysed using Colaizzi's seven-step method. This rigorous analytical process yielded four key themes. (1) The tension between professional responsibility and personal life, (2) the role of contextual factors in shaping communication techniques, (3) multiple barriers to communication, such as family denial and misunderstandings, and (4) the importance of

compassion and patience in effective nurse-patient-family communication. These themes were richly supported by participant quotations that revealed the emotional and ethical dilemmas ICU nurses encounter regularly.

The study addressed ethical considerations effectively, including institutional ethics approval and informed consent. However, it offered limited reflection on the researchers' own positionality or how their clinical backgrounds might have shaped the research process. Despite this, the findings provide useful insights into how ICU nurses in Indonesia handle emotionally intense situations and balance professional communication demands with personal strain.

This research provides a strong contribution to the field, particularly in emphasizing the culturally embedded nature of communication and the psychological strain that ICU nurses endure. It supports the need for both emotional support mechanisms for staff and structured communication training in critical care units.

2.10.4 Critical Analysis of the Study by Naef, R. et al. (2021)

Naef et al. (2021) qualitative multi-site study aimed at exploring ICU nurses' perceptions and practices of family engagement in adult intensive care units from a global perspective. The study employed a rigorous qualitative descriptive design using inductive content analysis and was conducted across 26 adult ICUs in 10 countries, spanning five continents. A total of 65 ICU nurses participated, with an average of 10 years of ICU experience, most of whom held ICU certification (72%). Participants were purposively recruited, and interviews were conducted either in English or native languages using a semi-structured guide.

Data were collected through individual interviews averaging 38.4 minutes in length and were conducted either at the hospital or at home, depending on participant preference. Interviews were recorded, transcribed, and translated where necessary, with coding performed by local researchers and reviewed through international interpretive collaborators, ensuring cross-cultural rigor and consensus. The study did not explicitly explore researcher reflexivity, which could have added depth to considerations of positionality, but it did maintain methodological transparency and credibility through a structured analytic process.

Three main themes were identified: (1) the ebb and flow of relational power *(the shifting balance of influence and authority*) between nurses and families, often governed by the nurse's perceived authority and role as gatekeeper of information; (2) fluctuations in nurse engagement practices, shaped by individual confidence, experience, and context; and (3) the influence of ICU culture, team collaboration, and structural resources on the degree to which families were engaged. Nurses described moments of empowerment and disempowerment, varying comfort with family involvement, and the influence of institutional policies and cultural expectations on their engagement decisions.

Overall, the study provides robust, globally relevant insights into the dynamic and relational nature of nurse-family communication in the ICU. It highlights the need for shared team cultures, formal education on engagement, and systemic support to foster consistent and inclusive family care practices.

2.10.5 Critical Analysis of the Study by Maharmeh et al. (2023)

Maharmeh et al. (2023) conducted a phenomenological study to explore ICU nurses' experiences of communication with patients' families in Jordanian critical care units. The research design was appropriate for uncovering the nuanced and emotionally complex interactions within a culturally embedded healthcare context. Eighteen ICU nurses were purposively sampled from three hospitals in Amman, all with at least one year of ICU experience. The interviews were conducted in Arabic, lasted between 30 and 60 minutes, and were transcribed verbatim and anonymized.

A thematic analysis approach was used to analyse the data, which identified two major themes: precarious relationships and disruptive communication patterns. These themes encompassed several subthemes, including doubtfulness, role ambiguity, victimization, being overwhelmed, disrespectful manner, and self-incompetence. These findings revealed systemic and interpersonal challenges such as mistrust from families, unclear role boundaries, cultural misinterpretations, emotional exhaustion, and a perceived lack of communication training among nurses. Participant quotations strongly illustrated how these issues strained the nurse-family relationship and interfered with communication effectiveness.

Ethical approval was obtained from the hospitals involved, and informed consent was secured. While the study emphasized credibility through prolonged engagement and careful transcription, it did not explicitly discuss researcher reflexivity or potential biases during data collection and analysis. Nevertheless, the use of verbatim quotes, thorough thematic development, and culturally specific insights support the trustworthiness of the findings.

This study is a valuable contribution to the nursing literature, particularly given the scarcity of qualitative research addressing nurse-family communication in Arab cultural contexts. It underscores the urgent need for culturally responsive communication training, institutional strategies to manage large family involvement, and interventions that support nurses in developing confidence and competence in emotionally demanding interactions.

2.10.6 Critical Analysis of the Study by Bloomer et al. (2016)

Bloomer et al. (2016) conducted a qualitative descriptive study exploring how critical care nurses navigate communication with families during the withdrawal of life-sustaining treatment in intensive care units across Australia and New Zealand. The study had a clear aim and appropriately employed a qualitative descriptive design based on naturalistic inquiry. Data were collected via semi-structured focus groups in four level three tertiary ICUs, two in Australia and two in New Zealand, each capable of complex life support provision. Twenty-one registered nurses participated, all of whom had experience with end-of-life care. Participants were purposively sampled, and the focus groups lasted between 39 and 58 minutes.

Data was analysed using inductive content analysis. Transcripts were read repeatedly by multiple researchers to identify emergent themes, and analysis was refined through panel discussions to ensure analytic rigour. Five key themes were derived, establishing the “who,” working out “how,” judging “when,” assessing the “what,” and identifying “where” these communication skills were learned. The findings offered practical insight into how nurses tailor communication based on

verbal and nonverbal cues, family readiness, timing, and context, rather than relying on formal scripts.

While the study briefly discussed how researchers monitored group dynamics during the focus groups, it lacked critical reflection on researcher positionality or how their presence may have influenced participant responses, an important consideration for transparency in qualitative research. Ethical approval was obtained in both countries, and informed consent was clearly documented.

The study underscored that communication during treatment withdrawal is shaped more by clinical experience and observational learning than formal training. Nurses reported learning to navigate these interactions through trial and error, peer observation, and intuition, highlighting a gap in formal education. The findings advocate communication training that goes beyond protocols, incorporating the subtle, often intangible interpersonal and emotional skills required in end-of-life care. This research makes a valuable contribution to the field by illustrating how relational, contextual, and emotional factors shape nurse-family communication during one of the most critical phases of care.

2.10.7 Critical Analysis of the Study by Cypress et al. (2024)

Cypress et al. (2024) conducted a qualitative descriptive study exploring ICU healthcare professionals' perceptions on the facilitators and barriers to family engagement during patient-and-family-centered-care (PFCC) interdisciplinary rounds. Although the study included a broad range of participants, registered nurses represented a substantial proportion of the sample (27 out

of 52), ensuring that nursing voices were strongly represented. The study had a clearly stated aim and employed a well-suited qualitative approach using conventional content analysis to examine open-ended responses from a cross-sectional electronic survey. This method allowed the researchers to capture rich, experience-based insights into family involvement in ICU care.

The sampling strategy was appropriate, drawing from licensed ICU staff across four hospitals in the southwestern United States. However, the use of convenience sampling may limit the transferability of findings. Ethical procedures were adequately reported, with institutional review board approval and informed consent obtained from all participants. Data analysis was systematic, involving multiple rounds of coding and categorization, although the study did not discuss researcher reflexivity or how the authors' professional backgrounds may have influenced interpretation, a limitation in qualitative transparency.

Findings were presented clearly and organized into five major themes: family presence, communication, interdisciplinary collaboration, care planning, and barriers to family engagement. Nurses' perceptions were especially prominent in themes related to emotional support, communication, and the challenges of balancing family needs with clinical responsibilities. Participant quotations enhanced the credibility of the themes and gave voice to frontline staff experiences.

2.10.8 Critical Analysis of the Study by Ahluwalia et al. (2016)

Ahluwalia et al. (2016) conducted a qualitative cross-sectional study to explore how ICU nurses perceive their roles in structured family meetings and the barriers they face in participating fully.

The study addressed a clearly focused issue and employed a suitable qualitative methodology; focus group discussions using a constant comparative method for analysis. A total of 30 nurses participated in six focus groups, which were facilitated by experienced researchers using a refined semi-structured interview guide. The use of focus groups was appropriate for exploring shared experiences and group dynamics among ICU nurses, allowing participants to build on each other's insights about structured family meetings. However, this method may also have limited the disclosure of more personal or sensitive views due to the presence of colleagues, potentially affecting the depth of individual perceptions. This sampling approach also maximised practical participation across shifts but relied on convenience sampling from a single Veterans Affairs ICU, which limits transferability.

Data collection was appropriately rigorous, with audio recording, verbatim transcription, and independent coding by two researchers using a pre-agreed codebook. Discrepancies in coding were resolved through consensus, and thematic development was systematic. However, the study did not explore the relationship between researchers and participants in any depth, nor did it reflect on how researcher positionality might have influenced data generation, representing a notable limitation regarding reflexivity.

The study identified three main themes: the multiple roles nurses could play in family meetings, barriers that inhibited their full involvement, and their position as intermediaries. Nurses described feeling undervalued and underempowered, especially when their insights conflicted with the physician’s message. They often withheld input during meetings due to unclear role expectations and moral discomfort, even when they held important knowledge about patient or family

preferences. These findings were supported by rich, illustrative quotations, adding authenticity to the analysis.

Ethical approval and informed consent procedures were clearly reported. Despite its single-site focus and lack of demographic data for participants, the study's findings are credible and offer important insight into nurse-physician communication dynamics in ICU family meetings. It makes a strong case for institutional interventions that include communication training, role clarification, and greater structural support to enhance nurses' active participation. The study contributes meaningfully to ICU practice by highlighting the need to address systemic and cultural barriers that limit nursing involvement in collaborative decision-making.

The key appraisal criteria applied to each study using the CASP Qualitative Research Checklist (2018) are summarised in ***Table 2.6***, which outlines how each study met or did not meet the ten core questions of the tool.

Table 2.6 - ***CASP tool for Retrieved Studies***

CASP Questions	Yoo et al. (2020)	Loghmani et al. (2014)	Emaliyawati et al. (2020)	Naef et al. (2021)	Maharmeh et al. (2023)	Bloomer et al. (2016)	Cypress et al. (2024)	Ahluwalia et al. (2016)
1. Was there a clear statement of the aims?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2. Is a qualitative methodology appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

CASP Questions	Yoo et al. (2020)	Loghmani et al. (2014)	Emaliyawati et al. (2020)	Naef et al. (2021)	Maharmeh et al. (2023)	Bloomer et al. (2016)	Cypress et al. (2024)	Ahluwalia et al. (2016)
3. Was the research design appropriate to address the aims?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4. Was the recruitment strategy appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
5. Was the data collected in a way that addressed the research issue?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
6. Has the relationship between researcher and participants been adequately considered?	Can't tell	No	No	No	No	No	No	No
7. Have ethical issues been taken into consideration?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
8. Was the data analysis sufficiently rigorous?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

CASP Questions	Yoo et al. (2020)	Loghmani et al. (2014)	Emaliyawati et al. (2020)	Naef et al. (2021)	Maharmeh et al. (2023)	Bloomer et al. (2016)	Cypress et al. (2024)	Ahluwalia et al. (2016)
9. Is there a clear statement of findings?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
10. How valuable is the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

2.11 Strengths and Limitations of Retrieved Literature

A notable strength across the reviewed studies was their shared focus on nurse–family communication within emotionally intense and culturally varied ICU contexts. Collectively, the research captured both global and context-specific perceptions, highlighting how communication practices are shaped by differing healthcare systems, cultural expectations, and emotional demands. Broader, multi-country studies, such as Naef et al. (2021), offered valuable international insight into shared global challenges in family engagement, strengthening the transferability of key themes such as relational power, variation in practice, and emotional burden. In contrast, single-centre studies (e.g., Emaliyawati et al., 2020; Maharmeh et al., 2023) provided deep, context-rich accounts of nurses' lived experiences, particularly around cultural miscommunication and emotional labour. This balance between breadth and depth enhanced the overall understanding of communication processes across diverse ICU settings, although location-specific recruitment may limit the generalisability of findings beyond particular institutional and cultural contexts.

Methodologically, most studies demonstrated rigorous qualitative approaches, using semi-structured interviews or focus groups supported by well-established analytical frameworks such as Colaizzi's method and thematic content analysis. This consistency enhanced methodological transparency and facilitated detailed exploration of complex relational and emotional dynamics. Multi-site designs, such as in Bloomer et al. (2016), improved the credibility and confirmability of findings by incorporating diverse ICU environments. However, the reliance on retrospective self-reporting in several studies may have led participants to filter or idealise past experiences, and limited discussion of researcher reflexivity as seen in Bloomer et al. (2016), could affect how data were interpreted. Only a small number of studies explicitly discussed reflexivity or participant validation, which may impact confirmability; for example, only Yoo et al. (2020) reported confirming findings with three participants.

Several studies also highlighted the influence of hierarchy, institutional structure, and culture on nurses' communicative roles and confidence (Loghmani et al., 2014; Yoo et al., 2020; Cypress et al., 2024). These findings enriched understanding of nurse hesitation and role boundaries, while drawing attention to the systemic pressures that constrain communication. At the same time, limited demographic reporting such as years of experience or level of ICU training restricted opportunities to analyse how professional background shapes communicative behaviour. In some instances, this may have reflected efforts to preserve anonymity in small or specialised clinical settings.

Across the literature, there was also a tendency to focus more heavily on individual-level perceptions rather than organisational or structural influences. Although Cypress et al. (2024) emphasised team collaboration and institutional support as facilitators of effective communication, broader exploration of policy, workload, and systemic barriers was limited. Consequently, while

the reviewed studies provide valuable insights into the interpersonal and emotional dimensions of nurse–family communication, they offer comparatively less understanding of the organisational and institutional factors that underpin or inhibit these interactions.

Finally, while each study contributed meaningful perspectives, the restriction to English-language publications may have excluded relevant work from non-English contexts, potentially narrowing the cultural diversity of the evidence base.

2.12 Discussion of Retrieved Literature Findings

Across the eight qualitative studies reviewed, five overarching themes were identified in the way ICU nurses perceive and engage in communication with patients' families. Themes were developed using an inductive thematic synthesis approach. I read through the findings of each study carefully, coding the key ideas line by line. Similar ideas were then grouped together into categories, which were refined and combined to form broader themes that reflected common patterns across all the studies. These themes reflect how nurses navigate professional roles, emotional complexities, institutional limitations, and their own personal coping strategies in the high-pressure environment of critical care. While each study reflects a unique cultural and clinical setting, the findings show considerable overlap, suggesting common experiences among ICU nurses internationally.

2.12.1 Communication as Relational Power and Role Negotiation

ICU nurses often find themselves navigating communication with families in ways that reflect professional boundaries, team dynamics, and cultural expectations. This role is rarely fixed. Instead, it shifts based on how nurses interpret their responsibilities, how much autonomy they have, and how families respond. Communication in this context is not just about transferring information, but involves negotiation, judgement, and a careful balancing act between transparency and sensitivity.

In their international study, Naef et al. (2021) described communication as an "ebb and flow of relational power," with nurses adjusting their involvement based on family behaviour, unit culture, and the level of trust between care providers. This power was not formally assigned but was constantly negotiated at the bedside.

Nurses involved in end-of-life care described relying on emotional cues and timing to guide difficult conversations. Rather than simply delivering information, they often "read the room" to determine whether families were ready to hear the full scope of the situation (Bloomer et al., 2016). These strategies were shaped by empathy and intuition more than by formal guidelines.

Cypress (2024) similarly highlighted the relational aspect of communication, noting that ICU nurses often functioned as emotional buffers between families and the medical team. Nurses used their proximity to patients and their families to assess readiness and emotional tone, which influenced how and when they delivered information. Their communication style evolved through experience and often reflected a deep commitment to holistic care.

In other contexts, particularly those influenced by cultural hierarchy and physician-led communication norms, nurses were more likely to take a passive role. For example, in Jordan and Iran, nurses often refrained from initiating family discussions, citing uncertainty about whether it was appropriate to speak on sensitive topics like prognosis (Maharmeh et al., 2023; Loghmani et al., 2014). Despite knowing the patient and family well, they typically deferred to the physician's authority, even when their own understanding of the family dynamic could have enhanced the interaction.

This pattern was echoed in South Korea, where Yoo et al. (2020) reported that nurses often hesitated to contribute to communication unless explicitly prompted, reflecting a cultural emphasis on deference to medical hierarchy. As a result, even when nurses felt they had relevant emotional or contextual insights, they often held back.

Across all these settings, communication was revealed not as a scripted task but as a relational process, one that required nurses to constantly weigh their clinical insight, professional boundaries, and interpersonal judgement.

2.12.2 Communication Barriers: Emotional, Institutional, and Cultural

While nurses strive to communicate clearly and compassionately, their efforts are often hindered by multiple, intersecting barriers. These include emotional strain, structural limitations, unclear expectations, and cultural differences that complicate even routine exchanges.

In many of the studies, nurses reported difficulty managing family emotions, especially when families were in denial, angry, or unprepared to hear difficult news. The emotional weight of these conversations, combined with the urgency of ICU care, left nurses feeling vulnerable and often unsupported. For example, Indonesian ICU nurses noted how the lack of privacy and high-stress environment made it challenging to explain procedures or comfort distressed relatives (Emaliyawati et al., 2020).

Institutional constraints such as time pressure, understaffing, and lack of communication protocols also impeded meaningful interaction. Cypress et al. (2024) highlighted how ICU nurses struggled with the logistics of interdisciplinary rounds, noting that even when families were invited to participate, inconsistent timing and lack of role clarity created confusion and missed opportunities for engagement.

Communication was also affected by sociocultural dynamics. In Iran, nurses described feeling conflicted when deciding how much truth to disclose, especially when families preferred reassurance over transparency (Loghmani et al., 2014). Similarly, in Jordan, nurses reported facing large numbers of visitors and strong family expectations for continuous updates, which were difficult to meet given clinical demands (Maharmeh et al., 2023).

Language and health literacy posed additional challenges. Nurses reported that even when they tried to simplify explanations, families often struggled to grasp the implications of test results or treatment plans. Yoo et al. (2020) observed that in Korean ICUs, the physical layout and rigid routines created further barriers to open conversation, reinforcing brief and functional communication styles. Collectively, these findings reveal that communication in the ICU is constrained by far more than interpersonal skill. Environmental design, staffing, institutional

values, and social expectations all shape and sometimes obstruct the way nurses connect with families.

2.12.3 Individual Variation in Nurse Communication Practices

Although communication is considered a fundamental nursing skill, how it is practiced varies greatly among individuals. This variation reflects differences in personality, emotional readiness, clinical experience, and the amount of support received from colleagues and supervisors.

Some nurses embrace communication as a key part of their role and actively seek connection with families. In the study by Naef et al. (2021), these nurses saw themselves as relationship-builders, engaging with families not only to provide updates but to offer continuity, reassurance, and compassion. However, others in the same study were more hesitant, focusing solely on tasks and avoiding extended interaction, particularly when emotional or cultural tensions were high.

Training or the lack of it, was a common factor. In Australia and New Zealand, nurses explained that they had not received formal education on communication and instead relied on instinct or peer modelling (Bloomer et al., 2016). This led to uncertainty during high-stakes conversations, such as those involving end-of-life decisions or emotional breakdowns.

Emaliyawati et al. (2020) found that personal stress and emotional exhaustion shaped how nurses communicated. Participants shared that on difficult days, when they were distracted by personal problems or fatigued from the workload. they were less empathetic and more likely to keep

interactions short. This unintended withdrawal sometimes increased family distress and undermined trust.

Similarly, Korean ICU nurses described how their comfort level in engaging families often depended on how much support they felt from their team. Those who felt secure in their role and trusted by their colleagues were more likely to initiate conversations. Others avoided communication entirely, fearing that they might say something inappropriate or contradict the physician (Yoo et al., 2020).

Cypress et al. (2024) also observed that nurses' communication behaviours were shaped by whether they felt emotionally and professionally supported within their teams. The presence or absence of structured interdisciplinary collaboration played a key role in either empowering or limiting nurses' engagement with families.

These studies suggest that variation in communication practices is not a matter of competence alone. It reflects deeper differences in emotional capacity, perceived role clarity, and access to support, reminding us that even experienced nurses can struggle if the conditions around them do not encourage open, relational care.

2.12.4 Nurses as Intermediaries and Emotional Anchors

Across the studies, nurses described acting as the key link between families and the rest of the ICU team, translating clinical information, offering emotional reassurance, and helping families

understand what was happening. While this role was common, it was often informal and not fully acknowledged by physicians or institutions.

In their global study, Naef et al. (2021) found that nurses regularly took the initiative to engage with families, especially when physicians were unavailable or had delivered information in a way that families struggled to process. Nurses filled this gap by using simpler language and showing empathy, positioning themselves as a continuous, trusted presence.

Similarly, Bloomer et al. (2016) highlighted how nurses in Australia and New Zealand used relational strategies like reading family body language and offering quiet support during moments of distress to establish connection. These efforts were often spontaneous and built on accumulated bedside interactions rather than structured communication sessions.

Ahluwalia et al. (2016), in a U.S. setting, found that nurses frequently played multiple roles during family meetings, including acting as advocates, coordinators, and translators. However, many reported feeling undervalued or excluded, particularly when physicians dominated the conversation and failed to solicit nursing input. This exclusion often created tension and left nurses feeling responsible for managing family distress afterward, without formal recognition of their role.

The study by Maharmeh et al. (2023) in Jordan echoed these findings, revealing that nurses often held critical knowledge about patient and family needs but were reluctant to speak during official meetings. This was compounded by cultural expectations around hierarchy to physicians, which left many nurses feeling "caught in the middle."

In more emotionally intense contexts, such as those described by Emaliyawati et al. (2020) and Loghmani et al. (2014), nurses provided comfort through small acts like making eye contact, offering brief updates, or physically assisting family members during care. These acts of relational care helped families cope and build trust, even when formal communication was limited.

Yoo et al. (2020) also noted that Korean ICU nurses viewed emotional support as part of their professional identity, even though it was rarely acknowledged in clinical documentation or ward policy. Many nurses expressed a sense of responsibility to bridge emotional gaps left by physicians' brief, task-focused interactions.

Together, these findings illustrate that nurses consistently serve as emotional anchors and communication intermediaries, even when these roles are informal, unsupported, or invisible within ICU hierarchies.

2.12.5 The Need for Structural and Educational Support

Nurses in all studies expressed a strong desire for better training and organisational support to help them communicate more effectively with families. Many noted that while they were expected to manage emotional conversations and respond to family distress, they had received little or no formal preparation for this role.

Bloomer et al. (2016) reported that most nurses developed communication skills informally, through peer observation and practice. Nurses in their study voiced a clear need for training on how to handle difficult conversations, particularly in end-of-life care. This was reflected by

Emaliyawati et al. (2020), whose participants described feeling unprepared to explain complex ICU procedures to families with limited health literacy, especially in high-stress or culturally sensitive situations.

Ahluwalia et al. (2016) found that U.S. nurses desired clearer guidance and structural inclusion in family meetings. Many recommended that communication roles be formally integrated into care planning, with nurses given designated time and space to speak during discussions about patient goals and prognosis.

From a Middle Eastern perspective, both Maharmeh et al. (2023) and Loghmani et al. (2014) highlighted the importance of culturally sensitive education. Nurses in these studies faced additional challenges stemming from family dynamics, religious expectations, and social norms about who should deliver bad news. Participants called for training that addressed not only communication techniques, but also cultural humility and family-centred approaches within specific religious and social frameworks.

Yoo et al. (2020) also recommended integrating joint physician-nurse communication training, noting that in Korean ICUs, rigid team structures often limited nurse involvement. Nurses felt that shared training sessions could promote collaboration and reduce misunderstandings between professionals, leading to more unified communication with families.

Naef et al. (2021) stressed that communication cannot rely solely on individual experience. They advocated for hospital-wide systems such as structured protocols, reflective practice sessions, and leadership engagement to ensure that communication is consistent and equitable, regardless of the individual nurse on shift.

These studies collectively argue that communication must be supported not only by interpersonal skills but by policies, education, and team dynamics that value and reinforce the nurse's role in family engagement.

2.13 Research Gaps

Several gaps stand out in the current research. To begin with, most studies come from a limited range of countries, with very little representation from places like Malta or other Mediterranean and African regions. While many studies highlight the difficulties nurses face in communicating with families, few look at formal systems or approaches that support nurses in this role. Also, even though the emotional impact of these conversations is mentioned, it's rarely explored in depth, and the mental wellbeing of nurses often goes unnoticed. Most of the research is descriptive, pointing to a clear need for studies that test practical solutions to improve communication between nurses and families. These gaps show why more research is needed, especially in less-studied settings like Malta.

Furthermore, the researcher of this study noted that there is a conspicuous absence of contemporary, Malta-based research that examines ICU nurses' perceptions of communicating with patients' families. The only local works that were identified address different facets and are decades old; Bellizzi (2004) focused on nurse–patient communication with mechanically ventilated, sedated patients in a Maltese ICU, not nurse–family dynamics, while Griscti's dissertation (1992) explored relatives' needs in the Intensive Therapy Unit rather than nurses' perceptions. The researcher strongly believes that a local qualitative study centred on ICU nurses'

perceptions is therefore warranted to tailor training, protocols, and resources to the local population's needs.

2.14 Conclusion

This chapter presented a thematic synthesis of qualitative studies exploring ICU nurses' experiences and perceptions of communicating with patients' families. A structured search strategy was applied across several electronic databases and platforms, using Boolean operators, truncation, and controlled vocabulary to identify relevant peer-reviewed studies. The review highlighted five overarching themes: communication as an evolving negotiation of relational power and role boundaries, the cumulative emotional demands on nurses with a constant balancing of honesty and sensitivity, variability in individual nurse communication practices, the nurse's intermediary and emotional-anchoring role with families within the wider healthcare team, and the shaping influence of organisational structures, resources and cultural context, including the need for formal training and support. While the included studies offered valuable insights, several gaps were identified in the existing literature, including limited research from underrepresented regions like Malta, a lack of formal institutional support for nurses in communication roles, and minimal focus on their emotional wellbeing. These findings provide a strong foundation for understanding the complexities of nurse-family communication and support the need for further research that addresses these overlooked areas. The next chapter will outline the methodology used to explore this topic within the local context.

Chapter 3

Research Methodology

3.1 Introduction

This chapter outlines the methodology and methods used to explore ICU nurses' perceptions of communication with patients' families. As the study is concerned with understanding how nurses make sense of their interactions and experiences with family members in the intensive care environment, a qualitative research approach was deemed most appropriate. This chapter describes the study's aims and objectives, the philosophical foundations underpinning the research, the selected methodological approach, and details regarding data collection, analysis, rigour, and ethical considerations.

3.1.1 Research Question

To contextualise the methodology used in this study, it is important to restate the research question that guided the design, data collection, and analysis. Grounded in the literature and the study's aim, the central research question was:

"How do ICU nurses perceive their role in communication with patients' families, and what facilitators, challenges, and strategies shape these interactions in ICU settings?"

This question shaped the choice of qualitative methods and informed the development of the semi-structured interview guide, the sampling approach, and the thematic analysis process detailed in this chapter.

3.1.2 Aims and Objectives

The primary aim of this study was to explore how intensive care unit (ICU) nurses perceive and experience communication with patients' families during critical illness. The following objectives guided the study:

1. To explore ICU nurses' perceptions of their role in communicating with patients' families
2. To identify perceived barriers and facilitators in nurse-family communication in the ICU
3. To explore the strategies nurses use to manage communication with family members in ICU settings

3.2 Research Approach

3.2.1 Research Methodology and Design

Given the focus of this study on understanding how ICU nurses perceive and experience communication with patients' families, a descriptive and exploratory qualitative research design was adopted. This approach is well-suited for studies that aim to offer a rich, straightforward account of participants' perceptions, staying close to the language they use and the meanings they assign to their experiences (Doyle et al., 2020). Rather than seeking to develop theory or abstract concepts, a descriptive qualitative approach aims to produce a detailed and contextually grounded portrayal of a phenomenon, making it ideal for research questions focused on practical understanding rather than theoretical generalization (Kim et al., 2017).

Qualitative research, more broadly, is particularly appropriate for exploring complex human behaviours, emotions, and interactions, as it allows researchers to capture the depth and details of participants' lived realities (Kim et al., 2019). In this context, the aim was not to quantify communication practices or test predefined variables, but to explore how nurses themselves make sense of their roles, strategies, and challenges when engaging with families in emotionally intense and ethically sensitive ICU environments.

This approach is grounded in the understanding that reality is socially constructed, and that each nurse brings a unique perspective shaped by their personal, cultural, and professional background. Communication in critical care is not simply about conveying information; it is embedded in emotional dynamics, institutional expectations, and interpersonal relationships. Qualitative inquiry offered the flexibility and depth required to explore these interrelated dimensions meaningfully. Unlike quantitative methods that may overlook emotional, ethical, and symbolic aspects, qualitative methods enable participants to express themselves in their own words. This is especially important in ICU settings, where communication is often layered with emotional labour, ethical dilemmas, and organisational pressures (Seers, 2011). Through open-ended interview questions and reflective dialogue, this study sought to uncover the details of how ICU nurses manage communication with families during times of uncertainty.

Qualitative research is also particularly valuable when exploring sensitive or emotionally charged issues (Silverio et al., 2022). ICU nurses frequently encounter role ambiguity, moral distress, and compassion fatigue when engaging with families, particularly around end-of-life care or during difficult clinical decisions (Wells, 2021; Langley et al., 2015). The descriptive qualitative approach used in this study allowed space for these often under discussed experiences to emerge.

In summary, a qualitative descriptive design was chosen for its ability to generate rich context and meaningful insights into how ICU nurses perceive and experience communication with patients' families. The goal was not to generalise, but to offer a detailed account that captures the complexity of real-world communication in critical care settings.

3.3 Philosophical Underpinnings

This study is situated within a naturalistic orientation, which underpins qualitative descriptive research. Naturalistic inquiry assumes that reality can be understood through careful and direct engagement with people in their natural environments, and that knowledge arises from describing how individuals experience and articulate their everyday realities (Sandelowski, 2000).

Qualitative descriptive studies aim to stay close to what participants actually say, focusing on their words and experiences without adding deep layers of abstract interpretation (Neergaard et al., 2009). However, some level of interpretation is involved, especially when using a guiding framework like Symbolic Interactionism (*explored further in the Chapter 5*). In this study, interpretation focuses on how participants make sense of their interactions, rather than applying complex or hidden meanings. This approach remains well-suited to applied healthcare research, as it allows findings to be both grounded in participants' realities and useful for clinical practice (Bradshaw, Atkinson, & Doody, 2017).

3.4 Sampling Strategy

This study employed purposive sampling to recruit registered nurses with direct experience in communication with patients' families within an intensive care unit (ICU) setting. Purposive sampling, also known as purposeful sampling, is a non-probability sampling technique commonly used in qualitative research to identify and select information-rich cases or individuals related to, or with expertise in, the phenomenon of interest. Rather than seeking statistical representativeness, purposive sampling involves intentionally selecting participants who are especially knowledgeable about or have direct experience with the subject under study (Palinkas et al., 2015). This approach is particularly valuable when the aim is to gain deep insights into specific experiences, behaviours, or perspectives, as it allows researchers to focus on those most likely to provide meaningful data relevant to the research questions. In this study, purposive sampling was applied by selecting participants strictly according to the predetermined inclusion & exclusion criteria *(provided in **Table 3.1** below),* which were dedicated to registered nurses working in the ICU and regularly communicating with patients' families. This ensured that the sample was specific to the ICU context and included only those individuals best suited to provide insights into nurse-family communication within this setting.

Table 3.1 - ***Inclusion & Exclusion Criteria***

Inclusion Criteria	Exclusion Criteria	Justification
Registered nurse currently working in a general adult ICU	Not currently practising in ICU nursing	Ensure participants have active, current ICU experience, keeping the context clinically relevant and up to date.
At least one year of full-time ICU nursing experience	Less than one year of ICU experience	Guarantees sufficient exposure to complex communication scenarios, contributing to data richness and depth.
Regularly engage in communication with patients' family members	Do not routinely communicate with family members (e.g. admin roles)	Focuses on participants with first hand, ongoing involvement in nurse-family communication, ensuring data is directly aligned with the research focus.
Fluent in English	N/A	Ensures participants can fully understand and respond to interview questions, supporting clarity, accuracy, and quality of the data collected.
Provided informed consent to participate in the study	Declined to give informed consent	Upholds ethical standards, voluntary participation, and informed understanding of the research process.

3.5 Research Setting

This study was conducted at a general state hospital in Malta. The hospital serves as the main acute general hospital for the Maltese islands and provides a comprehensive range of specialised services, including intensive care.

The research took place specifically within a general 'adult' intensive care unit (ICU), which occasionally accommodates critically ill patients aged three years and above, although the vast majority of patients are adults. This unit was selected because it operates under an adult ICU model, with its organisation, staffing, and clinical practices primarily centred on adult critical care. The main aim was to explore the experiences of nurses communicating with families of adult patients, as these interactions differ significantly from those in paediatric or neonatal ICUs. The unit normally comprises 20 beds and provides high-acuity care for individuals with a wide range of medical and traumatic conditions, including sepsis, multi-organ failure, respiratory distress, and post-operative complications. The patient population is therefore diverse and includes complex cases requiring multi-disciplinary input and continuous monitoring.

The unit is staffed by nurses who are trained in critical care, with education and clinical experience in managing critically ill patients requiring intensive monitoring, life-sustaining therapies, and complex interventions. These nurses regularly engage with family members as part of their role, particularly in relation to patient updates, support during crises, and end-of-life discussions. Communication between staff and families is typically conducted in either English or Maltese, depending on family preference, reflecting the bilingual context of Malta's healthcare system. Within the Maltese population, language use varies; some individuals prefer speaking Maltese, others English, and many switch fluidly between both languages. Additionally, Malta's

increasingly multicultural healthcare environment includes a growing number of nurses and other care providers, patients, and families whose first language is neither Maltese nor English. This linguistic diversity is a significant feature of the national context and may influence everyday communication practices in hospital settings.

The Hospital in which this research study was conducted operates under the Maltese government as a public health facility. Relatives are usually permitted to visit patients during two daily time slots, between 11:30 a.m. and 1:00 p.m., and again from 5:00 p.m. to 6:00 p.m. Exceptions to these restricted visiting hours are occasionally made in special circumstances, such as end-of-life situations or clinical emergencies, where additional family presence may be deemed necessary.

3.6 Sampling and Saturation

In line with qualitative sampling principles, the goal of this study was not statistical representation but thematic depth and richness. Sampling continued until data saturation was reached, defined as the point at which no new codes or themes emerged from successive interviews, and redundancy was evident in participants' responses (Saunders et al., 2018; Hennink et al., 2017). As illustrated in ***Table 3.2***, all final themes and subthemes had emerged by the 5th interview. The 6th and 7th interviews contributed confirmatory data but did not generate new codes or conceptual categories. This indicates that thematic saturation was achieved, in line with established guidance that saturation occurs when no new themes emerge and further data become redundant (Hennink et al., 2017; Saunders et al., 2018). The final sample therefore consisted of seven ICU nurses. This ensured the adequacy and sufficiency of the data set for meaningful thematic analysis.

While “saturation” is widely referenced as a standard for sample adequacy, its definitions and applications vary. As Saunders et al. (2018) emphasize, saturation is not a singular concept, nor a simple methodological rule, but is open to interpretation, requiring clarity and transparency in its application and reporting. Furthermore, while code saturation was reached after five interviews, two additional interviews were conducted to confirm thematic stability and deepen meaning saturation, in line with recommendations from Hennink et al. (2017), who distinguish between identifying themes ("hearing it all") and fully understanding them ("understanding it all"). The sample in this study was relatively homogeneous, comprising registered ICU nurses working within the same clinical environment, sharing comparable training, responsibilities, and exposure to nurse-family communication. According to Hennink, Kaiser, and Marconi (2017), homogeneity within a study population facilitates earlier attainment of both code and meaning saturation, as participants are more likely to share overlapping experiences and perceptions.

Given that the nurses in this study operated within a shared institutional culture and clinical routines, fewer interviews were sufficient to capture the thematic breadth and depth of communication practices in this context. Malterud et al. (2016) further propose “information power” as a guiding principle, explaining that the more information the sample holds, relevant for the actual study, the lower number of participants is needed. Factors such as sample specificity and the quality of dialogue are thus crucial in determining adequacy. Finally, in line with Braun and Clarke (2021), for such analysis, sample size should be determined by the richness and complexity of the data, not simply by reaching a set number or relying on saturation as a rhetorical device. Given the specific context and participant group, the achieved sample provided sufficient informational power to address the research objectives and allowed for robust thematic analysis.

Table 3.2 - ***Evidence of Thematic Saturation Across Interviews***

Theme / Subtheme	First Emerged	Repeated In	Saturation Point	Notes on Redundancy
1. Communication as a Strategic and Adaptive Practice	Interview	2, 3, 4, 5, 6,7	No new themes after Interview 5	Consistently described across early interviews, stable and repeated after Interview 5.
- Simplification & Clarification	Interview 1	2, 3, 4, 5, 6, 7	Interview 4	Strong recurrence; fully saturated by Interview 4.
- Use of Analogies & Repetition	Interview 2	3, 4, 5	Interview 5	Confirmed by multiple participants; no variation post-Interview 5.
- Reading Emotional Readiness	Interview 3	4, 5, 6	Interview 5	Described consistently by Interview 5.
- Proactive Engagement	Interview 2	3, 4, 5, 7	Interview 5	No new content or strategies were described after Interview 5.
2. Emotional Navigation in Clinical Communication	Interview 1	2, 3, 4, 5, 7	Interview 5	Emotional themes deepened but were not expanded beyond Interview 5.
- Balancing Truth & Sensitivity	Interview 2	3, 4, 5, 7	Interview 5	Strong repetition and consistency across participants.

- Presence & Nonverbal Support	Interview 3	4, 5, 6	Interview 5	No new behaviours or descriptions added after Interview 5.
- Relational Anchoring	Interview 3	4, 5, 7	Interview 5	The concept stabilised across interviews.
3. Navigating Role Boundaries & Team Dynamics	Interview 2	3, 4, 5, 6, 7	Interview 5	All role-related insights captured by Interview 5.
- Nurse as Interpreter	Interview 3	4, 5, 6	Interview 5	No new function or nuance described beyond Interview 5.
- Role Ambiguity & Trust	Interview 4	5, 6	Interview 5	Confirmed but not expanded.
- Interdisciplinary Gaps	Interview 3	4, 5, 6, 7	Interview 5	Theme remained unchanged post-emergence.
4. Structural and Organisational Barriers	Interview 2	3, 4, 5, 7	Interview 5	Fully saturated by Interview 5.
- Time Constraints	Interview 2	3, 4, 5, 6, 7	Interview 4	Early and strong recurrence; no new content in later interviews.
- Visiting Policies & Workflow	Interview 3	4, 5, 7	Interview 5	Theme confirmed and stable by Interview 5.

- Interpreter / Psychological Support	Interview 3	4, 5, 7	Interview 5	Saturated through repetition by 5th Interview.
- Absence of Formal Training	Interview 1	2, 3, 4, 5, 6, 7	Interview 5	Descriptions consistent; theme complete.
5. Communication as Humanising Professional Practice	Interview 4	5, 6, 7	Interview 5	Emerged later but did not develop further after Interview 5.
- Valuing Communication	Interview 1	2, 3, 4, 5, 7	Interview 5	Confirmed but not expanded in content.
- Learning Through Experience	Interview 3	4, 5, 6	Interview 5	Reinforced the theme; no new concepts introduced.
- Shaping Professional Identity	Interview 4	5, 6	Interview 5	No new material added after initial emergence.

3.7 Recruitment Process

Participant recruitment was facilitated through the involvement of charge nurses within the ICU department. These intermediaries were informed about the study's purpose and inclusion criteria and were asked to help identify and approach eligible nurses, on the basis of the inclusion criteria, who might be interested in participating. This strategy enabled access to a relevant, information-rich sample while respecting institutional procedures and minimising workflow disruption. To ensure no pressure from these senior intermediaries, it was clearly communicated that participation was voluntary, confidential, and would not affect nurses' employment or evaluations.

Nurses who were initially approached by the intermediaries and who have shown interest after being offered to participate in this study were provided with a participant information sheet and invited to contact the principal researcher directly. This approach aligned with purposive sampling by targeting information-rich participants, while also ensuring that participation remained voluntary.

This method aligns with established practices in qualitative clinical research, where intermediaries such as charge nurses, unit managers, or clinical coordinators often act as gatekeepers, facilitating both ethical and practical access to participants (Dahlke et al., 2020; Loades et al., 2019).

3.8 Data Collection

Data for this study were collected through individual, semi-structured interviews with ICU nurses. This method was chosen to allow participants to speak openly and in their own words about their perceptions, thoughts and strategies when communicating with patients' families in the critical care setting. Participants were selected through purposive sampling and recruited via the process outlined previously, which involved the support of the intermediaries in identifying eligible and willing participants.

Interviews were conducted face-to-face in a quiet and private space within the hospital, such as a staff room or office, to ensure privacy and comfort. Each interview lasted between 30 and 60 minutes, depending on the extent of the participant's responses. The average interview length was 40 minutes. Although all interviews were ultimately conducted in English, participants were informed beforehand that they could speak in whichever language they felt most comfortable. With the participants' consent, all interviews were audio-recorded to ensure accuracy during

transcription and analysis. Data collection took place between June and August 2025. The interviews followed a semi-structured format using open-ended questions that were designed to explore how ICU nurses perceive their role in communication, the barriers and facilitators they encounter, and the strategies they use. The interview guide was structured using a funnel approach, starting with broad, general questions to encourage storytelling, before gradually moving into more specific topics relevant to the research objectives. This method is often recommended in qualitative research to facilitate participant comfort and depth of response, while maintaining coherence with the research focus (DiCicco-Bloom & Crabtree, 2006).

Although the interview guide provided structure, the interviews were flexible and guided rather than strictly controlled. This allowed participants to bring forward what felt most meaningful to them. Where appropriate, the researcher used follow-up prompts such as “Can you tell me more about that?” or “How did that situation unfold?” to encourage deeper reflection. In certain cases, some participants deviated from the topic and shared information not directly relevant to the study, when this happened, the researcher gently steered the conversation back to the main topic using respectful, topic-related prompts, an approach recognized as both ethical and effective in maintaining focus while preserving participant voice (Adams, 2010). Pauses and moments of silence were also used intentionally to give participants time to think and reflect. These techniques are shown to enhance the depth and authenticity of responses by allowing participants space to formulate thoughtful answers (Müller et al., 2024). As the researcher became more experienced through each interview, they developed greater awareness of verbal cues and adjusted the pacing and tone accordingly. The full semi-structured interview guide used to conduct the interviews is provided in ***Appendix E*** for reference.

During transcription, participants' speech was transcribed as accurately as possible. However, minor edits were made in a few places to improve sentence clarity and flow for readability, without altering the meaning or intention of what was said. These edits involved the removal of filler words such as “umm,” “uhh,” and repeated phrases or stutters that did not contribute to meaning. Care was taken to ensure that these changes did not alter the content, intention, or tone of the participants’ responses. Interviews continued until data saturation was achieved, that is, when no new themes or significant insights were emerging from additional interviews. This approach ensured the study collected rich, relevant data suitable for thematic analysis.

3.9 Reflexivity

Although researcher subjectivity is recognised in qualitative research, efforts were made to maintain a low-inference analytic process. As the researcher I remained reflexively aware of my positioning while focusing on presenting participants’ views as clearly and accurately as possible. This ensured coherence between the study’s descriptive aims and its analytic strategy (Bradshaw, Atkinson, & Doody, 2017).

3.9.1 Researcher Positionality and Insider Role

Conducting this study as both an ICU nurse and a researcher positioned me as an “insider” within the research setting. Insider research refers to a researcher who shares characteristics, roles, or experiences with participants, which in turn can offer distinct advantages, including improved access, enhanced rapport, and a deeper contextual understanding of the field (Dwyer & Buckle,

2009; Asselin, 2003). In this case, shared professional background and familiarity with ICU culture allowed for more open and comfortable conversations during interviews, as participants may have felt understood without the need to over-explain technical or emotional aspects of their work. However, this dual role also raised potential challenges around bias and preconception. As an insider, there was a risk of "shared assumptions" influencing data collection or interpretation, such as unconsciously overlooking meaningful insights because they seemed self-evident (Brannick & Coghlan, 2007). To manage this, I engaged in active reflexivity throughout the research process, critically examining how my own professional experiences might shape the way I asked questions, responded to participants, and interpreted the data. A reflexive writing strategy was used to support analytic rigour and maintain awareness of the influence of my dual role.

To support this, a reflexive journal was kept throughout the process. It helped the researcher think through what was going well, what could be improved, and how their own background might be influencing the interviews. Reflexive journaling is widely recognised as a critical tool in qualitative research for enhancing self-awareness, maintaining transparency, and strengthening the credibility of the findings (Ortlipp, 2008). After the first couple of interviews, a few things stood out. Some of the questions were too leading or closed, which risked steering participants toward certain answers. These were reworded in later interviews to be more open, giving participants more space to share their views in their own way.

Another point that emerged through reflection was related to missing chances to dig deeper into interesting points. In the first interview, sometimes the conversation moved on too quickly, especially when the researcher felt the participant had already given a "complete" answer. By time, the researcher learned to pause more, ask for examples, and follow up when something seemed worth exploring further. Overall, these early lessons helped improve how the interviews were

carried out. By staying aware of his role and adjusting the approach along the way, the researcher aimed to ensure that participants' voices were heard clearly and that their perceptions and thoughts were captured as accurately as possible.

Figure 3.1 below presents an extract from the researcher's reflexive diary following the first interview. This entry was written immediately after the interview and supported the researcher in reflecting on their role, recognising areas for improvement, and making sense of the interaction. All subsequent reflexive entries following each interview are included in ***Appendix F*****.**

Figure 3.1 ***Reflexive Diary Extract After First Interview***

Today I carried out the first interview. It went fairly well in terms of flow, participant was open and willing to talk. I could sense some comfort because we work in the same field, and that seemed to help build trust early on. However, listening back to the recording, I realised I leaned too much on closed and leading questions. For example, I found myself finishing their sentences or guiding them toward expected answers instead of letting them shape their own. I think I was too focused on sticking to the question guide and forgot to leave enough room for natural storytelling.

I also noticed that when the participant gave an interesting response, I sometimes moved on too quickly instead of pausing or asking them to explain more. Maybe I was afraid of making it feel like an interrogation. Next time, I'll remind myself to sit with the silence if needed and follow up more.

Another thing I caught was that I was nodding a lot or softly agreeing, "mhmm," "yes" which I normally do in conversation, but now I wonder if that unintentionally affirmed their answers. I'll try to be more neutral and just let them talk next time without giving the sense that there's a "right" answer.

Overall, the interview gave me useful data, but I know I can do better. For Interview 2, I'll focus more on keeping questions open, slowing down, and following the participant's lead more naturally.

Furthermore, during the analysis phase, I remained mindful of how my insider position as an ICU nurse could shape the way I interpreted the data. To manage this, I used a reflexive diary to track moments where personal experience risked influencing coding decisions. In one particular entry (***Figure 3.2*** - Thematic Analysis Phase Entry), I reflected on how I initially coded a participant's description of being a "buffer" between families and doctors as emotional burden, drawing from my own clinical assumptions. On closer reading, I recognised the participant was highlighting role ambiguity, not emotional strain. Revising this code helped reinforce my commitment to keeping the analysis grounded in participants' intended meanings rather than my own professional lens.

Figure 3.2 ***Thematic Analysis Phase Entry***

Today I spent a considerable amount of time coding transcripts, and I became very aware of how my background as an ICU nurse influenced my interpretation of the data. My familiarity with the clinical setting made it easy to relate to what participants were saying. Still, I started to notice how quickly I was connecting their experiences to my own. For instance, when one participant spoke about feeling like a "buffer between the family and the doctors," I immediately understood the sentiment and almost coded it as an emotional burden without fully considering the context. On reflection, her point was more about role ambiguity than emotional exhaustion, and I revised the code to better match her intent rather than my instinct.

This was a useful reminder that while my professional identity helps in understanding the nuances of ICU work, it can also bias my interpretations if I'm not careful. I found myself questioning whether I was truly analysing what the participant had said, or what I *expected* them to say based on my own experiences. Moments like this are showing me just how important it is to stay reflexive throughout the entire research process, not just during data collection, but during analysis too.

Overall, I'm realising that managing my positionality requires constant attentiveness. While shared experience can build trust and insight, it also brings the risk of projecting. Today reinforced the need to slow down, question my assumptions, and make sure that the themes I'm developing remain grounded in the participants' voice, not my own.

3.10 Data Analysis

The data collected from the interviews were analysed using thematic analysis, following the six-phase method outlined by Braun and Clarke (2006, 2021). This approach was selected for its flexibility and suitability for descriptive qualitative research, allowing for the identification of patterns within the data without abstract theorising or inference about underlying meaning. It supports the aim of qualitative descriptive studies to generate findings that remain close to participants' language and experiences and are accessible for clinical application (Neergaard et al., 2009).

Thematic analysis was conducted primarily manually, with coding applied across the entire dataset. Manual coding was selected to allow for closer engagement with the data and to support reflective, interpretive thinking during analysis. As noted by Mattimoe, Edwards, and Skinner (2021), manual approaches encourage a slower, more tactile process, using tools like colour coding and manual notes, which can foster deeper immersion and richer insight. Basit (2003), similarly argues that for small-scale studies, manual coding is both practical and effective, enabling researchers to remain closely connected to participants' language without the potential distancing effect of software. Based on these considerations, manual analysis was deemed appropriate for the study's scale and goals.

The analysis followed Braun and Clarke's six-phase framework, which involves familiarising oneself with the data, generating initial codes, identifying potential themes, reviewing these themes, defining and naming them, and ultimately compiling the final report. In the table below ***(Table 3.3)*** an illustration of this process related to this study is provided to readers. Alongside

manual coding and clustering, I made limited use of generative AI (ChatGPT, OpenAI, 2025) during later phases of theme development. AI was prompted to suggest possible labels for some clusters of codes, which I critically evaluated and used only when they aligned with the data. Such alignment was checked by systematically comparing AI suggested labels with the underlying coded data extracts. A term was only retained if it reflected the language, experiences, and meanings expressed by multiple participants, and if it remained consistent with the researcher's interpretive reading of the dataset. Suggestions that were too generic, lacked sufficient support in the data, or distorted participants' accounts were rejected. This supplementary use of AI is explained in detail in *Section 3.11* further on to maintain transparency.

Table 3.3 - ***Illustrating the Six Phases of Braun & Clarke Thematic Analysis Using Examples from This Study***

Phase	Description	Example from This Study
1. Familiarisation	Reading and re-reading transcripts; noting initial ideas	During initial readings of Interviews 1, 5, 6, and 7, notes highlighted how nurses simplified complex terminology, adjusted tone, used repetition, and took emotional cues from families to guide their communication.
2. Initial Coding	Generating data-driven codes manually from transcript data	Codes included: simplifying language, using analogies, repeating information, checking family understanding, emotional cue reading, proactive engagement, and reading non-verbal cues.

3. Searching for Themes	Organising codes into broader candidate themes	Codes were grouped under a candidate theme initially titled *"Communication Tactics"*, later refined to ***Communication as a Strategic and Adaptive Practice,*** as they represented practical, flexible communication behaviours.
4. Reviewing Themes	Ensuring themes accurately reflect the breadth and depth of the data	Returned to all transcripts and confirmed that the majority of participants described adaptive strategies for facilitating family understanding suggesting strong thematic coherence and relevance across the dataset.
5. Defining Themes	Naming and defining the core idea of the theme	***Defined theme:*** *"*ICU nurses dynamically tailor their communication in response to families' emotional states, comprehension levels, and situational context to enhance clarity and trust."
6. Writing Up	Presenting finalised themes with narrative and supporting quotes	Quotes such as: "I try not to use medical jargon…" and "I use comparisons… like the heart working like a pump…" (Interview 5 and 7) were used to show how communication was strategically simplified and adapted in real time. Interpretation emphasized flexible, emotionally intelligent communication practice.

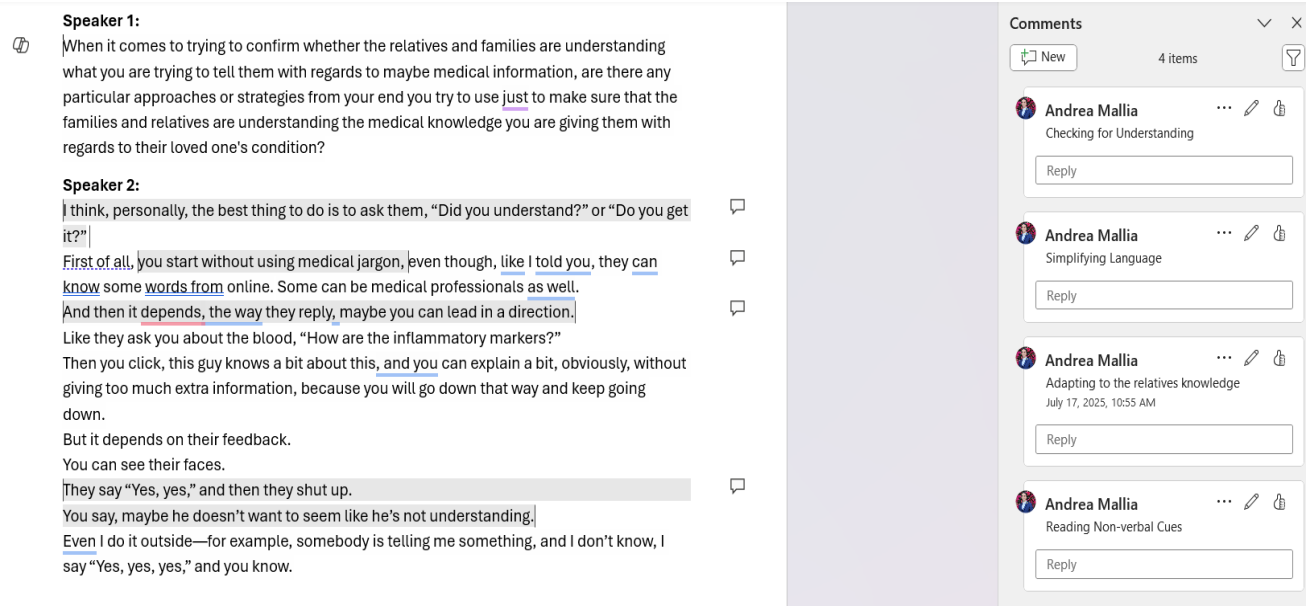
Note: In phases 3–5, AI (ChatGPT) was occasionally used to suggest labels for clusters of codes & alternative wording for candidate themes. All final themes were confirmed, refined, and named by the researcher.

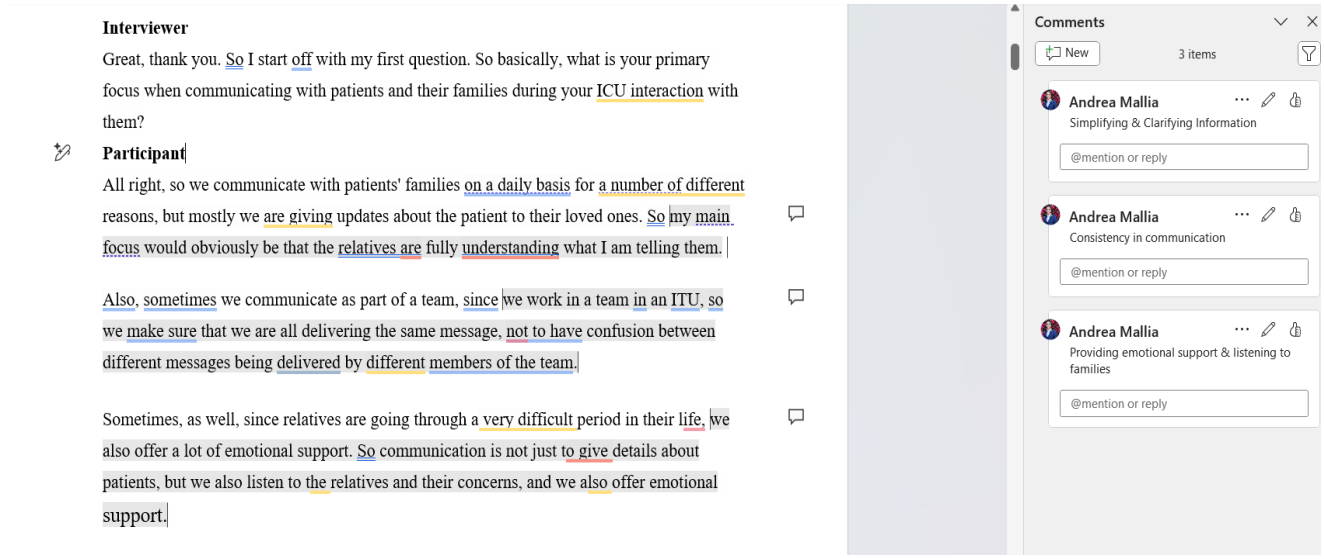
In the first phase, familiarisation with the data, all interviews were transcribed using the transcription feature in Microsoft Word to generate an initial draft of each recording. Each

transcript was then carefully reviewed and cross-checked against the original audio recordings to ensure accuracy, clarity, and completeness. This process involved multiple readings of the transcripts to develop a deep understanding of the content. Notes and margin comments were made to capture initial impressions, highlight meaningful phrases, and note recurring language, emotional tone, and references related to communication.

Initial codes were then generated manually and systematically, working through each transcript line by line. Segments of text relevant to the research questions were highlighted and labelled with short descriptive phrases or keywords that captured their underlying meaning ***(Figure 3.3)***. At this stage, broad and inclusive coding was employed to avoid overlooking any potentially significant data. Codes were written as side comments alongside highlighted fragments in a digital document to maintain organisation.

Figure 3.3 - Screenshots illustrating code generation secondary to transcripts segments *(Step 2)*





Once coding was completed across all transcripts, the researcher grouped similar codes into broader conceptual categories based on shared meaning and contextual relevance. These code clusters formed the foundation for identifying initial candidate themes. To support this process, colour-coded notes were employed, enabling visual experimentation with how different codes related to each other and how patterns emerged. For example, as illustrated in ***Table 3.4,*** quotes reflecting communicative strategies such as simplifying language, using analogies, or initiating dialogue were grouped into conceptual categories like "*Simplification Strategies," "Clarification through Visuals & Analogies*," and "*Creating Openness.*" This thematic structure led to the development of overarching themes, such as *"Communication as a Strategic and Adaptive Practice."*

Table 3.4 - ***Generating codes & candidate themes from quote transcripts (Step 3)***

Illustrative Quote	Focused Code	Code Cluster (Category)	Candidate Theme
"I try not to use medical jargon, so simple language, making sure that everything is clear."	Use of simple language	Simplification strategies	Communication as a Strategic and Adaptive Practice
"You don't go into explaining haemoglobin… you adjust… you find other words."	Adapting terminology to lay understanding		
"I use comparisons… like the heart working like a pump… pictures help more than words."	Use of analogies and visuals	Clarification through visuals & analogies	
"Sometimes I give them similar situations… basically making it much more simpler in words."	Storytelling for clarity		
"You have to read the room… sometimes relatives just need to sit in silence."	Situational emotional awareness	Emotional attunement	

Illustrative Quote	Focused Code	Code Cluster (Category)	Candidate Theme
"Sometimes people just need to sit in silence and process everything that they are seeing."	Allowing emotional processing		Communication as a Strategic and Adaptive Practice
"I like to initiate. Because sometimes families feel like they're disturbing you…"	Proactive communication initiation	Creating openness	
"If you don't approach them, they are just so scared that they don't speak."	Encouraging family openness		

Candidate themes were then re-examined in relation to the coded extracts and the full data set to ensure that they accurately reflected the participants' words and experiences. This iterative process included splitting, collapsing, or discarding themes where appropriate ***(****as illustrated in* ***table 3.5****)* and returning to the original transcripts to validate findings.

Table 3.5 - ***Example of Splitting, collapsing and discarding themes (Step 4)***

Modification Type	Original Theme or Code	Action Taken	Rationale
Split	*Communication Adaptation*	Split into two distinct themes: 1. **Communication as a Strategic and Adaptive Practice &** 2. **Proactive Efforts to create comfort & Engagement**	Participants' accounts showed a clear difference between how nurses adapted communication style (e.g., simplification, analogies) vs. when and why they initiated contact.
Collapsed	*Emotional Labour*	Merged into **Emotional Navigation in Clinical Communication**	Emotional labour was not a separate concept in most interviews but woven into broader efforts to balance truth and empathy, provide presence, and manage emotional responses.
Discarded	*Humour and Lightness in Communication*	Discarded as a theme	Referenced only briefly by one or two participants without thematic saturation or depth. Not strong enough to support inclusion as an independent theme.

Each theme was subsequently defined and named, with subthemes identified where needed to capture specific aspects within broader patterns. Definitions were refined through reflective writing and, where applicable, discussions. This ensured that each theme told a distinct part of the overall story of the data.

The full presentation of findings is provided in Chapter 4 and this final phase of analysis involved selecting representative quotes and writing interpretive commentary to illustrate the themes. The final report was constructed logically, with themes linked to the study's aims and supported by verbatim excerpts from participants. Manual analysis enabled a close, immersive engagement with the data and facilitated the development of rich, nuanced themes rooted in participants' lived experiences.

Throughout the analysis, a reflexive journal was maintained to record thoughts, analytic decisions, and potential biases ***(Figure 3.1).*** This reflexivity helped ensure that the interpretation remained grounded in the data and that participants' voices were represented as authentically as possible.

3.11 Generative AI Integration in Analysis

During the theme development stage, I primarily relied on manual coding and clustering to identify patterns across the data. Once preliminary themes and subthemes began to emerge, I used generative Artificial Intelligence (AI) (ChatGPT (OpenAI, 2025)) in a limited way as a reflective tool to test alternative wording and to explore possible labels for certain clusters of codes. Sometimes, AI suggested words or phrases that helped me think about how to describe things, which I then critically evaluated against the dataset. A small number of these suggestions were retained and adapted where they aligned with participant accounts and offered clarity in expression. In most cases, however, AI-generated terms were discarded because they were too generic, did not capture the specifics of the data, or conflicted with my interpretation as the researcher.

Importantly, the integration of AI was not about handing over the analysis but about enhancing reflexivity. By comparing my manually constructed clusters with AI-suggested labels, I was able to examine and question my own interpretations more carefully, deciding whether a proposed label genuinely reflected participants' accounts. This ensured that the thematic structure remained grounded in the data while also benefiting from the additional reflexive prompt provided by AI. The final set of themes and subthemes was therefore researcher-led and data-driven, with AI serving only as a supplementary source of alternative phrasing.

In practice, most AI-suggested terms were rejected because they were either too abstract, too generic, or did not fit the details of the dataset. However, on several occasions, AI outputs prompted useful reflection. For example:

- For a cluster of codes around simplifying terminology, repetition, and avoiding jargon, AI suggested *"Accessible Communication."* I ultimately refined this to *Simplification and Clarification*, which better reflected the active strategies described by participants.

- For codes about nurses initiating contact, checking in, and setting the tone for updates, AI proposed terms such as *"Proactive & Structured Engagement"* and *"Trust Building."* These were considered but ultimately set aside in favour of "*Proactive Efforts to create Comfort & Engagement"*, which reflected both the intent and a more grounded observation in the data.

- For a cluster of codes focused on guiding families through decision-making, offering presence, and providing stability, AI suggested *"Relational Anchoring."* Unlike many other AI outputs, this term resonated with the data and was retained, supported by rich participant quotes.

These examples show that while AI was sometimes used to suggest possible labels for clusters of codes during theme development, and at times offered alternative wording for subthemes, the real interpretive work, such as deciding what genuinely reflected the data, what matched participants' voices, and what needed to be set aside, was entirely led by me as the researcher. The final set of themes was therefore grounded in the data and shaped through reflexive thinking, with AI serving as a supplementary tool to prompt reflection on terminology and labelling. It is important to note that no raw interview data were uploaded into the AI platform; instead, only anonymised summaries of code clusters were used, ensuring participant confidentiality and ethical integrity.

3.12 Trustworthiness and Rigour

Ensuring trustworthiness in qualitative research is essential for establishing credibility, consistency, and relevance of findings. This study applied the four widely accepted criteria for qualitative rigour, credibility, dependability, confirmability, and transferability, originally developed by Guba and Lincoln (1985) and expanded by subsequent scholars to promote quality and reduce bias in qualitative inquiry (Shenton, 2004; Ahmed, 2024).

3.12.1 Credibility

Credibility refers to the accuracy of findings as perceived by participants and is comparable to internal validity in quantitative research. In this study, prolonged engagement with interview data. through transcription, repeated listening, repeated reading, and thematic immersion, supported the development of rich, accurate interpretations (Shenton, 2004). Semi-structured interviews enabled participants to express their experiences freely, which enhanced the authenticity of the data collected (DeJonckheere & Vaughn, 2019). While member checking was not feasible due to participants' limited availability and time constraints commonly associated with ICU work, active clarification of participant meanings during interviews and the use of probing questions helped strengthen the truthfulness of interpretations (Ahmed, 2024).

Maintaining a reflexive journal allowed the researcher to critically examine personal assumptions and track interpretive decisions. This process is widely endorsed as a way to enhance credibility by promoting continuous self-awareness during analysis (Nguyen et al., 2020).

3.12.2 Dependability

Dependability refers to the consistency and stability of the research process over time. In this study, dependability was supported through a clearly defined and consistently applied methodology, from participant recruitment to data analysis (Daniel, 2019). The use of a semi-structured interview guide ensured that similar topics were explored with all participants, while allowing flexibility for individual expression. Consistent procedures for transcription, coding, and theme development were followed throughout the analysis. Reflective notes and regular review of emerging findings further contributed to maintaining clarity and consistency in the research process. To ensure rigour and transparency, strategies such as reflexive journaling, peer debriefing, and maintaining an audit trail were implemented throughout the study. The audit trail documented each stage of data collection and analysis, allowing readers to evaluate the consistency and logic of the research process and thereby strengthening the study's auditability (Nowell et al., 2017).

3.12.3 Confirmability

Confirmability ensures that the findings reflect the data rather than researcher bias. This was addressed by using low-inference descriptions during thematic analysis, that is, describing participants' views using language that stays as close as possible to their actual words and intended meanings, without adding subjective interpretation or abstraction (Kyngäs et al., 2019). A reflexive diary further helped distinguish between the researcher's interpretations and participants' perceptions, aligning with best practices for achieving confirmability (Peddle, 2022). The inclusion of direct participant quotes alongside thematic insights strengthened transparency by linking interpretations directly to raw data (Ahmed, 2024). Confirmability was further supported

by documenting and disclosing the supplementary use of ChatGPT (OpenAI, 2025) during the analytic process. AI suggestions were critically reviewed, with most being set aside upon researchers review, ensuring that final themes reflected participants' accounts and the researcher's interpretive judgement.

3.12.4 Transferability

Transferability pertains to the relevance of findings beyond the immediate study context. While qualitative research does not seek statistical generalisation, providing "thick description" of the setting, participants, and procedures *(as indicated in previous sections regarding Researcher background & Research Setting,* ***Sections 1.2 & 3.5****)*, helps readers determine how applicable the findings may be in their own contexts (Shenton, 2004). This strategy supports informed comparisons and judgments about relevance (Kyngäs et al., 2019). Including rich quotations from participants as done in this study supports this by providing context to the findings and helping readers judge whether the results are relevant or applicable to their own settings. (Ahmed, 2024).

3.13 Ethical Considerations

Before data collection, ethical approval was obtained from the Faculty of Health Sciences Research Ethics Committee. In addition, formal permission was secured from multiple institutional stakeholders, including the Chairperson of Anaesthesia and Intensive Care, the Chief Executive Officer of the hospital, the Data Protection Officer, the Nursing Services Manager, and the ICU Charge Nurses. These approvals ensured that the study was conducted in line with local research

governance standards and institutional expectations. This approval ensured that the research complied with the ethical standards set by the University of Malta, the hospital's internal research policies, and the principles outlined in the Declaration of Helsinki (World Medical Association, 2024).

This study involved interviews with ICU nurses discussing professional experiences related to communication with patients' families. The topic was not considered to involve significant emotional risk or psychological harm; therefore, no formal emotional support services were arranged. Nonetheless, participants were informed that they could decline to answer any question or withdraw at any time if they felt uncomfortable. Also, psychological support services are available for members of staff of the hospital in which the study was conducted.

3.13.1 Informed Consent and Participant Information

In line with the ethical principle of respect for autonomy, all participant recruitment was not performed by the researcher but facilitated exclusively through intermediaries who identified and distributed study information sheets to eligible participants. This method ensured that participation was entirely voluntary and helped reduce the risk of perceived coercion, especially given the researcher's insider status as an ICU nurse. The researcher did not approach potential participants directly, upholding principles of respect for autonomy, voluntary participation, and independence.

Each participant received a participant information letter and informed consent form, which outlined the purpose of the study, the voluntary nature of participation, expected benefits and risks,

and the procedures for safeguarding confidentiality. It was clearly stated that participants could decline to participate or withdraw at any stage without the need to provide a reason—again reinforcing autonomy and dignity.

The expected duration of the interviews (approximately 45–60 minutes) and the use of audio-recording were clearly communicated. Before beginning the interview, the researcher checked understanding, clarified questions, and obtained written informed consent. This process ensured informed decision-making and met ethical standards for transparency and respect.

3.13.2 Privacy, Confidentiality, and Data Security

In accordance with the ethical principle of confidentiality, all identifiable data were carefully protected. Pseudonyms were used during transcription and analysis, and any identifying information was removed from the data. Audio recordings were stored on a password-protected device accessible only to the researcher and were permanently deleted after transcription. Handwritten notes were stored in a locked drawer in a secure location.

These data protection measures were explained in both the participant information sheet and the consent process, supporting trust, transparency, and compliance with ethical and legal standards such as GDPR. All data were used solely for academic research purposes and were not shared beyond the scope of the study.

3.13.3 Researcher Role and Boundaries

Although the researcher is an ICU nurse by profession, they had no supervisory or managerial role over participants. In adherence to the principle of justice and to avoid any perception of power imbalance, participant recruitment was conducted exclusively through intermediaries, with no direct approach made by the researcher.

During the consent process and interviews, the researcher made it clear that they were acting in the role of a researcher, not as a nurse or colleague. This boundary setting helped reduce the risk of role confusion and upheld the principles of honesty and respect. No participants reported discomfort or concern regarding the researcher's professional background during or after participation.

3.14 Conclusion

In summary, this chapter has outlined the philosophical foundations, methodological design, and practical steps taken to explore ICU nurses' perceptions of communication with patients' families. Rooted in a qualitative descriptive approach, the study's design was carefully aligned with its naturalistic orientation, enabling a rich and authentic exploration of lived experiences. Purposeful sampling, semi-structured interviews, and a rigorous yet reflexive stance ensured that participants' voices were represented with integrity. The next chapter will present the findings that emerged from thematic analysis of the interview data.

Chapter 4

Findings

4.1 Introduction

This chapter presents the findings from semi-structured interviews with ICU nurses, exploring their perceptions and experiences of communicating with patients' families. The findings are grounded in the participants' own words, with verbatim quotations used extensively to illustrate and enrich the data presentation. Quotations were carefully selected to reflect both shared and individual perceptions, and the language chosen by participants is prioritised over the researcher's interpretation to maintain authenticity and credibility (Sandelowski, 2000; Braun & Clarke, 2006; Lincoln & Guba, 1985; Yeo & Han, 2025).

Seven registered nurses participated in this study, all of whom were working in the adult Intensive Therapy Unit (ITU) of Malta's main public hospital at the time of data collection. The group included three female and four male nurses. Participants' years of experience in ICU nursing ranged from 5 to 16 years, with an average of approximately 9 years. Their ages ranged between 27 and 45 years, reflecting a mix of early- to mid-career professionals. All participants were registered nurses with recognised critical care training and had regular contact with patients' families as part of their clinical responsibilities

4.2 Themes

Thematic analysis of the interview data revealed five overarching themes: *Communication as a Strategic and Adaptive Practice*, *Emotional Navigation in Clinical Communication*, *Navigating Role Boundaries and Team Dynamics*, *Structural and Organisational Barriers*, and *Communication as a Professional and Humanising Practice.* Each theme, together with its associated subthemes, is presented in the sections that follow, supported by illustrative participant quotations.

All the nurses who took part in this study had between five and fifteen years of ICU experience. Their views, therefore, reflect a high level of knowledge and experience in caring for critically ill patients and communicating with families. To protect confidentiality, pseudonyms are used in this chapter.

4.3 Theme 1 - Communication as a Strategic and Adaptive Practice

This theme reflects the complex and evolving ways in which ICU nurses interact with families in critical care contexts. Communication is a process that changes depending on context and intent, rather than proceeding in a strictly linear manner. Nurses reported using various strategies and adjusting their approaches based on families' emotional states, cultural backgrounds, and understanding of medical information. The findings indicate that communication involves more than simply conveying information; it also includes consideration of sensitivity, timing, and intuition.

4.3.1 Subtheme 1.1 - Simplification and Clarification of Medical Information

ICU nurses consistently reported using simplification and clarification when communicating medical information. Aware that families may lack familiarity with technical terminology and experience emotional stress, participants indicated that they intentionally avoided jargon in favour of clear and accessible language. “Translation” of complex medical terminology to simpler language was identified as a means for families to participate more effectively in discussions regarding patient conditions, viewed as an important aspect of communication rather than a reduction of information content. As one nurse stated:

“I try not to use medical jargon, so I use simple language, making sure that everything is clear.”
(Marlon)

Another participant described how even common clinical concepts could be a barrier to understanding, highlighting the importance of simplifying explanations for clarity:

“You don’t go into explaining haemoglobin. You say oxygen or the blood. You adjust. Sometimes they don’t even know what ‘inflammation’ means. So, you find other words—hence, you can explain things better.” (Carol)

Making language accessible was considered an ongoing, thoughtful process, with nurses continually tuning in to how well families understood as conversations unfolded. They described needing to "break things down," staying attentive to confusion, and flexibly shifting their approach based on families’ needs.

“Sometimes people don’t understand what you're actually telling them and you have to break it down for them to understand.”
(Matthias)

To ensure that families had genuinely grasped what was being conveyed, nurses frequently invited relatives to paraphrase or summarize the information in their own words. This not only provided

an immediate check on understanding but also fostered a more collaborative and open environment:

"I ask them what they've understood from what I said. That way I know if I need to repeat or re-explain."
(Sandra)

Through these adaptive techniques, participants felt that they were able to empower families, reduce anxiety, and build trust, ensuring that critical information was not only delivered but also genuinely understood;

"You could see they felt calmer once they really got it … they seemed more reassured."
(Sandra)

4.3.2 Subtheme 1.2 - Use of Analogies, Visuals, and Repetition

Nurses addressed the knowledge gap with families by using analogies, visual aids, and repetition. They noted that complex medical details can overwhelm relatives, especially in the ICU. To make clinical explanations more accessible, participants frequently relied on comparisons drawn from everyday life and simple, tangible images. As one participant explained:

"I use comparisons… like the heart working like a pump, or draw a quick sketch… especially when they don't speak much English or are panicking, pictures help more than words."
(Matthias)

Another nurse echoed the value of connecting unfamiliar clinical realities to more relatable concepts:

"Sometimes I give them similar situations which are not medically related to kind of explain better… basically making it much more simpler in words, terms."
(Carol)

These creative communication methods helped families understand and retain information, easing feelings of helplessness and confusion during critical illness.

In addition to analogies and visuals, repetition emerged as an equally vital tool. Nurses observed that families, caught in states of shock or distress, often found it difficult to retain information, even when it had been delivered clearly. Recognizing this, nurses made it a point to repeat key points patiently and without judgment. As one participant reflected:

"You have to repeat three to four times… the relatives at times don't register anything because of the emotional burden they are going through."
(Jennifer)

Others emphasized the importance of reiterating explanations over multiple encounters:

"Sometimes, by just communicating to them once or twice, it would not be enough. You need to communicate a number of times with them to get your message, because maybe the initial time and the time after that, they wouldn't really be fully understanding and fully listening to you."
(Philip)

This process of checking and rechecking for understanding was often built into daily routines:

"The first time they might be in shock, or not understand anything. So, I check again, I ask, 'What do you remember from what we said yesterday?' And sometimes I have to explain the same thing a few times before it is clear."
(Jacob)

The findings suggest that participants saw adaptability and patience as important in communication, and that repeating information was often used to help families understand in high-pressure, stressful situations.

4.3.3 Subtheme 1.3 - Reading the Room and Emotional Adaptation

A notable aspect of ICU nurse-family communication is the importance claimed to place on observing and understanding families' emotional cues, body language, and psychological states during periods of distress. Participants described how communication was never a “one size fits all” process; instead, it required continual emotional assessment and adaptation. Nurses paid close attention to family members’ facial expressions, tone of voice, posture, and willingness to engage, using these cues to determine not only what to say, but also how and when to say it.

As one nurse explained,

“You have to read the room… at certain times relatives just need to sit in silence and process everything. They might not even want information straight away, it’s about timing, not just facts.”
(Philip)

This situational awareness shaped every interaction, particularly during periods of crisis, grief, or overwhelming uncertainty. Nurses recognised that the urge to deliver information could sometimes be counterproductive if families were emotionally unready to receive or absorb it. Instead, they described intentionally slowing down conversations, inserting pauses, and allowing for silence as powerful therapeutic tools:

“I slow down or break things up. And I always encourage them to ask questions.”
(Matthias)

Adapting their communication style was not limited to words, but extended to pacing, tone, and presence. One participant described the flexibility required:

“If they seem to be overwhelmed, for example, I try to slow down. Maybe, you know, even pause and come back later if, you know, they need some space. I offer to talk again later. Some families want details. Others, for example, just only want reassurance…. Or even sometimes just sitting quietly is better.”
(Jacob)

Silence and physical presence were highlighted as forms of emotional support, especially when words might be inadequate or unwelcome. Another nurse reflected on the importance of simply "being there":

"Sometimes people just need to sit in silence and process everything that they are seeing. Just your presence… you being there… is enough."
(Philip)

Through these adaptive strategies, nurses acted as caring guides rather than only providers of clinical details. By showing emotional awareness, they built trust and reassurance, helping families feel recognised and supported even when clear answers were not possible or outcomes were hard to face. In this way, assessing the emotional signs and adjusting to each family's emotions became a key part of skilled ICU nursing communication.

4.3.4 Subtheme 1.4 - Proactive Efforts to Create Comfort and Encourage Engagement

A recurring finding across interviews was the proactive stance nurses claimed to adopt in engaging with families. Rather than passively waiting for relatives to initiate conversation, a common occurrence in high-stress ICU settings where families may feel overwhelmed, anxious, or unsure about protocols, nurses described actively seeking out family members, offering introductions, and setting a communicative tone from the beginning.

This approach was rooted in both empathy and experience. Many participants observed that families often hesitated to speak up out of fear of "disturbing" staff or from not knowing the right questions to ask. By taking the lead, nurses aimed to break down barriers, pre-empt confusion, and establish themselves as approachable sources of support and information.

As one nurse put it:

"I like to initiate conversations. Because sometimes families feel like they're disturbing you… but if you go to them first, they open up more."
(Jennifer)

Similarly, another nurse reflected:

"Usually when a relative walks in, I introduce myself and give them an update, see what they know so far… if you don't approach them, sometimes they are just so scared that they don't speak."
(Jacob)

This structured and proactive approach was also seen as especially important at key transition points such as during admissions, major clinical changes, or before and after family meetings. Nurses described deliberately "checking in" at these times, offering briefings, and inviting questions to ensure families did not feel lost or neglected;

"From my experience, I like to initiate, like approach them, you know, because when you have a critical relative there (as a patient) and you're very worried, you're concerned, you want to ask a lot of questions, you want reassurance. So I think it's really important for us nurses to approach them."
(Matthias)

Another participant explained the logic behind this strategy:

"Waiting for them to come forward might result in missed opportunities to support them. So it's really, I think, it's really important to approach them. Brief introduction about you, kind of, that you're taking care of their family."
(Philip)

Proactive engagement also helped establish clear expectations and built trust:

"I like to be very approachable, because if you're not approachable, they won't ask anything, or else they ask something in a different way. I like to make them at ease. I like to open a conversation with them also, and I would know that they would be satisfied because they will start asking more questions, asking more questions about situations that may arise, and I give

information accordingly."
(Marlon)

Furthermore, participants like Marlon, noted that taking initiative fostered a sense of partnership, reassuring families that they were not alone in the ICU journey.

In summary, this theme shows that nurses were not only giving information but actively shaping how it was shared so families could follow and cope. They made a point of explaining things in clear terms, checking understanding, and adjusting their style when they saw signs of confusion or stress. These small but deliberate efforts helped families feel listened to and cared for, even in difficult moments. Having looked at these practical ways of guiding conversations, the next theme moves closer to the emotional side of communication, showing how nurses managed feelings, both their own and the families', during critical and uncertain times.

4.4 Theme 2 - Emotional Navigation in Clinical Communication

This theme encompasses the emotional complexity embedded in the communication process between ICU nurses and patients' families. Beyond the transfer of information, communication served as a medium through which nurses provided comfort, fostered resilience, and supported families during moments of crisis and uncertainty. The emotional labour involved in these interactions was deeply felt, and often internalized, by the nurses themselves.

4.4.1 Subtheme 2.1 - Balancing Facts with Sensitivity

A defining challenge for ICU nurses lay in their constant negotiation between honesty and emotional protection. Participants repeatedly described the importance of "telling the truth," but

in ways that would not overwhelm or traumatise families already in distress. This balance demanded careful judgement, as well as empathy and skilful communication. Nurses described avoiding blunt or clinical declarations, instead opting for language that was accurate yet gentle, allowing families time and space to process devastating information at their own pace.

As one nurse reflected:

"You need to be honest, but also compassionate… because some people are too blunt. And although you're being honest, it can be a little bit cruel."
(Jacob)

Others spoke of the need to frame news in ways that families could emotionally tolerate, guiding them gradually toward acceptance:

"You cannot just say 'He's going to die.' That would destroy them. You have to help them get there mentally… It means the same thing, but it allows them to process it gradually."
(Sandra)

This approach extended to conversations where relatives sought direct confirmation about dire prognoses. Nurses recognized that even when faced with pointed questions, their responses required delicacy:

"Sometimes they ask directly, 'Is he dying?' And you can't lie, but you also don't want to confirm it bluntly. I say, 'He's very, very sick. We're doing our best, but things are not improving.'"
(Jennifer)

Such strategic communication not only helped to shield families from abrupt psychological shock, but also promoted trust and a sense of partnership. By managing the flow of information, nurses sought to provide opportunities for families to adjust and prepare for potential loss.

The importance of closure was also underscored in participants' accounts, with nurses emphasizing that sensitive, compassionate communication, particularly at end-of-life enabled families to feel at peace with the care provided:

"Even though this particular patient ended up passing away, they had a good element of closure. They knew that we did everything for him."
(Philip)

Further accounts from the interviews reinforced these practices:

"But not tell them 'For sure he's going to die.' What we're seeing is something that is very bad. You give it in a softer way, and use compassion.'
(Marlon)

This balancing act, truth with sensitivity, was central to participants' sense of professional identity, and to their ability to support families in the most critical moments of their loved ones' care.

4.4.2 Subtheme 2.2- Empathy Through Presence and Nonverbal Support

Beyond the spoken word, ICU nurses frequently described the power of nonverbal communication in supporting families during critical and emotionally charged moments. Recognizing that language sometimes failed in the face of profound distress, participants described how silent presence, physical closeness, and gentle gestures became central expressions of empathy and support. Such actions communicated care, stability, and solidarity in ways that transcended speech.

One participant emphasized the healing value of being quietly present:

"Sometimes silence is better than speaking. I just sit with them and hold the space."
(Carol)

Another nurse highlighted how, in the most difficult moments, simply sharing space was itself a form of meaningful communication:

"I just sat with her. I didn't say anything for five minutes. That was communication too."
(Matthias)

Physical touch was another recurring motif, as nurses reflected on the reassurance and comfort offered by a gentle hand or steadying presence:

"Sometimes I just hold their hand. They [relatives] might not even register what I say, but they feel me there."
(Sandra)

These nonverbal forms of care were described as deeply remembered by families, with one participant reflecting on the enduring impact of emotional presence:

"They don't always remember what you say, but they remember how you made them feel. That's what sticks with them."
(Marlon)

Through these subtle yet profound gestures, silent companionship, touch, and a calm, grounding presence, nurses provided emotional anchoring for families in the midst of uncertainty and chaos. In many cases, according to participants' perceptions, these nonverbal acts did more to foster trust and reassurance than any words could, serving as the foundation of compassionate ICU communication.

4.4.3 Subtheme 2.3 - Relational Anchoring in Decision-Making Moments

ICU nurses described playing a central role as emotional anchors for families during moments of high-stakes decision-making, such as organ donation or end-of-life planning. Here, the term *relational anchoring* is used to refer to the way nurses act as steady points of connection for families, offering reassurance and stability during moments of uncertainty and decision-making. At these crucial junctures, when families faced both profound uncertainty and the need for difficult choices, nurses' presence, guidance, and calm delivery of information helped to create a sense of safety and dignity. Participants recounted how, through steady and empathetic communication, they enabled families to process their grief and reach decisions that aligned with their values and wishes.

One nurse recounted a sensitive experience with a family who initially could not accept the death of their loved one and were unable to even consider organ donation. She described spending considerable time in gentle, open conversation, listening to their fears and acknowledging their grief, while carefully explaining the process and its potential to help others:

"At first, they just couldn't bear the thought… they said they didn't want anything done. We talked for a long time, I listened, I explained every step, and I let them take their time."
(Jennifer)

Through this patient and compassionate dialogue, the family gradually reached a point of acceptance;

"It was still heartbreaking for them, but in the end, they agreed. They even thanked me for taking the time to talk it through with them, for not rushing, and for being honest."
(Jennifer)

The impact of relational anchoring extended beyond the point of clinical decision, shaping the

family's experience of loss and closure. Another nurse reflected on the enduring importance of communication following a patient's death:

"Even after this patient had passed away, we saw what the parents' wishes were for post-mortem care… through good communication, at least, these parents had some closure."
(Philip)

Through these accounts, it is clear that the role of the ICU nurse transcends the delivery of medical facts. At life's thresholds, nurses become guides, advocates, and sources of stability, supporting families through some of the most emotionally significant decisions they may ever make. Their relational presence and communication skills are vital in ensuring that these moments are navigated with clarity, compassion, and dignity.

Taken together, this theme shows how ICU nurses viewed communication as more than sharing information; however, it was also about managing emotions, showing empathy, and creating space for families to cope with difficult realities. By balancing honesty with compassion, offering presence and nonverbal support, and guiding families through decision-making, nurses helped relatives feel supported and respected during critical moments. While these accounts highlight the emotional depth of communication, the following theme shifts attention to the professional roles and boundaries nurses navigate in their communication with families, and how wider team and organisational dynamics shape these interactions.

4.5 Theme 3 - Navigating Role Boundaries and Team Dynamics in Family Communication

In the high-intensity environment of the ICU, communication with patients' families is rarely an individual effort. This theme explores how ICU nurses situate themselves within interdisciplinary teams while navigating professional boundaries, role expectations, and relational dynamics with doctors and allied health staff. Participants described being both the "bridge" and the "buffer" between families and other professionals, often filling in emotional and informational gaps left by others. This required tactful collaboration, role clarity, and, at times, negotiation.

4.5.1 Subtheme 3.1 - The Nurse as a Continuity Link and Interpreter

ICU nurses repeatedly emphasised their unique role as the most consistent presence for both patients and families. Their continuous proximity, not only at the bedside but also as emotional and informational anchors, meant that nurses often became the "go-to" resource for interpretation, clarification, and ongoing updates. While doctors and other professionals might enter briefly, nurses were there throughout the shift, cultivating trust and familiarity.

As one nurse described:

> *"We are there for a whole 12-hour shift with them continuously. Doctors come and go… spending a very short period of time (next to the bedside). I'm not saying that you build a strong bond (with relatives), but they kind of trust you and expect some different form of feedback from us nurses."*
> *(Carol)*

Families often struggled to absorb information given during physician-led meetings, particularly in moments of high stress or when technical language dominated the exchange:

"So most of the time when the meeting is approaching or they know that the doctors are coming to speak to them, they are very anxious… So they don't always absorb the information that the doctors are giving them."
(Sandra)

Nurses described frequently "filling in the blanks," reiterating or translating what physicians had said, and providing ongoing emotional support:

"We just fill in that information. I believe that if there was maybe a psychologist here, in order to debrief the relatives and help them understand their emotions… I think that would be very, very beneficial here."
(Jacob)

This constant thread in the patient and family narrative placed nurses in the central role of interpreters, not only of medical information but of emotional cues as well. They offered families a sense of stability in an otherwise unpredictable environment;

"Because we [nurses] are there much more, we can bring a more human touch. We can say things like, 'The patient rested for a while, he felt a bit hungry, he asked for this, he wished for that.' We can share details that aren't in the chart, the little things we've noticed during the day that might otherwise be lost."
(Marlon)

4.5.2 Subtheme 3.2 - Trust and Role Ambiguity

The trust established through sustained engagement proved to be multifaceted. Although nurses appreciated the rapport and credibility fostered with families, they simultaneously faced significant role ambiguity. Families, seeking reassurance or answers, sometimes projected unrealistic expectations onto nurses, expecting them to have all answers or make clinical decisions outside their scope.

One participant noted:

"Some expect us to know everything or… make decisions that the doctors should make. And I have to explain that, you know, I can't always give all the answers."
(Matthias)

Others reflected on the discomfort when their professional boundaries were misunderstood or overlooked:

"Sometimes they (relatives) do it so much (asking for specific medical details) that you start questioning yourself and you'd rather say, listen, let's speak to the doctors, because they would clarify this better, you know."
(Carol)

Conversely, nurses described moments of feeling sidelined or undervalued, especially when families expressed a preference for physician communication:

"It's not degrading, but you feel useless in a way. I mean, I'm there caring for the patient and that's it, then they (relatives) would rather speak to a doctor than a nurse sometimes."
(Carol)

Yet, at the same time, nurses took pride in being the family's mainstay:

"As ICU nurses, as a nurse in general, you feel the constant presence and you become the primary communicator, kind of. You spend most of the time with the patient and nurses know the most about the patients, more than the doctors do, more than the other healthcare professionals do."
(Jacob)

This dynamic, privilege and frustration, trust and tension reflected the complex social expectations placed on ICU nurses as both expert clinicians and accessible confidants.

4.5.3 Subtheme 3.3 - Multidisciplinary Support & Its Gaps

Participants offered detailed accounts of working with the broader multidisciplinary team, describing both fruitful collaboration and significant gaps. In the best scenarios, clear planning and communication across disciplines led to unified and supportive experiences for families:

"We always have these family meetings in a quiet room… together as a team, we have discussed before what is going to be said… So yeah, I do feel supported by the multidisciplinary team"
(Philip)

"*Usually, if there's a difficult conversation coming up, the doctors or physicians are willing to step in and help, or have a quick discussion… so everyone's on the same page."*
(Matthias)

However, in the majority of cases when nurses were asked regarding interdisciplinary support, nurses replied that often they found themselves compensating for shortcomings in the system, such as limited access to doctors, insufficient psychological support to relatives, or lack of time for team debriefs:

"It depends, not always. Especially since ICU doctors most of the time are super busy… their interaction with the families is very brief."
(Sandra)

"I believe it would be very beneficial to have a psychologist here to debrief the relatives and help them understand their emotions and what they are going through. We are not psychologists, and we are not trained to provide this type of support…"
(Jennifer)

Furthermore, the absence of allocated dedicated psychological professionals or sufficient staff often left nurses as the "default" support network for distressed families:

"We give support with what we have. But we are not psychologists… I believe there should be a designated psychologist here in ICU for these situations."
(Marlon)

This subtheme highlights how nurses balance collaboration in multidisciplinary teams and bridge institutional and interpersonal gaps, often taking on extra emotional and professional responsibilities when support is lacking.

Overall, this theme shows that ICU nurses are central to family communication, but their role is shaped by boundaries, expectations, and the wider team environment. They often act as interpreters and steady points of contact, yet also face moments of role strain, ambiguity, and dependence on/or gaps in multidisciplinary support. These dynamics highlight both the value and the pressures of being at the centre of communication in such a complex setting.

The following theme turns to the structural and organisational challenges that influence how communication unfolds, including time pressures, visiting policies, and resource limitations.

4.6 Theme 4 - Structural and Organisational Barriers to Effective Communication

Although nurses spoke about using empathy and communication strategies in their work with families, they highlighted that systemic and organisational barriers often limited how effectively this could be carried out. Time pressures, understaffing, rigid visiting hours, limited access to psychological or linguistic support, and the absence of formal training were recurrent concerns. This theme captures how these constraints created ethical tensions, emotional strain, and practical limitations in nurse-family communication.

4.6.1 Subtheme 4.1 - Time Constraints and Competing Priorities

Time emerged as a constant and often overwhelming barrier, shaping the very possibility of communication in the ICU. Nurses reported a consistently high clinical pace, with the requirements of managing acute, life-threatening conditions, conducting frequent procedures, and addressing unexpected patient deterioration often limiting interactions to only those that were absolutely necessary. The unpredictability of ICU workflow meant that even with one patient, the intensity of required interventions could rapidly obscure any planned moments for family dialogue. Nurses often felt forced to choose between hands-on clinical care and sustained communication, leading to a persistent sense of compromise and moral discomfort.

As one nurse explained:

"Sometimes, even if you have one patient, the workload is too heavy to speak to the relatives yourself, because you're too busy with the workload, dealing with the patient… you don't have time to speak to the relatives."
(Sandra)

Furthermore Carol stated:

"Sometimes we're extremely busy… we barely have time to communicate with the family."
(Carol)

Nurses felt a professional and ethical responsibility to be present for families, but described feeling "spread too thin," torn between vital patient care and emotional support for relatives. The result was often guilt and regret, as nurses were keenly aware that hurried or superficial communication failed to meet families' needs at their most vulnerable moments. This was deepened by the awareness that families, already in distress, may interpret the lack of communication as neglect or indifference:

"One of the biggest challenges is time… it's often difficult, you know, to spend as much time as I would like with families. That sometimes leaves them feeling, perhaps, a bit neglected or frustrated."
(Matthias)

4.6.2 Subtheme 4.2 - Visiting Policies and Workflow Interference

Structural factors, such as institutional policies and workflow organisation, further complicated communication barriers. In the ICU, care is typically provided on a one-to-one nurse-to-patient ratio, meaning each nurse is responsible for a single critically ill patient. However, nurses are still required to take breaks. During these times, a nearby colleague temporarily "watches over" the patient in addition to their own, ensuring safety until the primary nurse returns. Participants explained that visiting hours often overlapped with these scheduled breaks or with routine procedures and investigations. This sometimes led to unclear or broken communication, as updates were given by a covering nurse who was less familiar with the patient, or were delivered superficially while managing competing tasks.

Consequently, the consistency and personal engagement fundamental to strong nurse-family relationships were frequently compromised. The demands of managing concurrent care responsibilities alongside family needs often placed nurses in a complex logistical situation, limiting their ability to offer the reliable support that families expect:

"The breaks… they start during visiting hours, which sometimes stresses us out… because I want to be the one giving the information to the relatives rather than the nurse next to me (who will be covering for break)."
(Sandra)

The lack of coordination between staff schedules and family access times often forced hurried conversations or left families waiting for information, sometimes with no opportunity for meaningful dialogue:

"The visiting hours are at the same time as the lunch break… and sometimes we do book some extra investigations (non-urgent) such as x-rays (during visiting hours) but maybe if we plan beforehand, we can help keep this visiting hour free."
(Jacob)

Heavy workloads and the clustering of key tasks during visiting periods further amplified the problem:

"Sometimes we are so busy, we have so much work… and if the breaks happen at the time of the relatives' visiting hours, which it does, when we are with a heavy workload, we don't manage to give them the time that they would need."
(Jennifer)

These workflow issues were seen as not merely administrative inconveniences but as critical obstacles to building rapport, delivering sensitive news, and supporting families' emotional journeys.

4.6.3 Subtheme 4.3 - Lack of Psychological and Interpreter Support

The complexity of ICU care was further heightened by the frequent absence of trained psychological and linguistic support. Nurses described being thrust into roles for which they felt unprepared, acting as grief counsellors, mediators, and interpreters in addition to their clinical duties. The lack of on-site psychologists meant that nurses were left to manage intense emotional reactions such as grief, anger, denial, or trauma without specialist backup, a burden described as both "heavy" and "unfair.":

"I believe that there should be a designated psychologist here in ICU for these kind of situations. It is lacking. We do give support, but… we are not trained to give specific professional support."
(Marlon)

Language diversity added another layer of difficulty, with families often unable to fully understand or express themselves. Nurses described relying on ad hoc solutions such as multilingual colleagues, Google Translate, or gestures, but recognized these as imperfect and sometimes risky;

"Regarding Interpreters… I only came across [interpreters] maybe twice throughout my ICU experience."
(Sandra)

"If you have, for example, a Bulgarian patient… there are (in ICU) Bulgarian nurses who can act as interpreters. But if they're not available, you have to manage with gestures, repeat key points. It's not ideal, but I do my best."
(Matthias)

The absence of formal emotional and interpreter support left nurses feeling isolated, exposed to emotional burnout, and concerned that families might not receive clear or compassionate communication in moments of crisis.

4.6.4 Subtheme 4.4 - Absence of Formal Training in Communication

Despite the central role of communication in the ICU, most nurses reported little or no formal preparation for its demands. Experiences of structured communication training were rare, brief, and often outdated. Instead, nurses described learning "on the job," picking up techniques by observing senior colleagues or relying on intuition. This gap was particularly acute in the context

of challenging conversations such as breaking bad news, handling anger or grief, and navigating cultural or language barriers.

"We've never had these opportunities… we should have workshops. Not just lectures… but groups where we share our experiences regarding communication and talk to each other."
(Jennifer)

The only examples of formal training were described as isolated or insufficient:

"We had this one-day seminar… emotional intelligence… but that was like six or seven years ago… something more frequent would be much helpful."
(Philip)

The lack of structured support and feedback was felt as a vulnerability by nurses, who called for regular, practical, and team-based education to build confidence and resilience:

"Honestly, I haven't had any formal training… most of what I know has come from experience and watching senior nurses."
(Matthias)

Without such preparation, the emotional risks and uncertainty associated with family communication were heightened, making it more difficult for nurses to provide the high-quality, compassionate care they aspired to deliver.

This theme showed how systemic and organisational issues created major obstacles for nurse–family communication. Time pressures, visiting hours overlapping with staff routines, the lack of psychological and interpreter support, and limited formal training left nurses feeling overworked and unprepared. These barriers often led to rushed or surface-level conversations, leaving families distressed and nurses with feelings of guilt and frustration. Despite their best efforts, participants

stressed that without stronger institutional support, their ability to communicate well remained restricted.

While this theme has shown how structural barriers shape communication, the next theme looks at how nurses managed and adapted to these challenges, using personal strategies and resilience to keep supporting families under pressure.

4.7 Theme 5 – Communication as a Professional and Humanising Practice

For ICU nurses, communicating with families goes beyond sharing clinical information; it's central to patient care during critical illness. The findings show that communication integrates ethics, clinical skill, and human connection for these professionals. The daily realities of the ICU push nurses to enact and refine this skill, integrating it into their evolving professional identities. Communication is the arena in which technical expertise is transformed by emotional intelligence and where the humanity of both patient and practitioner is most visible.

4.7.1 Subtheme 5.1 – Valuing Communication as a Core Clinical Skill

Nurses saw communication not just as a task, but as a deeply human skill that mattered as much as technical expertise in the ICU. For them, connecting with families and patients was integrated into every moment alongside medical care. Over time, several nurses noted changes in their approach, identifying communication as essential for effective, comprehensive care. Nurses observed that, in intensive care settings where fear and uncertainty are common, clear and sensitive communication influences families' experiences and patient outcomes;

"Communication is one of the biggest skills in ICU and it is as important as the technical skills."
(Philip)

This was echoed in the advice nurses hoped to impart to new colleagues:

"I would really like that new nurses do actually realise that communication is one of the biggest skills in ICU… it is as important as the technical skills."
(Carol)

Several participants emphasised that families' memories of the ICU experience are strongly shaped by how they were made to feel through communication, sometimes more so than by any single medical intervention:

"Relatives actually remember how you made them feel… communication is as important as the medical care you are giving to the patient."
(Sandra)

Communication was not viewed as an optional extra, but as a critical, daily responsibility and a marker of clinical excellence.

4.7.2 Subtheme 5.2 - Growth in Communication Through Experience and Reflection

Another strong thread was the way nurses described communication as a skill shaped gradually through daily encounters and honest reflection. Instead of simply picking it up in classrooms, they spoke of learning over years at the bedside such as listening, responding, and adapting with every family they met. Step by step, nurses adjusted in to emotions, sensed the right moment, and found unique ways to support each family's needs.

"From my point of view… I feel that I have become more comfortable communicating with relatives. I know how to handle them better, how to read relatives better and use different techniques with different families."
(Carol)

For some, this growth represented a shift from focusing mainly on facts to understanding the equal, if not greater, importance of emotional support:

"Communication is a skill you have to learn… through experience and dealing with different patients and different families."
(Philip)

"I used to focus mostly on the facts, but now I see that emotional support is just as important. I'm more patient now and try to really see things from their perspective."
(Matthias)

This experiential learning, often fostered by informal mentoring and self-reflection, was seen as essential to becoming a competent and compassionate ICU nurse.

4.7.3 Subtheme 5.3 - Shaping Professional Identity Through Relational Encounters

Finally, nurses described how communication especially in emotionally charged, relational moments which shaped their self-understanding as professionals. Encounters with families were described as deeply meaningful, reinforcing values of empathy, dignity, and presence. Many nurses articulated that the way they communicated was inseparable from their identity as caregivers.

"At the end of the day, families remember how we made them feel. Not what we actually said, but how we made them feel."
(Carol)

These interactions, while often challenging, were also described as some of the most fulfilling aspects of nursing:

"Communication has become one of the most rewarding and challenging parts of my job."
(Matthias)

Small acts such as acknowledging a family's presence, offering reassurance, or simply listening, were recognised as powerful contributions to the therapeutic relationship:

"Even if you're extremely busy, the relatives can appreciate when you dedicate some time just to acknowledge their presence."
(Philip)

"Try to really listen to what families are saying… even a few minutes of your time can mean a lot to them."
(Sandra)

Through such moments, nurses expressed a sense of professional fulfilment, finding meaning in their ability to support and humanise the ICU experience for families, affirming that, ultimately, communication is both a clinical act and a profoundly human one.

4.8 Conclusion

This chapter has shared the voices and experiences of ICU nurses, showing how communication with families is influenced not just by personal skill but also by the realities of a demanding organisational context. Another aspect coming through is that, communication is never just about passing on clinical facts; it is about being present, offering reassurance, and finding ways to connect with people in moments of fear and uncertainty. Nurses often walk a fine line between professional responsibility and human compassion, adapting their words and actions to meet families where they are. At the same time, the challenges they described, from cultural differences

to structural constraints, highlight just how complex and emotionally charged these encounters can be.

Taken together, the findings emphasise the vital role of ICU nurses in guiding and supporting families through some of the hardest moments of their lives, while also revealing the pressures that can make this role so demanding. The next chapter will build on these insights, situating them within the wider body of literature and theoretical perspectives, and considering their implications for practice, policy, and the continuing development of family-centred care in intensive care settings.

Chapter 5

Discussion

5.1 Introduction

The purpose of this chapter is to interpret and discuss the findings in relation to the research aim through a symbolic interactionist lens. The intent is not to present and analyse the themes as separate pieces, but rather to explore them together as connected findings that show how ICU nurses perceive communication with patients' families. While five themes were identified through the analysis as presented in the previous chapter, they are best understood as overlapping parts of a broader communication experience shaped by emotional, relational, structural, and professional factors. The following sections, therefore, do not restate theme titles word for word, but instead use interpretive headings to highlight key aspects of the findings and their connections.

Guided by Symbolic Interactionism theory *(introduced & discussed in detail in sections 2.2-2.5 of this study)*, this chapter interprets the findings in relation to the study's aim and objectives and examines how meaning is built through nurses' interactions with families. Symbolic Interactionism guided this discussion by providing a lens to interpret how nurses construct and negotiate meaning through interaction. Specifically, it informed how I examined nurses' accounts of adapting their communication, reading emotional cues, and interpreting families' responses as socially meaningful acts. This approach allowed the findings to be understood not only as behavioural descriptions but as symbolic exchanges through which professional identity and emotional connection are constructed. The discussion also draws on relevant literature to show how these findings reflect the complex nature of ICU communication and the important role nurses play in supporting families during critical illness. In addition, this chapter intersperses practical

recommendations and areas for future research, which will be further developed in the next chapter.

5.2 Communication as Interpretive Nursing Practice

The findings of this study revealed that ICU nurses view communication as far more than just a technical exchange of medical information; they see it as a thoughtful and deeply human part of their professional role ***(Section 4.3).*** Nurses frequently described communication as intentional, flexible, and carefully shaped in response to families' needs. From a Symbolic Interactionism perspective, this affirms that meaning is continually formed and adjusted through ongoing interaction (Blumer, 1969).

One participant described trying not to use elaborate language related to medical information; however, he rather used simpler language, making sure everything is clear *(Section 4.3.1).* This instance shows clearly how nurses attempt to "translate" complex information into language that families can understand, thereby helping them make sense of care decisions. Communication here is not just about passing on facts; it is shaped by how nurses pick up on families' signs and use words, tone, and context to create shared meaning. In this sense, nurses' adaptation of language and tone illustrates Blumer's idea that meaning develops through interaction and is continually redefined as participants interpret each other's emotional signs (Blumer, 1969).

This effort to simplify and check for understanding was also evident in many nurses' accounts. A participant interviewed in this study (Sandra), for example, talked about asking families to

explain back what they heard, making sure everyone was on the same page *(Section 4.3.1).* Such strategies demonstrate nurses' commitment to ensuring shared understanding, which, from an SI perspective, emphasises the reflexive process of interaction. Meanings were regularly assessed, explained, and reassessed among the nurse and the family.

These insights are well supported by research. In their qualitative study of ICU nurses in the United States, Ahluwalia et al. (2016) found that nurses often acted as key intermediaries during family meetings, helping relatives interpret medical language and translate it into terms that made sense in their own lives. In a similar way, Yoo, Lim, and Shim (2020) found that nurses in Korean ICUs changed how they talked with families based on what they noticed in the moment, constantly adjusting and rephrasing to match families' needs. In their qualitative descriptive study across Australia and New Zealand, Bloomer et al. (2017) found that nurses responded in real time, particularly during end-of-life care by adjusting their tone, pace, and level of detail to help families process information and feel supported

In this study, participants described going beyond simply giving facts; instead, putting them into familiar terms that families could relate to (***Section 4.3.2*****).** Nurses' words, gestures, and delivery style became symbols that carried meaning beyond their literal content, showing reassurance, competence, and empathy. This dynamic confirms SI's claim that interaction is the foundation of meaning-making and that individuals act based on these constructed meanings.

In addition, the way nurses communicate shows that being a good communicator is a key part of their professional identity. Nurses did not see communication as just an extra task, but as central to their role in caring for others (*Section 4.2).* This idea fits with Naef et al. (2021), who explained that engaging with families in the ICU means nurses must act as a bridge between the technological environment of critical care and the basic human need for comfort, understanding, and support.

In summary, these findings show that communication in the ICU is an active, interpretive process shaped by symbolic interaction. Nurses didn't just pass on information, but they adjusted how they spoke based on what they thought families needed, using simple explanations, everyday examples, and checking for understanding. This way of communicating lines up with the ideas of Symbolic Interactionism, especially the tenet that meaning is not fixed but constructed together through back-and-forth conversation. By considering communication as a core part of their role, ICU nurses play a vital part in helping families understand what's happening and feel involved in the care process.

The study emphasises that communication is a key part of being an ICU nurse, a view supported by professional standards identified by professional organisations, such as the American Association of Critical-Care Nurses (AACN, 2016), which identify effective communication as central to safe and compassionate critical care. This could be built more strongly into education and training, with specific modules on nurse–family communication. Future research could examine how such teaching improves nurses' confidence, satisfaction, and professional development in the long term.

5.3 Handling Emotions and Finding Meaning

A second important dimension of nurse–family communication revealed by this study is the emotional labour that nurses experience. Participants described the difficulty of being open and clear about clinical issues while also remaining sensitive, so that families received the information they required and still felt supported through the fear and distress of critical illness *(Section 4.4)*.

This reflects the interpretive process highlighted in Symbolic Interactionism, which explains how meaning is shaped and reshaped through interaction (Blumer, 1969) *(Section 2.3).* In practice, ICU nurses recounted noticing signs such as silence, agitation, or tears, and letting these guide how they framed their words. Families' emotions were not viewed as secondary to the exchange but as central in shaping how information was delivered.

Nurses spoke about softening their language, pacing the delivery of difficult news, and offering reassurance to keep conversations supportive, especially when uncertainty or bad outcomes were involved *(Section 4.4.3).* These strategies reflect the handling of emotions and finding of meaning, showing that communication was shaped not only by what families needed to know but by how they expressed their capacity to receive it.

The broader literature *(discussed in detail in Chapter 2)* supports this view. Ahluwalia et al. (2016) described ICU nurses as emotional anchors in family meetings, noting how they adjusted their communication to help relatives manage anxiety, uncertainty, and emotional distress. Bloomer et al. (2017) likewise found that during withdrawal of life-sustaining treatment, nurses altered their tone and timing to comfort families without avoiding the truth. Yoo et al. (2020), conducted in South Korea also reported that nurses responded to emotional signals with empathetic dialogue, recognising distress while still keeping information clear.

Taken together, these findings show that emotional navigation is central to ICU communication. It is not an additional skill but a core aspect of how nurses interpret and respond to families. By paying attention to families' emotional reactions, nurses found ways to stay honest while still showing empathy, which helped maintain trust and connection. In this way, through the lens of Symbolic Interactionism, emotional expression can be understood as part of the interpretive process through which meaning is created, negotiated, and modified during interaction (Blumer,

1969).

The findings show that communication training should not only focus on giving medical facts but also on building emotional awareness and sensitivity. Training programmes that develop these skills could give nurses more confidence in difficult conversations. Further research could explore how such training influences family satisfaction and also supports nurses' own wellbeing in critical care.

5.4 Initiating and Structuring Communication

An important part of the findings was how nurses not only started conversations with families but also organised them in ways that gave a sense of continuity and predictability**.** Participants described beginning discussions early in the ICU stay, providing consistent updates, and clearly outlining expected outcomes and care plans *(Section 4.3.4).* This active approach may be interpreted from a Symbolic Interactionist perspective as illustrating how people act toward others based on the meanings that interactions hold for them (Blumer, 1969). By showing openness, availability, and reliability, nurses helped set expectations and reduce uncertainty for families.

Nurses explained that this approach helped lower anxiety and encouraged families to participate in decision-making. Rather than waiting for relatives to ask questions, nurses took the first step to ensure information flowed consistently and in a way that felt predictable. Within SI, this is an interpretive act, where nurses anticipate families' needs and deliberately shaped interaction to build trust and understanding.

The value of proactive communication is strongly supported in the literature. Cai et al. (2014) found that early and active communication improved care quality, reduced misunderstandings, and increased satisfaction. Maharmeh et al. (2023) also revealed that proactive engagement reduced stress, promoted trust, and helped families cope with uncertainty. Emaliyawati et al. (2020) found that structured family meetings lowered distress and clarified roles. Regular, interprofessional family meetings are now widely recommended as best practice because they build rapport, align expectations, and reduce stress even when no immediate decisions are required (Gay et al., 2009). More broadly, Naef et al. (2021) confirmed that proactive nurse–family engagement is a core element of ICU care that reflects empathy, professionalism, and respect for families.

In this study, strategies such as regular updates, early introductions to families upon admission, and routine contact carried symbolic meaning. According to the participants, families saw these actions as signs that they were respected, valued, and included. These practices not only conveyed information but also reassured families, eased their anxiety, and strengthened a sense of partnership in care. From this perspective**,** taking the initiative and organising communication was both practical and meaningful, helping nurses and families build understanding together and maintain trust.

These findings suggest that ICU practice could improve by adding regular family communication routines into daily care, for example through scheduled updates or planned family meetings. These approaches may help maintain consistency even when time is short. Future research should explore how such structured methods reduce family anxiety and support shared decision-making in different ICU settings.

5.5 Silent Presence and Non-Verbal Care

The findings of this study highlighted the importance that nurses attributed to non-verbal communication and quiet presence as a key part of ICU nurse–family communication *(Section 4.4.2).* Nurses often described how silence, touch, eye contact, and being physically close showed empathy and gave comfort more strongly than words in moments of crisis.

Nurses depicted these behaviours as ways of showing empathy and reassurance. Consistent with SI principles, such gestures can be interpreted as symbolic acts through which meaning and emotional connection are constructed during interaction (Blumer, 1969). Meaning is formed not only through spoken language but also through embodied interaction, a point Blumer (1969) stressed in his early description of SI. Empirical studies support this. In a focused ethnographic study in an Australian ICU, Al-Shamaly (2022) used participant observation and interviews to examine how nurses communicate care in daily practice. She found that nonverbal behaviours, such as touch, proximity, and eye contact were used to convey empathy and reassurance. These observational findings support what nurses in this study recalled during interviews, confirming that nonverbal actions form an important part of nurse–family communication in critical care. Similarly, Sandnes & Uhrenfeldt (2024) reflected how "caring touch," such as placing a hand over a relative's arm or giving a gentle hand squeeze, quietly communicates presence, reassurance, and shared humanity in critical moments.

Looking more broadly beyond the ICU context, a systematic review by Buono, Nygren, and Bianchi-Berthouze (2025) showed that in general, practical touch in healthcare carries emotional meaning, highlighting that touch communicates feelings as well as serving a practical role. Further evidence points to the importance of these behaviours. Wanko Keutchafo et al. (2020), in a review of nurse–patient communication, noted gestures such as touch, physical closeness, and body

language as consistent ways of showing emotional support and respect. McIntyre et al. (2019) also showed that affective touch alone could communicate complex emotions, such as gratitude or sympathy, even without words. These examples make clear that silent and non-verbal care was not just an extra gesture, but part of how families felt supported and understood during ICU care.

In the current study, nurses' descriptions of sitting beside families, holding their gaze, or placing a hand on a shoulder reveal the symbolic dimension of presence. Within SI, these non-verbal behaviours act as shared symbols that confirm solidarity and care when words are not enough. By showing empathy in these ways, nurses helped families feel recognised, supported, and less alone during times of uncertainty or loss.

In summary, nurses in this study described silent presence and non-verbal care as an essential aspect of their communication with families in the ICU. Nurses in this study claimed *(through interview accounts),* that families perceived their silence, touch, and attentive presence as reassuring signs of care and empathy. These practices align directly with SI's framework, which shows how meaning is built through symbols and interaction, demonstrating the power of non-verbal communication in building emotional connection and trust.

5.6 Steady Support in Family Decision-Making

A further important part of ICU communication revealed by this study was the way nurses claimed to act as steady supports during difficult decision-making moments. In end-of-life care especially, nurses offered families stability, continuity, and emotional support. According to the nurses interviewed, their calm and reliable presence at the bedside helped families, based on their perception, feel reassured and supported when facing complex choices *(Section 4.4.3).*

From a Symbolic Interactionism (SI) view, nurses' ongoing presence is a strong symbol through which, nurses believed, they helped families make sense of their experience. Their closeness and involvement conveyed not only information but also deeper messages of empathy, reassurance, and shared humanity. In this way, a nurse's guiding presence reflects SI's idea that actions and gestures gain meaning through interaction and interpretation (Blumer, 1969).

This understanding of nurses' supportive communication aligns with earlier qualitative work. Ahluwalia et al. (2016), in the United States, interviewed ICU nurses who described acting as emotional guides in family meetings, helping relatives cope by shaping communication and meaning. Likewise, Bloomer et al. (2017), in Australia and New Zealand, interviewed nurses who reported adjusting tone and timing to comfort families during withdrawal of life-sustaining treatment. Complementing these nurse-focused studies, Gunnlaugsdóttir et al. (2024) conducted a systematic review of qualitative research on family members' experiences of nurse communication in ICUs, finding that empathy, honesty, and timely information were central to families' sense of trust and inclusion. Together, these studies substantiate the perceptions of nurses in the present study, who described striving to provide clarity, stability, and reassurance through sensitive communication

In this study, nurses described their support not only as providing information but also as guiding and interpreting for families throughout the process. They explained how they sought to clarify technical details, offer context for decisions, and provide reassurance before, during, and after formal family meetings. From a Symbolic Interactionist perspective, particularly Blumer's third tenet, which emphasises that meaning is continuously interpreted and modified through social interaction, it may be argued that nurses' attempts to provide steady support function as a symbolic

bridge between the highly medicalised ICU environment and what they perceived as families' emotional and moral world.

In many ways, this role of guiding and supporting families brought together the different aspects of communication already discussed: adapting communication, handling emotions, initiating contact, and showing non-verbal care. Taken together, these practices, as described by the nurses, suggest that they often positioned themselves at the centre of communicative exchanges in the ICU. Interpreted within this theoretical lens (SI) , this may be interpreted as nurses engaging in meaning-making processes that help sustain steadiness and understanding during uncertainty.

5.7 Structural and Organisational Barriers to Communication

While nurses claimed strong adaptability and communication skills, the findings also highlight the perceived structural and organisational barriers that often limited these practices. Participants frequently described how heavy workloads, staff shortages, paperwork, and strict visiting hours reduced their ability to have meaningful conversations with families *(Section 4.6).*

From a Symbolic Interactionism (SI) perspective, these barriers are more than practical issues, they limit the space where nurses and families can build meaning together. Time pressures, interruptions, and rigid routines left fewer chances for nurses to notice families' signs, provide silent presence, or act as steady supports. Without enough time or flexibility, the complex process of communication through back-and-forth interaction was disrupted.

The importance of these structural factors is well shown in the literature. Borhani et al. (2014) found that lack of staff and missing communication policies were major barriers to nurse–family dialogue in Iranian ICUs. Abukari & Petrucka (2021) also identified common obstacles such as too much documentation, limited time, and strict rules, all of which get in the way of patient-centred communication. Nassar Junior et al. (2019) further showed that ICUs with more flexible visiting rules reported higher family satisfaction and stronger emotional involvement than those with restrictive policies. This demonstrates how unit design and rules can directly shape the quality of family–nurse interaction.

The literature also points to possible solutions. A Canadian review (CJCCN, 2022) recommended tools such as SBAR, VALUE, and PACE to help overcome systemic barriers and make family communication more consistent across the team. These tools not only improve efficiency but also provide reassurance to families by showing clarity and alignment in what the care team communicates.

The accounts of nurses in this study confirm that organisational conditions strongly shape communication. When nurses were overloaded or restricted by rules, their ability to listen, interpret emotions, or support families during uncertainty was reduced. These barriers were not only practical difficulties but also limited the space for meaningful connection with families.

Therefore, the findings show that effective communication is not just about individual skills. It is also a system-level issue, tied to the structures and policies of the ICU. Communication support cannot rely only on the nurse. Hospitals may need to improve staffing, set aside time for family updates, or use simple structured tools to keep communication clear. Further research should

examine how such organisational changes improve the quality and consistency of nurse–family communication in ICUs.

5.8 Synthesis through Symbolic Interactionism

The findings of this study suggest that, from the nurses' ICU nurse–family communication is an interactive and interpretive process, not just the transfer of facts. Symbolic Interactionism (SI) was chosen as the theoretical framework because it views communication as an ongoing creation of meaning through human interaction (Blumer, 1969). This perspective is especially relevant in the ICU, where families face uncertainty and nurse–family interactions carry both emotional and informational weight.

Symbolic Interactionism offers a useful lens for interpreting how nurses in this study described adapting their communication in complex settings. Nurses adjusted their words and approach based on families' verbal and nonverbal cues, showing that communication relies on the meanings built during interaction, not only on information itself. In the ICU, this ongoing cycle of interpretation was described by nurses as promoting mutual understanding between themselves and families.

Through the lens of this theory (SI), the nurses' accounts illustrate the perceived symbolic impact of nonverbal presence, such as a nurse quietly sitting nearby, giving a reassuring touch, or holding steady eye contact. These simple acts often conveyed empathy, reliability, and solidarity more strongly than words. Within SI, they are understood as shared symbols that build trust and emotional connection, which families rely on to make sense of critical illness and feel supported.

Equally important were nurses' efforts to connect with families through clear and consistent communication. By starting conversations, giving regular updates, and explaining what to expect, nurses attempted to provide families with a sense of routine and inclusion. When supporting families through difficult choices, they offered comfort and stability, acting not only as conveyors of information but also as reliable sources of reassurance in times of uncertainty.

SI also helps explain how structural pressures, such as heavy workloads or restricted visiting hours, limited opportunities for these connections. These systemic factors reduced the space for meaningful interaction, showing that communication depends not only on individual skills but also on the wider organisational environment.

In summary, Symbolic Interactionism (SI) offers a clear framework that connects the different communication practices identified in this study. Nurses' actions, whether simplifying language, providing silence, or giving structured updates can all be seen as symbolic behaviours that help families make sense of crisis. SI highlights the depth of ICU nurse–family communication, showing that it is not made up of isolated techniques but of symbolic processes shaped by both human interaction and organisational context.

5.9 Linking Findings to the Study Aim and Objectives

The overall aim of this study was to explore how ICU nurses perceive their role in communication with patients' families, with particular attention to the factors that help or hinder this process and the strategies nurses use to manage it. The findings discussed in the previous and the current chapter show that this aim was achieved.

Across the themes, nurses consistently described communication as central to their professional identity, moving beyond the delivery of medical facts to a process of interpretation, emotional support, and meaning-making. This directly addressed the objective of understanding nurses' perceptions of their role. Facilitators, such as proactive updates, structured conversations, and the use of silence or non-verbal gestures, were identified, showing how nurses attempt to create trust and reduce anxiety, thus meeting the objective of identifying what supports effective communication. At the same time, barriers such as limited time, workload pressures, and restrictive visiting policies emerged, clearly demonstrating how systemic conditions limit the space for meaningful dialogue. The findings also highlighted the strategies nurses adopt to navigate these challenges, including simplifying information, responding sensitively to emotions, and offering steady support in decision-making moments.

Taken together, these insights confirm that the study's objectives have been met. They also contribute to the final objective of informing practice and policy in the Maltese context by pointing toward practical recommendations such as strengthening communication training, embedding structured family routines, and addressing organisational constraints that will be elaborated further in Chapter 6. In this way, the discussion not only reflects the complexity of nurse–family communication but also lays the groundwork for future improvements in practice and research.

5.10 Conclusion

This chapter has shown that ICU nurse–family communication is more than relaying medical information. It is a dynamic process where nurses adjust how they speak and act in response to families' needs and emotions. Through their words, presence, and support, nurses attempt to help families make sense of critical illness, cope with uncertainty, and feel included in decisions.

The discussion also highlighted that communication is influenced not only by individual skills but also by wider organisational conditions. Time pressures, staffing, and visiting rules can either make these interactions easier or place limits on them. Recognising this dual influence is essential for understanding how communication unfolds in the ICU.

Symbolic Interactionism helped explain these findings by showing how meaning is built through everyday interactions. Simple gestures, consistent updates, and steady support all carried symbolic value that shaped how families experienced care and trust.

Overall, nurse–family communication emerges as a central part of ICU nursing and professional identity. For such communication to thrive, it requires both committed nurses and supportive organisational structures. This chapter has therefore laid the foundation for the next stage of this thesis, which will present concrete recommendations for practice, education, and future research.

Chapter 6

Conclusions & Recommendations

6.1 Overview of the Study

This study explored how ICU nurses in Malta perceive and experience communication with patients' families. Using a qualitative descriptive approach guided by Symbolic Interactionism, it examined how nurses view their role, manage challenges, and communicate within the demanding ICU environment. Interviews with seven nurses showed that communication is part of daily practice, shaped by teamwork, relationships, and organisational context.

Findings revealed that communication is not a task to complete but an ongoing process that combines clear explanations with empathy and timing. Nurses saw themselves as interpreters of medical information, steady points of contact, and emotional support for families in distress. These results echo international research showing that nurse–family communication depends on team dynamics and clear roles. When communication systems, such as family meeting routines or coordination between staff are weak, families receive mixed messages and nurses must bridge the gaps (Dees et al., 2022).

Symbolic Interactionism helped explain why, from the nurses' perspective, *how* something is said, including tone, pacing, presence, and the ability to "read the room", often matters as much as *what* is said. In critical moments such as treatment withdrawal, nurses' communicative behaviours before, during, and after discussions play a key role in shaping how families interpret and understand what is happening. While this study did not directly explore how families themselves

interpret these interactions, nurses described being aware that their tone, body language, and level of attentiveness shaped how families understood and coped with information.

6.2 Contribution of the Study to Knowledge and Practice

The study achieved its objectives in four distinct ways. Initially, it demonstrated that nurses view their responsibilities as extending beyond the transmission of information, positioning themselves as bedside coordinators, interpreters, advocates, and providers of emotional support.

Second, the study identified what helps communication from the nurses' perspectives, such as early and regular updates, everyday presence at the bedside, plain language, empathy, and a team culture that backs nurse involvement. These facilitators recur across countries and cultures, suggesting that predictable contact and clarity reduce confusion and foster trust.

Third, the study mapped barriers that make conversations hard to sustain including workload and time pressure, mixed messages between professionals, visiting-policy pressures, language or cultural gaps, and the emotional intensity of critical illness.

Finally, the findings suggest several practical, locally relevant implications, which are elaborated later in this chapter. These include introducing structured, nurse-inclusive family touchpoints, consistent plain-language updates across shifts, and training to support nurses in managing distress, anger, and uncertainty.

6.3 Limitations

This study offers important insights into ICU nurses' perceptions regarding communication with patients' families however; several limitations should be noted. The participant group, comprising seven individuals from a single intensive care unit in Malta, may restrict the applicability of the findings. While qualitative research does not aim for statistical generalisation, using a small group of participants from a single ICU department limits how far the findings can be applied to other settings. Malterud, Siersma, and Guassora (2016) explain this through the idea of informational power, meaning that the more focused and relevant the participants are to the research aim, the fewer are needed. However, such findings are usually only useful for similar organisational and cultural contexts. The perspectives gathered reflect the institutional culture, visiting policies, and team dynamics of a single Maltese ICU department, which may differ markedly from those present in other hospitals or healthcare systems organised under different cultural or policy frameworks.

The specific demands of the ICU in which the participants work, such as caring for highly unstable patients, making rapid clinical decisions, and working within time-critical situations inevitably shaped the findings. The strategies and perspectives described by participants may not fully reflect those of nurses working in healthcare systems that follow different policies, cultural norms, or expectations regarding family involvement.

Another limitation relates to the recruitment process. Participants were identified and approached through charge nurses acting as gatekeepers. Although this purposive sampling strategy was necessary to access information-rich participants, it may have introduced some degree of bias, as those who agreed to participate could have been particularly reflective or motivated to discuss

communication. This could mean that certain perspectives, such as those of less confident or less communicative nurses, may not be fully represented.

As with all qualitative research, the potential for researcher bias must also be acknowledged. The principal investigator's own background as an ICU nurse may have influenced how interviews were conducted and how the data were interpreted. Berger (2013) and Peddle (2021) explain that a researcher's background always shapes how data are collected and interpreted. Although steps were taken to manage this, such as the use of reflexive journaling, transparency in decision-making, and attention to participants' exact words during analysis, the interpretation is inevitably shaped by the researcher's positionality *(Section 3.9 - 3.9.2).*

Finally, while Symbolic Interactionism offered a useful lens for interpreting how meaning is co-constructed during nurse–family encounters, the theory was applied primarily at the analysis stage rather than guiding the structure of the interview schedule. Consequently, the connection between participants' accounts and the theoretical framework was identified retrospectively, rather than being purposefully embedded in the data collection process. While this still added depth to interpretation, Bradbury-Jones, Taylor, and Herber (2014) warn that using theory only after data collection can reduce how strongly it connects to the study findings.

Another limitation of this study is that it explored communication solely from the perspective of ICU nurses. While this focus provided valuable insight into how nurses perceive their communicative role, including challenges, facilitators faced and communication strategies used, it did not include the viewpoints of patients' relatives, whose experiences would offer a fuller understanding of how communication is received and interpreted. As a result, some inferences

about family meaning-making are based on nurses' observations rather than direct accounts from families themselves. Likewise, the perceptions of other healthcare professionals such as physicians, allied health staff, or psychologists, were not included. Their involvement could have provided a broader view of how interdisciplinary dynamics shape communication with families. Future research could therefore benefit from incorporating multiple perceptions to develop a more comprehensive and balanced understanding of communication processes within the ICU.

Another limitation of this study is that it relied entirely on self-reported accounts from participants rather than direct observation of communication practices. As such, the findings reflect how nurses perceive and describe their communication with families, rather than how these interactions actually unfold in practice. Participants may have unintentionally presented their actions in a more positive or socially desirable light, or may have recalled events selectively. Although self-reporting is an accepted method in qualitative research for exploring perceptions and meanings, future studies incorporating observational methods could provide a more comprehensive understanding by comparing reported practices with actual communicative behaviour in the ICU.

6.4 Strengths

Despite these limitations, the study also has several notable strengths. One of its primary strengths lies in its qualitative design, which allowed for in-depth exploration of how ICU nurses perceive and experience communication with families. The use of semi-structured interviews encouraged open and flexible dialogue, enabling participants to articulate their perceptions about the subject under study and experiences in their own words. Doyle et al. (2020) note that this type of design

is especially useful in nursing research, where the aim is to stay close to practice and to participants' real experiences. This approach revealed detailed strategies such as simplifying language, using analogies, recognising emotions, and adapting communication styles, elements that might not appear in studies using fixed questionnaires or quantitative tools.

Another strength is the originality of the study in the Maltese context. To the researcher's knowledge, secondary to a thorough search, no prior research has specifically examined ICU nurses' perceptions of communication with patients' families in Malta. This study therefore, makes a novel contribution by filling a local gap and situating Maltese nurses' experiences within the broader international literature.

A key feature that reinforces the rigour of this study is the transparent audit trail maintained throughout the research process. Detailed records of each stage of data collection and analysis were kept, allowing others to trace how decisions were made and themes were developed, thereby enhancing auditability and dependability. In addition, the study provides rich contextual information about the ICU setting, participants, and procedures, which supports readers in judging the transferability of the findings to similar clinical environments.

The consistent use of reflexivity is also a key strength. By actively reflecting on personal assumptions and documenting the research process, the study enhanced credibility and provided a transparent account of how findings were shaped. As Finlay (2002) notes, reflexivity is a key tool to enhance the integrity and trustworthiness of qualitative work by making the researcher's role explicit. This helped tone down the influence of insider bias while still drawing on the researcher's professional understanding of ICU practice.

Finally, the study's theoretical grounding in Symbolic Interactionism added depth to the analysis. It highlighted how communication involves not only the transfer of information but also the negotiation of meaning, the use of symbols, and the establishment of trust. This theoretical perspective highlighted the careful relationship-building work that nurses do with families and helped make the study's findings clearer and more meaningful.

In summary, while limited by its scope and context, this study offers rich, practice-based insights into the communicative role of ICU nurses, providing both local relevance and connections to international evidence. It highlights the complex, relational nature of communication in critical care and contributes valuable perspectives for improving practice, training, and policy.

6.5 Implications for Practice and Education

The findings of this study highlight that effective ICU communication depends not only on nurses' interpersonal skills but also on the wider systems, policies, and culture that shape everyday practice. Participants described that communication often became inconsistent when structures were unclear or when nurses were excluded from discussions. To address this, ICU managers and senior nursing leadership should ensure that interdisciplinary family meetings are scheduled at key points such as at admission, after major care changes, and at regular intervals during the patient's stay with nurse participation made a formal requirement. Nurses bring valuable bedside insights that help align the information given by physicians with families' understanding. However, as nurses in this study noted, their involvement is sometimes overlooked or informal. Establishing clear protocols and assigning responsibility to unit coordinators can make nurse inclusion routine and reduce the risk of conflicting messages for families (Gay et al., 2009).

Participants also highlighted the importance of consistency across shifts, as families often became confused by differing updates. ICU managers should therefore implement a standardised, plain-language communication template for shift handovers and family updates. This format could briefly cover what has changed, the next steps, and whom families can contact for clarification. Charge nurses or shift leaders could oversee that these updates are delivered regularly. Evidence shows that predictable, jargon-free communication helps families feel informed and reduces anxiety (Checa-Checa et al., 2025).

This investigation also revealed that nurses often relied on personal experience rather than formal preparation when navigating emotionally charged situations. Hence, education and training programmes should go beyond teaching what to say and focus on *how* to say it. Nurse educators and clinical training departments should include simulation-based communication workshops that develop skills in pacing information, recognising non-verbal cues, and addressing strong emotions, particularly in end-of-life situations. Peerboom et al. (2023) emphasise that during treatment withdrawal or major care transitions, tone, empathy, and timing shape how well families comprehend information and how they later recall the experience.

At the organisational level, supportive structures are crucial for sustaining effective communication. As identified by participants, strategies such as allocating protected time for family updates, assigning a "family liaison" nurse per shift, and ensuring interpreter access can enhance family-centred care. Hospital administrators and ICU leadership should work together to balance visiting policies with staffing realities and provide private spaces for sensitive discussions. The physical and procedural environment including timing of medical rounds and leadership visibility directly affects whether families feel included or excluded from care discussions.

Finally, participants acknowledged the emotional labour involved in communication, especially in distressing or ethically complex situations. They emphasised that while emotional support is an inherent part of their role, *"they are not psychologists,"* and felt that having a psychologist available within the ICU would be highly beneficial. This highlights the need for institutional recognition of the psychological demands placed on nurses. ICU management and occupational health services should therefore consider providing access to on-site psychological support, alongside regular debriefings, peer-support groups, and counselling opportunities after challenging encounters. Such measures would not only protect staff wellbeing but also help sustain communication quality and strengthen multidisciplinary team cohesion over time.

6.6 Recommendations for Future Research

Future research in Malta should move beyond descriptive accounts and instead test structured interventions that support nurse–family communication. such as nurse-inclusive family meetings, standardised update routines, and communication training programmes. Outcomes, such as family satisfaction, decisional conflict, and nurse moral distress, would provide valuable measures. International studies show that nurse-led interventions can improve family satisfaction and reduce stress (Naef et al., 2023; Kiwanuka et al., 2021). Evaluating these strategies in Maltese ICUs would provide locally relevant evidence for practice.

Multi-site and mixed-methods studies are also needed to identify which challenges are common across ICUs and which are specific to local organisational culture, staffing, or policies. Including families and physicians in such studies would create a fuller picture of communication processes,

particularly as inconsistencies between professionals are a common source of family confusion (Collet et al., 2024). Longitudinal research is equally important to examine how repeated exposure to complex and emotional conversations impacts nurses' wellbeing, retention, and resilience, as moral distress has been shown to predict burnout and workforce attrition (Maunder et al., 2023). Nurse moral distress measures the emotional strain nurses experience when unable to act according to their professional or ethical beliefs often heightened when communication with families is unclear or constrained by organisational barriers (Oldenmenger et al., 2024). Reducing moral distress can improve both nurse wellbeing and communication quality. Assessing these outcomes would therefore provide meaningful evidence of how well new communication practices enhance both family experiences and professional sustainability in Maltese ICUs.

Finally, given that participants in this research emphasised the difficulty of end-of-life communication, future research should evaluate simulation and mentorship-based training models focused on real-life communication scenarios, such as delivering bad news, discussing treatment withdrawal, and supporting families in distress. Evidence shows these approaches can strengthen nurses' ability to pace sensitive conversations, manage emotions, and communicate uncertainty with compassion (Peerboom et al., 2023). In this way, the findings of this Maltese study provide a foundation for intervention studies that can inform practice, education, and policy, ensuring that communication in the ICU becomes a consistently supported and evidence-based aspect of family-centred care.

6.7 Personal Learning Growth

Looking back on this dissertation, I recognise how much I have learned, both about communication in the intensive care environment and about the research process itself. Hearing the nurses' perceptions gave me a deeper understanding of the many dimensions of communication that go beyond simply providing information. I came to appreciate how nurses constantly balance honesty, empathy, and timing, often adapting their approach to meet each family's emotional state and level of understanding. Listening to their reflections helped me see communication as a dynamic and relational process, shaped by teamwork, workload, and institutional routines, rather than a fixed skill or one-way exchange.

From a research perspective, carrying out this project strengthened my appreciation for the discipline and reflection that qualitative work requires. Designing interview questions, managing data, and engaging in thematic analysis taught me the importance of organisation, transparency, and keeping an open mind. Maintaining an audit trail and reflecting regularly on my role as both a nurse and a researcher helped me understand how my background could influence interpretation and how to remain faithful to participants' voices.

Overall, this study has expanded my understanding of communication as both a professional responsibility and a human interaction. It has also enhanced my confidence in conducting independent research and my commitment to applying its lessons to future nursing practice and academic work.

6.8 Conclusion

The findings of this study make it clear that communication between ICU nurses and families in Malta is not a straightforward transfer of information but a deeply relational practice. Nurses occupy a pivotal position at the bedside, where they translate complex clinical realities into language families can grasp, while also offering steadiness in moments of fear and uncertainty. Yet this role is carried out under considerable strain, shaped by time pressures, inconsistent team messages, institutional rules, and the emotional toll of working at the intersection of life, illness, and loss. This research adds to existing knowledge by providing the first in-depth account of ICU nurse–family communication within the Maltese context, showing how local culture, language, and organisational conditions shape nurses' communicative roles and meaning-making with families.

Looking ahead, what is needed is not abstract theory but practical, workable changes. Ensuring that nurses have a defined place in family encounters, establishing routines for clear and empathetic updates, and creating unit structures that allow privacy, time, and organisational backing would go a long way toward improving family-centred care. Equally important is preparing nurses for the emotional and communicative complexity of these conversations through training that focuses on the "how" of dialogue, not only the "what." By taking these steps, ICUs can deliver communication that is reliable and humane for families, while also protecting and sustaining the nurses who shoulder this demanding work.

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Appendices

Appendix A

University of Malta's Faculty of Health Sciences Research and Ethics Committee Approval

L-Università ta' Malta

Andrea Mallia <andrea.mallia.11@um.edu.mt>

FHS-2025-00207 Andrea Mallia

Paulann Grech <paulann.grech@um.edu.mt> 22 May 2025 at 07:49
To: Andrea Mallia <andrea.mallia.11@um.edu.mt>
Cc: Research Ethics HEALTHSCI <research-ethics.healthsci@um.edu.mt>, Josef Trapani <josef.trapani@um.edu.mt>

Dear Andrea,

Thank you for the update. Your recent amendments have been reviewed and approval is granted on behalf of FREC.

Please make sure that the updated documents forwarded to FREC have also been uploaded on the URECA portal, without track changes.

You may continue with your data collection.

Good luck.

Best wishes,

Paulann

L-Università ta' Malta

Prof. Paulann Grech
Ph.D.(Sheffield), M.Sc.(Psych.), M.Sc.(Hlth.Sci.)

Chair/ FREC - Faculty of Health Sciences
Department of Mental Health
Faculty of Health Sciences
Room 59, Block A, Level 1
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Appendix B

Information Letter

L-Università ta' Malta

Information letter

03/18/2025

Dear **XXX**

My name is Andrea Mallia, and I am a student at the University of Malta, presently reading for a Master's in Nursing in Critical Care. I am conducting a research study for my thesis titled "ICU Nurses' Perceptions of Communication with Patients' Families: Roles, Facilitators, and Challenges." This study is being supervised by Dr. Josef Trapani. This letter is an invitation to participate in this study. Below you will find information about the study and what your involvement would entail, should you decide to take part.

The aim of my study is to explore ICU nurses' perceptions of communication with patients' families, including their role, key facilitators, challenges, and strategies for improvement. Understanding these perspectives is important as it can provide valuable insights into the complexities of nurse-family communication in ICU settings. Your participation would contribute valuable perspectives that can inform strategies for improving communication effectiveness. By sharing your experiences, you may also gain personal insights into communication practices while contributing to potential improvements in patient and family care. Any data collected from this research will be used solely for the purposes of this study.

Should you choose to participate, you will be required to take part in a semi-structured, face-to-face interview lasting approximately 45–60 minutes. The interview will explore your perceptions and insights regarding communication with patients' families in the ICU, including your role in these interactions, factors that facilitate or hinder effective communication, and potential strategies for improvement.

A follow-up interview may be required in some cases, but participation will be limited to a maximum of one additional interview if necessary. In this case, you will have the right to decline to take part in the second interview, even if you would have taken part in one interview.

Data collected will be treated confidentially and pseudoanonymized to protect participant identities. All interview recordings will be securely stored on an encrypted external hard drive, which will be kept in a locked, secure location when not in use. Transcriptions will be coded to remove any identifying information and stored on a password-protected computer. Identifiable data, such as consent forms, will be stored offline in a secure, locked cabinet. Access to the data will be restricted to the researcher only, and all data will be retained for the period required by university guidelines before being securely destroyed. Any material in hard copy form will be placed in a locked cupboard. Only my supervisor and myself (and in exceptional cases, examiners) will have access to this pseudo-anonymised data.

The findings that emerge from this research may be published (e.g., in a dissertation, academic journals) and/or presented (e.g., at conferences, meetings). Your name (or any other identifying information) will not appear when the findings are reported.

Participation in this study is entirely voluntary; in other words, you are free to accept or refuse to participate, without needing to give a reason. You are also free to withdraw at any time without providing any explanation and without any negative repercussions. Should you choose to withdraw, any data collected from your interview will be erased, as long as this is technically possible (for example, before it is anonymized or published).

If you choose to participate, please note that there are no direct benefits to you; however, it may help enhance understanding of nurse-family communication in the ICU and contribute to improving communication strategies in critical care settings. Your participation does not entail any known or anticipated risks.

Please note also that, as a participant, you have the right under the General Data Protection Regulation (GDPR) and national legislation to access, rectify and where applicable, ask for the data concerning you to be erased.

All data collected will be stored in a pseudo-anonymised form upon completion of the study and retained in accordance with the University of Malta's data protection and research ethics guidelines. The data will be securely erased following the retention period specified by the University's Records Management Policy and Research Ethics & Data Protection procedures

A copy of this information sheet is being provided for you to keep and for future reference.

Thank you for your time and consideration. Should you have any questions or concerns, you may contact myself or my supervisor on the details provided below.

Yours Sincerely,

Andrea Mallia
andrea.11.mallia@um.edu.mt

Dr. Josef Trapani
josef.trapani@um.edu.mt

Appendix C
Consent Form

L-Università ta' Malta

Participant's Consent Form

ICU Nurses' Perceptions of Communication with Patients' Families: Roles, Facilitators, and Challenges.

I, the undersigned, give my consent to take part in the study conducted by Andrea Mallia. This consent form specifies the terms of my participation in this research study.

1. I have been provided with written and/or verbal information about the purpose of the study. I have had the opportunity to ask questions, and any questions I had were answered fully and to my satisfaction.

2. I understand that my participation in this study is entirely voluntary. I am free to accept or refuse to participate without needing to provide a reason and without any penalty. I also understand that I have the right to withdraw from the study at any time without any consequences. Should I choose to withdraw, any data collected from me will be erased, as long as this is technically possible (for example, before it is anonymized or published). However, if erasing the data would make it impossible or seriously impair the achievement of research objectives, it will be retained in an anonymized form.

3. I understand that I have been invited to participate in a semi-structured, face-to-face interview, where I will be asked about my perceptions of communication with patients' families in ICU settings, including my role, key facilitators, challenges, and strategies for improvement. The interview will take approximately 45–60 minutes, and I understand that a follow-up interview may be required in some cases, but I have the right to decline to take part in the second interview, even if I would have participated in the first one. The interview/s will be conducted at a time and place that is convenient for me.

4. I am aware that, by marking the first-tick box below, I am giving my consent for this interview to be audio recorded and converted to text as it has been recorded (transcribed).

   ☐ I agree to this interview being audio recorded.
   ☐ I do not agree to this interview being audio recorded.

5. I understand that my participation does not entail any known or anticipated risks.

6. I understand that this research aims to provide valuable insights into ICU nurses' perspectives on communication with patients' families, helping to improve communication strategies, inform nursing education, and contribute to policies that enhance nurse-family interactions in critical care settings.

6. I understand that, under the General Data Protection Regulation (GDPR) and national legislation, I have the right to access, rectify, and where applicable, request the deletion of any personal data concerning me.

7. I understand that all data collected will be stored in an pseudoanonymized form and retained for the period required by university guidelines before being securely erased.

8. I am aware that my identity and personal information will not be revealed in any publications, reports, or presentations arising from this research.

9. I have been provided with a copy of the information letter and understand that I will also receive a copy of this consent form for my records.
   I have read and understood the above statements and agree to participate in this study.

Name of participant: _____

Signature: _____

Date: _____

Andrea Mallia
andrea.11.mallia@um.edu.mt
Contact number - 99031582

Dr. Josef Trapani
josef.trapani@um.edu.mt
[Supervisor's office number]

Appendix D
Interview Guide

L-Università ta' Malta

INTERVIEW GUIDE

Section 1: General Experiences with Family Communication

1. **What is your primary focus when communicating with patients and their families?"**

2. **In what situations do you typically communicate more with families? Do you find yourself communicating more during specific circumstances?**
(e.g., updates, emotional support, decision-making, end-of-life discussions)

    - *Probe: Are there situations where you feel more comfortable or more challenged?*

3. **Can you share any experiences where communication with a patient's family was particularly meaningful?**

    1. *Probe: What made it meaningful for you? How did it impact the family?*

Section 2: The Role of ICU Nurses in Family Communication

4. **What do you see as the ICU nurse's role in communicating with families?**
    - *Probe: How does this role compare with that of doctors and other healthcare staff?*
5. **How do you typically initiate communication with family members?**
    - *Probe: Do you wait for families to ask questions, or do you approach them first?*
6. **How do you balance providing medical information with offering emotional support?**
    - *Probe: Do you ever feel one aspect takes priority over the other?*

7. **Do you feel that family members understand your role in communication, or do they expect more/less from ICU nurses?**
    - *Probe: Have you ever been in a situation where a family member had unrealistic expectations about your role?*

Section 3: Factors That Facilitate Effective Communication

8. What factors do you think help make communication with families in the ICU more effective or easier?

- *Probe: Would you say effective communication depends more on clearly explaining the patient's condition and treatment, on building emotional connection with the family, or on both?*

9. Do you use any particular approaches or strategies to support understanding when communicating with families in the ICU?

Probes:

- *Can you describe any ways you try to help families understand the information you're sharing?*
- *If a family seems overwhelmed, emotional, or disengaged, do you find yourself changing how you communicate?*
- *Have you noticed whether certain approaches work better with some families or in particular situations?*

10. **Can you recall an instance where good communication led to a positive outcome for a family?**

- *Probe: Did it improve their understanding, reduce their stress, or help decision-making?*

Section 4: Challenges and Barriers in Communication

11. **Can you describe some of the biggest challenges you face when communicating with families in the ICU?**

- *Probe: Are these challenges more related to emotions, time constraints, or institutional barriers?*

12. **How do you handle situations where families struggle to process medical information?**

- *Probe: Do you break down complex information, use analogies, or involve other staff?*

13. **What do you do when families have unrealistic expectations about a patient's prognosis?**

- *Probe: Do you balance honesty with compassion in these discussions?*

14. **Have you encountered language barriers while communicating with families? If so, how do you manage them?**

- *Probe: Do you use interpreters, body language, or other techniques?*

15. **How do you approach communication with families in distress, denial, or grief?**

- *Probe: Do you adjust your tone, body language, or wording in such situations?*

16. **Have you ever been in a situation where a family disagreed with medical recommendations? How did you navigate that?**

- *Probe: Did you involve a senior colleague or mediator? What was the outcome?*

Section 5: Strategies for Improvement

17. **What strategies do you use to build trust and rapport with families?**

- *Probe: Are there specific words or actions that help establish trust?*

18. **Are there any tools or training programs that have helped you improve your communication skills?**

- *Probe: Have you had formal training in difficult conversations? Was it helpful?*

19. **How do you think the healthcare system could better support ICU nurses in communicating with families?**

- *Probe: Do you feel understaffing, stress, or lack of training impacts communication?*

20. **What advice would you give to new ICU nurses on effectively communicating with families?**

- *Probe: What lessons have you learned that you wish you knew earlier?*

Section 6: Closing Reflections

21. **Looking back on your experiences, what are some of the most important lessons you have learned about communicating with families in the ICU?**

- *Probe: Have your views on communication changed over time? If so, how?*
- *Were there particular situations that shaped how you communicate today?*

Q22: **Has communicating with families become easier or more difficult over time as you've gained more experience?**

Have changes in the ICU environment (e.g., policies, patient acuity, technology, staffing) affected how you communicate with families?

Appendix E

Reflexive Entries Related to Interviews During The Study

Reflexive Diary – Interview 2

After the second interview, I felt more confident and relaxed than during the first one. The participant was open and thoughtful, which made the conversation flow easily. I noticed my interview style improved, I was less rigid and allowed the participant more space to speak freely. I also made sure not to finish their sentences, which helped them share richer responses.

I responded more naturally this time, especially when the participant mentioned emotional aspects or working with doctors. I asked follow-up questions that encouraged deeper discussion, making the interview feel more like a real conversation.

However, when listening back, I noticed I still used too many verbal nods like “mm-hmm” and “very good.” Although meant to show engagement, these might influence how participants respond. I also sometimes repeated what they said, which could unintentionally change their meaning.

As an ICU nurse, I easily understood their workplace language and found myself silently agreeing. This reminded me that being an insider helps build trust but can also affect neutrality. I’ll stay aware of this in future interviews. Overall, I’ve learned to slow down, listen carefully, and let participants guide the discussion.

Reflexive Diary – Interview 3

This interview felt deep and emotional. The participant was very honest about their personality and the emotional strain of communicating with families. I felt more confident letting the conversation flow naturally and allowed longer pauses, which encouraged more openness.

Listening back, I realised I missed chances to ask follow-up questions, such as when they mentioned legal concerns about phone communication. Exploring this could have given more insight.

The participant's reflections on the emotional impact on nurses reminded me of my own experiences. I managed to stay neutral but recognised how easily personal feelings can surface. Staying aware of this will help during analysis.

The interview was rich but sometimes jumped between themes like workload and emotions. I stayed focused to keep the conversation clear. This experience reinforced that my role is to listen, not lead. Next time, I'll work on asking more thoughtful follow-up questions and staying grounded during emotional topics.

Reflexive Diary – Interview 4

This interview gave valuable insights into communication during end-of-life care. The participant explained how nurses often clarify what doctors say and support families emotionally afterward. Their examples helped me understand the deeper emotional side of communication in the ICU.

I felt more confident and avoided interrupting. I also reduced verbal affirmations, though I still sometimes repeated points to show understanding. I'll try to limit this to avoid changing meaning.

The participant often compared nurses and doctors, and I had to resist agreeing since it reflected my own experience. Staying silent but aware helped me remain objective. The emotional stories reminded me of my own memories, but I stayed focused on the participant's experience.

Reflexive Diary – Interview 5

This interview was emotional yet balanced. The participant highlighted that families remember how nurses make them feel more than what is said, which deeply resonated with me.

I managed the pacing well, letting the participant speak fully. My follow-up questions felt meaningful and helped keep a natural flow. However, I avoided exploring sensitive comments, such as differences among relatives, because I didn't want to sound judgmental. I hope to handle such moments more confidently in future.

I also noticed how closely my values matched the participant's views. While this connection helps understanding, it can affect objectivity during analysis. I'll stay mindful of that. Overall, the interview reinforced the importance of empathy, listening, and presence in ICU communication.

Reflexive Diary – Interview 6

This interview was emotionally intense, especially when the participant spoke about organ donation and distressed families. Their story about a young boy was very powerful, and I had to manage my emotions carefully.

The participant felt comfortable and open, likely because trust was built early. I avoided overusing affirmations and allowed space for reflection, which resulted in deeper insights.

I found myself silently agreeing again, especially when they discussed the lack of emotional support for nurses. Staying reflexive helped me keep a balanced perspective. The participant's strategies; like adjusting communication to family understanding and using small talk to build rapport showed how experience shapes effective communication.

Reflexive Diary – Interview 7

This interview had a relaxed, conversational tone. The participant spoke in simple, genuine language, focusing on empathy and being emotionally present. Their reflections reinforced ideas seen in earlier interviews but from a very practical viewpoint.

I felt comfortable letting them lead the discussion and avoided interrupting or rephrasing, which helped keep their voice authentic. I also noticed I agreed with their statement that "communication is just as important as an intervention," but reminded myself to stay analytical, not emotional.

The participant mentioned that most nurses learn communication informally rather than through training. This echoed what others said and revealed an important pattern in the data. The interview showed how flexibility and tone are key to effective communication with families.