Australian Critical Care 38 (2025) 101295

Contents lists available at ScienceDirect

Australian Critical Care

journal homepage: www.elsevier.com/locate/aucc

Research paper

Improving satisfaction with intensive care nursing: Perspectives of nurses and patients

Marta Romero-García, RN, PhD [a, b, c], Pilar Delgado-Hito, RN, PhD [a, b, c, *], Llúcia Benito-Aracil, RN, PhD [a, b], Elisabet Gallart Vivé, RN, PhD [d, e], Rocío Tabernero-Gallego, RN, MSc [d, e], M. Pilar Muñoz-Rey, RN, MSc [f, g], Laura Martinez Rodríguez, RN, PhD [a], Isidro Alcalá-Jiménez, RN, PhD [d, e]

[a] *Fundamental and Clinical Nursing Department, Faculty of Nursing, University of Barcelona, Barcelona, Spain;* [b] *IDIBELL, Bellvitge Biomedical Research Institute, Avinguda de la Granvia, L'Hospitalet de Llobregat, Spain;* [c] *International Research Project: HU-CI Project, Collado Villalba, Spain;* [d] *Intensive Care Unit, Hospital Vall d'Hebrón, Barcelona, Spain;* [e] *VHIR, Vall d'Hebron Institut de Recerca, Spain;* [f] *Hospital Universitario Germans Trias i Pujol, Barcelona, Spain;* [g] *Nursing Research Group (NURECARE-IGTP), Instituto de Investigación Germans Trias i Pujol, Spain*

ARTICLE INFORMATION

Article history:
Received 14 September 2024
Received in revised form
8 May 2025
Accepted 3 June 2025

Keywords:
Patient satisfaction
Nursing care
Critical care
Qualitative nursing research
Strategies
Phenomenological study
Nurses

ABSTRACT

Background: Interest in measuring patient satisfaction as an indicator of the quality of nursing care has led to the development of various measurement instruments. However, to date there are no studies that propose multidimensional strategies to improve satisfaction with intensive care nursing from the perspective of both nurses and patients.
Objectives: The objective of this study was to describe strategies to improve satisfaction with nursing care identified by nurses and critically ill patients.
Methods: This was a qualitative descriptive study. This multicentre study was conducted in intensive care units in Spain. The population consisted of discharged patients and critical care nurses, and the sample was recruited using convenience sampling. Four online focus groups were held with patients and nurses until theoretical saturation of the data was reached. The focus groups were led by a moderator, recorded on video after obtaining informed consent, and then transcribed. Next, content was analysed, and the information was triangulated. Guba and Lincoln's criteria of trustworthiness and authenticity were followed.
Results: The strategies identified were (i) strategies for holistic care; (ii) strategies related to forms of communication; (iii) strategies related to professional behaviours; and (iv) strategies related to the infrastructure of the unit. The most frequently mentioned strategies were continuously monitoring pain, documenting pain, promoting patient autonomy, fostering patient privacy, showing empathy, listening attentively, using medication for rest, meeting recreational needs, using simple language, making eye contact, receiving communication training, practicing interdisciplinary communication, and using clinical judgement. Reporting complied with Consolidated Criteria for Reporting Qualitative Research.
Conclusion: Nurses and patients identified similar strategies to improve satisfaction with the nursing care received during intensive care unit admission. Implementing and evaluating the identified strategies will support the ongoing improvement of humanised care, driven by the commitment of healthcare professionals.

1. Introduction

Patient satisfaction with nursing care is the most significant indicator of overall satisfaction with hospitalisation and plays a crucial role in health maintenance and rehabilitation.[1,2] Therefore, patient satisfaction with nursing care has emerged as a key determinant of the quality of hospital care.[3,4] In intensive care units (ICUs), patients consider satisfactory nursing care to be that which arises from a combination of humanistic and technical perspectives, in which humane treatment is directly linked to evidence-based care.[5,6]

Critically ill patients require holistic care in which not only biological, physical, and emotional needs but also those linked to

* Corresponding author.
E-mail address: pdelgado@ub.edu (P. Delgado-Hito).

https://doi.org/10.1016/j.aucc.2025.101295

their experiences, values, beliefs, and culture are addressed.[7] The use of technology and personalised care should support physical safety as well as psychological, spiritual, social, human, and ethical well-being, drawing on a holistic understanding of the person.[5,8,9] Therefore, nurses working in an ICU must acquire all the competencies that allow them to treat the patient in light of their subjective realities.[10]

In the 1970s and 1980s, the concept of patient satisfaction was conceived from the point of view of professionals. In this sense, healthcare professionals assumed that they understood what satisfied patients, relying on professional standards and assessments that may not align with patients' priorities. As a result, patients' own views on what truly satisfies them have often been overlooked or unknown.[5,11]

This perspective changes when we understand the person as an active participant in their own health rather than a mere object of care. In this regard, in 1998, the World Health Organization recognised that the patient's opinion is an aspect of consumer participation in care. If the primary goal of healthcare delivery is to meet the needs of the healthcare consumer, it is essential to tailor the service to their genuine needs, expectations, and priorities. To do so, we must understand their opinions, attitudes, and experiences.[3] We follow the Beryl Institute[12] in defining the patient experience as the sum of all interactions—shaped by an organisation's culture—that influences patient perceptions across the continuum of care.

The concept of satisfaction is complex and multidimensional.[5,11–13] In this context, Kitson[13] presents three dimensions of fundamental care: establishing the nurse–patient relationship, integrating fundamental care into the patient's care plan, and ensuring that the setting or context where care is provided and coordinated is conducive to achieving person-centred care and family-centred outcomes. Person-centred care is defined by the Australian Commission of Safety and Quality in Health[14] as care that respects and responds to the preferences, needs, and values of healthcare consumers as a foundation for safe, high-quality health care.

In terms of satisfaction, Romero-García et al.[5] define four dimensions of care through the Multifactorial Model of Nursing Intensive Care Satisfaction. The four dimensions are holistic care, forms of communication, professional behaviours, and consequences (experiences of and feelings about the nursing care received). The provision of individualised care improves the quality of life and satisfaction of patients, fosters their autonomy, and enhances the quality of care.[15] The interest in measuring patient satisfaction as an indicator of the quality of nursing care has led to the development of different instruments both nationally and internationally. Studies show that patient satisfaction with nursing care is the aspect that best predicts satisfaction with the hospital stay, which is itself an important component in the maintenance and restoration of the patient's health.[16,17]

In recent years, scholars have begun to study patient satisfaction in ways that take the patient's perspective directly into account. Studies by Hummel et al.[18] and Antonio et al.[19] focus on the importance of communication between the nurse and the patient. Antonio et al.[19] propose strategies to improve patient satisfaction through education in communication skills for nursing staff, and Jover-Sancho et al.[20] add aspects related to the holistic view of the person and professional behaviours.

The scientific literature shows studies focussed on the satisfaction of the patient in ICUs. Several studies[5,20–23] describe holistic nursing care or specific forms of communication that are related to patient satisfaction, such as trust, personal hygiene, respect, teamwork, pain management, technical skills, and attentiveness, among others. Hernández et al.[22] focus solely on nursing care related to the forms of communication that intervene in patient satisfaction, such as knowing how to listen, being approachable, explaining what is going to be done, and practicing good interdisciplinary communication, unlike other studies, such as those by Romero-García et al.[5] and Jover-Sancho et al.,[20] which describe aspects beyond communication. In contrast, Dikme[23] links satisfaction solely to psychoemotional aspects such as active listening, being attentive, and being able to empathise.

A literature review carried out by Ahmed et al.[24] highlights the need to understand the satisfaction of hospitalised patients as multidimensional. The articles analysed in the review highlight strategies such as nurse attitude, punctuality, emotional support, respect, smiling, patient participation in care, and effective communication. To a lesser extent, we find articles that address the aspects that nurses believe are involved in patient satisfaction during hospital admission. Studies such as those by Mehta et al.[25] focus on the worst period of the COVID-19 pandemic, describing the possible alteration in patient satisfaction that occurred when introducing protection and isolation measures that interfered with nurse–patient communication, health professionals' fear of infection, lack of protocols or changing protocols, use of technology in communication with family members, and restrictions in physical contact.

Finally, there are studies detailing strategies to improve the quality of care for critically ill patients in relation to family participation,[26] emotional support and comfort,[27] and pain management,[28] among others.

In sum, we identified a range of studies addressing specific aspects of patient satisfaction with nursing care and improvements in care for the critically ill. However, we identified no studies that focus on the multidimensional nature of satisfaction in critically ill patients with respect to nursing care. This study fills this gap in the literature.

2. Objective

The objective of this study was to describe the strategies for improving satisfaction with nursing care identified by nurses and critically ill patients.

3. Methods

3.1. Design

This study is part of a larger mixed-method project using a two-phase sequential explanatory design.[29] Phase I involved a quantitative assessment of critically ill patients' satisfaction and its association with sociodemographic, clinical, and organisational variables.[6] Phase II, reported here, is a qualitative, exploratory, multicentre study with a descriptive and interpretive design,[30] following the COnsolidated criteria for REporting of Qualitative studies-32 guidelines. The study adopts a constructivist paradigm,[31] which views reality as a collection of diverse mental constructions shaped by individual experience and context. In this framing, knowledge is coconstructed through the interaction between researcher and participant and interpreted through hermeneutic analysis.

3.2. Study setting and recruitment

The study was carried out in eight medium- and high-complexity university hospitals in Spain (Table 1) between January and March 2022. The specific context consisted of eight multipurpose ICUs with single beds and a nurse-to-patient ratio of 1:2.

The patients who took part in the study had the following characteristics: (i) over 18 years of age; (ii) admitted to the ICU for at least 48 h; (iii) verbal consent after the explanation of the study;

(iv) able to speak, read, and write in Spanish; and (v) oriented to person, place, and time. The orientation of recruited patients was assessed in person for those who were still admitted to the hospital and via telephone for those who had already been discharged. Participants were chosen by means of nonprobabilistic convenience sampling until theoretical saturation of the data was achieved among those discharged from any of the eight participating ICUs, starting in January 2022 (Table 2).

We recruited nurses at meetings held during different shifts, in which we provided them with written information about the study objectives. Those interested in participating sent information regarding their age, years of experience in the ICU, and work shift via email. The nurses who took part in the study had the following characteristics: (i) experts in the care of critically ill patients with a minimum of 5 years of experience in the ICU and (ii) gave informed consent. The nurses were selected using nonprobabilistic convenience sampling until theoretical data saturation was achieved (Table 3).

3.3. Data collection

Data were obtained through online focus groups,[32] using the Teams application. Participants received a link via email to connect to the focus group 24 h before the established start time. In total, four focus groups were conducted—two with nurses and two with patients—each consisting of five to seven participants and lasting approximately 1 h. The groups of nurses were constructed for heterogeneity across the different work shifts and public and private hospitals.

At the beginning of each focus group, patients completed a questionnaire to find out their sociodemographic profile (age, sex, marital status, level of education, and hospital of admission), and nurses completed a questionnaire covering their socio-occupational profile (age, sex, care profile, years of experience in the ICU, training, work shift, type of ICU, hospital level, and hospital type). All groups were moderated by an expert female author with experience in this data collection technique accompanied by a novice male author as observer. Neither worked at any of the ICUs under study.

Table 4 presents the open-ended script used in the four focus groups. The purpose of the script was to encourage participants to express their perspectives in relation to the nursing care provided or received. All questions were included by consensus of the research team and supported by the existing literature.[33]

The sessions were recorded in both video and audio formats to ensure the reliability of data transcription. Notes were taken by the observer in a field diary. The transcripts were returned to the participants to confirm or correct the content.

3.4. Data analysis

Speech from the focus groups and the field diary was transcribed verbatim, and we performed a content analysis of it using NVivo 12 (QSR International. (2022). NVivo (Version 12.6.1, 2021). Lumivero. This approach is suitable for analysing and categorising qualitative data based on empirical or theoretical criteria.[30] All data obtained from focus groups and diaries were recorded word for word. Once the participants confirmed the authenticity of the transcript (content verification), the text was segmented into descriptive codes assigned purely according to their semantic content. In the second stage, these codes were grouped into more analytical subcategories, according to the meaning of the linguistic units and their combinations. In this way, the third hierarchical stage was reached, in which the subcategories were classified according to the purpose of the study, based on the semantic analysis. The data analysis was performed jointly by two researchers in the first phase of data coding and independently during the subsequent analysis. Finally, a comparison of the findings obtained was conducted until a consensus was reached on the analysis.

Table 1
Description of participating hospitals.

Hospitals	Level	Private	No. of beds	Number of ICU beds
H1	III	No	404	18
H2	III	No	516	46
H3	III	No	1146	56
H4	III	No	831	56
H5	II	No	400	14
H6	II	Yes	172	10
H7	II	No	385	12
H8	II	No	402	18

ICU: intensive care unit.

3.5. Ethical considerations

During the study, national and international guidelines and legal regulations on data confidentiality were followed (Organic Law 3/2018 of 5 December on the Protection of Personal Data and Guarantee of Digital Rights). The directors of the participating hospitals and the ethics committee of Hospital del Mar approved the protocol (Code nº2018/7818/l dated 21 February 2018). Regarding the ethics of the participation process, the individuals voluntarily agreed to participate and signed the informed consent form after receiving oral and written information related to the study and its objectives. To preserve the confidentiality of the study participants, alphanumeric codes were used (N for nurses and P for patients). Only the research team had access to the password-protected database; no personal data appeared in the reports to avoid the identification of patients.

3.6. Rigour and reflexivity

Guba and Lincoln's[31] criteria of reliability and authenticity were applied. To give credibility to the study, we have provided a detailed description of the participants and the context. The privacy of patients who were still admitted to the hospital was ensured so that they would not feel pressured to respond in a certain way. The data were recorded in audio and video formats so as not to miss any details. Finally, transcripts were verified by the participants, and the data analysis was triangulated across two researchers. In cases of disagreement, a third researcher was consulted.

4. Findings

4.1. Characteristics of participants

There were 25 participants in the study (11 patients and 14 nurses). Of the 11 patients, eight were men and three were women, with a mean age of 59.54 years (min: 31; max: 79). Of the 14 nurses, 11 were women. The mean age was 38.28 years (min: 27; max: 53), and the mean ICU experience was 11.64 years (min: 5; max: 25). In terms of work shifts, five of the nurses worked during the day, three at night, and six on a rotating shift.

4.2. Thematic findings

Strategies to improve critically ill patients' satisfaction with nursing care are organised into four inter-related themes, all important for both patients and nurses. Specifically, strategies for

Table 2
Sociodemographic profile of the participating patients.

Identification	Age	Sex	Marital status	Education level	Hospital	Hospital level
P1	57	F	Married	University	H4	III
P2	61	F	Married	EGB	H4	III
P3	49	M	Married	Baccalaureate	H5	II
P4	70	F	Widow	No studies	H4	III
P5	31	M	Unmarried	Student	H1	III
P6	57	M	Married	ESO	H4	III
P7	66	M	Widower	EGB	H5	II
P8	67	M	Married	Student	H4	III
P9	46	M	Married	Baccalaureate	H4	III
P10	79	M	Married	EGB	H4	III
P11	72	M	Married	University	H5	II

Note: EGB is an educational level typically finished at age 13–14 years under Spain's previous education system. ESO is a level typically finished at age 15–16 years and is the culmination of obligatory schooling in Spain's current system. Baccalaureate is an optional 2-year college preparatory level typically finished at age 17–18 years. Level II hospitals have specialities including general surgery, gynaecology, anaesthesiology, and internal medicine. Level III hospitals are equipped with advanced technology and offer highly specialised care, covering areas such as cardiology, dermatology, psychiatry, neurology, and nephrology.

Table 3
Sociodemographic profile of the participating nurses.

Identification	Age	Sex	Years in nursing	Years in the ICU	Contract	Shift	Hospital	Hospital level
N1	30	F	09	06	Interim	Rotating	H4	III
N2	31	F	07	06	Permanent	Rotating	H6	II
N3	45	F	19	18	Interim	Day	H3	III
N4	45	F	23	21	Interim	Night	H8	II
N5	28	F	07	07	Interim	Day	H1	III
N6	51	F	28	25	Permanent	Rotating	H5	II
N7	37	F	15	15	Interim	Night	H1	III
N8	40	F	08	08	Permanent	Night	H1	III
N9	53	F	14	14	Permanent	Day	H4	III
N10	41	F	15	10	Permanent	Rotating	H2	III
N11	41	M	20	14	Interim	Day	H7	II
N12	27	F	05	05	Permanent	Rotating	H6	II
N13	37	M	17	08	Interim	Day	H4	III
N14	30	M	09	06	Interim	Rotating	H7	II

ICU: intensive care unit.

Table 4
Interview script for study participants.

Presentation	Hi! How's it going? I would like to thank you personally and also on behalf of the entire research team for your valuable collaboration. [For patients]: All of you present here are individuals who have recently been hospitalised in an intensive care unit. Each of you has your own experience and knowledge regarding the hospitalisation you have undergone, so the aim of this focus group is to identify strategies to improve the quality of nursing care in intensive care units. [For nurses]: Each of you has professional experience and knowledge as the professional who spends the most time with the patient in intensive care units. This focus group aims to identify strategies to improve the nursing care received by patients during their stay in an ICU.
Framework	As you can see, this is a focus group in which various people participate remotely. The duration will be approximately an hour to an hour and a half. However, we will use just the right amount of time needed so that no one feels uncomfortable or tired. To ensure that no detail of the conversation is missed, it will be recorded in both audio and video, as previously discussed.
Opening question	I will ask you a few broad questions so that you can freely express your opinion. To start, I will pose an initial general question to set the stage, and then we will delve into different topics. Drawing from your experience, let's begin with a very general question and later focus on other issues: (1) What should an intensive care unit have in order to offer excellent nursing care? (2) What aspects/strategies related to nursing care provided/received during hospitalisation can be improved?

holistic nursing care encompass physical care strategies and psychoemotional and spiritual care. Strategies related to forms of communication include both verbal and nonverbal communication. Strategies concerning professional behaviours cover teamwork and scientific–human skills. Finally, strategies to improve unit infrastructure involve the physical structure, human resources, and unit policies (Fig. 1.) In this section, we present the themes along with their associated categories and subcategories.

4.2.1. Strategies for holistic nursing care

This category groups the subcategories that are related to strategies aimed at improving physical care and psychoemotional and spiritual care.

4.2.1.1. Physical care strategies. The strategies identified by participants in this subcategory are related to pain management, hygiene and hydration, and sleep and rest.

Strategies to improve pain management include pain monitoring and recording, the use of validated scales and training, and postanalgesia assessment. **Pain monitoring and recording** was discussed as follows:

> *"(…) It's a problem of documentation rather than assessment. I consider that all of my colleagues manage pain correctly, but we fail when it comes to documenting it" (Nurse 1).*

> *"(…) So I believe it's essential to have that control and ensure they don't experience pain at any time, meaning, trying to administer it*

quickly, in short intervals, every 2 hours or every 3 hours, asking the patient about the pain; everything is fundamental (…)" (Nurse 4).

"(…) The nurses paid a lot of attention to you. They constantly asked you: 'What hurts?' You see? (…)" (Patient 6).

"Yes, because it gave me a lot of confidence in them. Of course, they explain to you at all times what they're going to do, and they continuously ask if I'm in pain" (Patient 9).

Regarding the **use of validated scales**, a nurse stated that

"(…) scales are used for patients. For example, for those who are awake, we use scales like VAS or scales like ESCID in patients who are sedated (…)" (Nurse 4).

In addition, some participants mentioned **training in the use of scales**:

"(…) The training that we said before, especially in the use of the scales, there are lots of mistakes when it comes to knowing how to correctly assess or use these scales and sometimes it's due to lack of training (…)" (Nurse 1).

Finally, nurses and patients described the **postanalgesia assessment**, as seen in these examples:

"(…) So the assessment before administering analgesia and after administering analgesia normally doesn't get done" (Nurse 1).

"(…) Even after giving me the medication, they would ask me about the pain" (Patient 10).

Secondly, the strategies to improve hygiene and hydration identified in the participants' talk include promoting patient autonomy and their participation in care, favouring privacy, and providing comprehensive assessment. **Promoting patient autonomy/participation in care** was described as follows:

"(…) They are aware and independent for certain things, to wash their faces, to be able to brush their teeth, and even to wash their genitals. Sometimes we start doing things and we forget about their autonomy as we chat between one thing and another (…)" (Nurse 5).

Patient privacy would be improved with bathrooms in the unit, as reported in the following examples:

"(…) A bathroom for patients who, if they can get up, because we don't have a bathroom and the poor things have a terrible time and say, 'But do I really have to go in the bedpan?'" (Nurse 12).

"There is a lot of normalisation of the situation; they don't expose you; they cover you, they protect you. Well, I felt comfortable (…)" (Patient 1).

Taking advantage of the moment of bathing to carry out a **comprehensive assessment** is essential:

"The moment of grooming is essential for us to conduct a comprehensive examination of the patient's body and see what points they may have that are susceptible to forming sores (…) and make them an active part of the care" (Nurse 2).

Ultimately, in relation to the strategies identified for promoting sleep and rest, participants highlighted the clustering of nursing interventions, regulation of light and noise levels, the use of earplugs, and pharmacological measures to facilitate sleep. Concerning the clustering of care activities, one participant noted

"(…) I believe it's crucial that as professionals, we ensure that during a time frame that can be from 11:30 pm or midnight until 6 or 7 in the morning, we minimise techniques and care tasks" (Nurse 2).

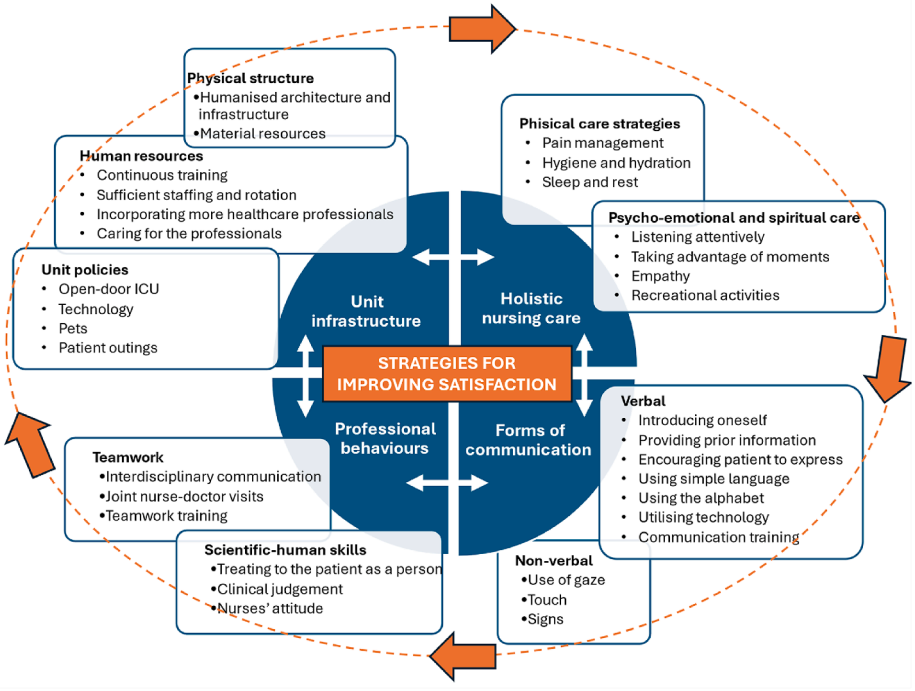

Fig. 1. Relationships between categories, subcategories and emerging codes. ICU: intensive care unit.

Managing the intensity of light and noise was described by participants in the following ways:

"(…) I believe it's crucial to lower the intensity of the lights, to talk in separate areas so as not to disturb them (…)" (Nurse 2).

"(…) They respected me a lot, they spoke very softly so as not to bother me at night (…)" (Patient 9).

Nurses provided **earplugs**:

"(…) We have earplugs that we give to them. They are offered these [earplugs] that are made out of foam rubber to try to promote sleep (…)" (Nurse 12).

Finally, participants described the **use of sleep aids:**

"(…) At night, it was terrible, and I made the decision to take pills early in the evening to be able to sleep because otherwise, I wouldn't sleep all night: my nerves would attack me" (Patient 2).

"*(…) If possible, we should add the use of painkillers or some type of sedative or sleep inducers that encourage rest (…)*" (Nurse 2).

4.2.1.2. Strategies related to psychoemotional and spiritual care. Participants identified the following strategies for improvement: listening attentively, taking advantage of moments in which patients decide to express themselves, employing empathy, and offering recreational activities.

Listening attentively was described as follows:

"(…) Talking to the patient, listening to them, that is, attending to what the patient is really worried about. Normally we're always on the run and we don't stop to talk a little with the patient, to listen to them, to see what they really need (…)" (Nurse 4).

The nurses also emphasised **taking advantage of moments when patients expressed themselves**:

"(…) Taking advantage of the moment when the patient wants to talk to us or tell us something or communicate something. I mean taking time out and ensuring that there are good conditions between the patient and the nurse to make sure that both verbal and nonverbal communication is the best possible (…)" (Nurse 2).

Also, both nurses and patients highlighted the importance of **empathy**:

"(…) Having empathy for the patient, right? (…) There are times when they lose control. [You have to] have a lot of patience when it comes to addressing the problem they have and try to be a psychologist with respect to the problems they may have at that moment" (Nurse 4).

"A lot of nurses put themselves in your shoes and tried to find a solution, you know? As if they were unwell themselves (…)" (Patient 1).

Finally, nurses and patients agreed on the need to offer **recreational activities** during ICU admission:

"*(…) Or even if the patient reads a book, something, talk to the patient and find out what they need, music or whatever they ask for and talk to the family so that they can facilitate that type of thing (…)*" (Nurse 7).

"*(…) "From there they asked me, 'Do you want to watch movies? Do you want to listen to music?'" I went like this, giving them a thumbs up, and they put on some music for me (…)*" (Patient 6).

4.2.2. Strategies related to forms of communication

Strategies related to forms of communication included verbal communication and nonverbal communication.

4.2.2.1. Strategies related to verbal communication. The strategies identified by the participants to improve verbal communication include introducing oneself, providing prior information, encouraging expression when the patient wants to talk, using simple language, using the alphabet, utilising technology, and receiving communication training.

Nurses and patients stressed the importance of **introducing themselves**, saying

"*(…) When we address a patient for the first time or start the shift, 'Good morning, Antonio, I'm Juana and I'm going to be your nurse this morning'. Let him have a name, a reference (…)*" (Nurse 2).

"*(…) The nurse would arrive first and introduce herself to you: 'Look, my name is such and such, I'm going to be your nurse today (…)'*" (Patient 6).

Second, they also detailed the importance of **giving prior information** before any nursing actions are taken. In this sense, nurses and patients agreed.

"(…) *Telling them what we're going to do, what we're going to administer to them since they often feel disoriented within the unit, they don't know their progress, what's happening to them, or what is being administered to them (…)*" (Nurse 6).

"*(…) They explained to me before doing something so that I could understand what actions are going to be done, so that I can be calmer and feel secure. In my case, I felt very safe being there (…)*" (Patient 12).

Thirdly, strategies were identified to answer questions and promote communication, such as the need to encourage patients to express themselves, the use of simple language, the use of the alphabet, the use of technology, and communication training. **Encouraging patients to express themselves** was described as follows**:**

"(…) Make it easier for them to express their emotions, if they're afraid, if they're sad, if they're happy, if they're angry … understand that sometimes you get into topics that are a bit complicated, but they need it (…)" (Nurse 3).

"(…) The moment is when they want, when they feel like it, when they see us passing, when they tug on our uniform, because at that moment we know how to recognise it, and we're able to put aside other things and focus on what they want to tell us" (Nurse 2).

As for **using simple language**,

"(…) Adapting our message according to the interlocutor in front of us, I think it's also important (…)" (Nurse 3).

"(…) An older person, because perhaps things should be explained to them in a way that is more understandable, simpler. Each person is different, but the language has to be simple (…)" (Nurse 12).

"(…) And they explained things to me in a simple way" (Patient 7).

Nurses and patients also detailed the benefits of **using the alphabet**:

"(…) Sometimes to communicate you only need something simple, a few sheets of paper with the alphabet, with drawings and numbers, I don't know, things like that (…)" (Nurse 1).

"(…) They gave me a piece of paper, with an alphabet, with the alphabet put there so that I could spell letter by letter, and the letters formed what I wanted to say (…)." (Patient 6).

Using technology was also highlighted:

"(…) So in the ICU, we use a system with the nonverbal communication tablet that uses a face, with [pictures of] people, with a 'yes', with a 'no' and then in patients, especially those who are on mechanical ventilation, who find it more difficult to communicate, it makes it much easier for us to communicate with the patient (…)" (Nurse 3).

Finally, they detailed the need for **communication training**:

"(…) We have a "support unit", it's called, which consists of other nursing colleagues who have more resources, strategies, training, and communication skills. So if we see that someone needs additional help in difficult moments or for something important, we alert these colleagues. (…)" (Nurse 5).

4.2.2.2. Nonverbal communication strategies. The strategies identified by the participants to improve nonverbal communication are related to the use of gaze, touch, and signs.

Patients grasped the nurses' **use of the gaze** and its meaning:

"(…) They transmitted confidence to you, their gestures, how they looked me in the eyes when it came to telling me things and you thought, 'It's all right; he's telling me with his eyes' (…)" (Patient 4).

"(…) When the nurse passes by and looks at you, you know that things are going to be okay. The look is everything. They don't have to take off their masks for you to be able to see their faces (…)" (Patient 8).

Nurses described the importance of the **use of touch:**

"(…) Just having contact by putting a hand on them, holding their hand, gives them a lot of security, much more than the words you say (…)" (Nurse 14).

"(…) They held my hand, touched me, told me not to worry, that nothing bad was going to happen to me. That reassured me (…)" (Patient 5).

Finally, with regard to the **use of signs** during the hospital stay:

"(…) With the pandemic, due to the issue of the mask, communication is very complicated, well, you can use your hands and such, but it's very complicated because we don't see each other's mouths" (Nurse 4).

4.2.3. Strategies related to professional behaviours

In this category, participants identified strategies related to teamwork and scientific–human skills.

4.2.3.1. Teamwork strategies. The strategies to promote teamwork include interdisciplinary communication, joint nurse–doctor visits, and teamwork training.

Both nurses and patients stressed the importance of **interdisciplinary communication**:

"(…) Having good communication of information between the different professionals and a good working environment, good transmission of information (…)" (Nurse 2).

"(…) Everyone has to work as a team. In fact, I saw them holding meetings in the morning to organise the day a bit (…)" (Patient 12).

The need for **joint nurse–doctor visits** was described as follows:

"(…) When a doctor informs the family with the patient in front of me, I always try to be with them, mostly to know exactly what information they have about the current state (…)" (Nurse 3).

Finally, **training in teamwork** was described as follows:

"(…) This year, we did something like hypothetical cases … and then all the staff participated: The trainers would give you a case and explain the situation, and then you realise that if you work as a team, everything works better (…)" (Nurse 7).

4.2.3.2. Strategies to enhance scientific–human skills. The strategies identified to enhance scientific–human skills include treating the patient as a person, clinical judgement, and attitude.

The importance of **treating the patient as a person** was manifested in the following words:

"*(…) Treating the patient really as what they are, a person, a human being, not a number, a pathology, an organ. Call them by their name, not by their illness (…)*" (Nurse 2).

"Treating me as the person that I am is fundamental" (Patient 6).

As for the use of **clinical judgement,** one nurse said,

"(…) Anticipating [their needs]. Often they won't ask us, but often we need to anticipate those problems they have" (Nurse 4).

"(…) They anticipate, they stay a step ahead by analysing the situation" (Patient 11).

Finally, they highlighted the **nurses' attitude**:

"(…) It's important to monitor what we communicate, how we express ourselves, and what we say, right? The image we convey to them or the impression they have of working with serious and trustworthy people, rather than with those who are sometimes a bit more careless, well, I think that's important" (Nurse 8).

4.2.4. Strategies to improve unit infrastructure

Strategies identified by participants to improve the unit's infrastructure include addressing the physical structure, human resources, and the unit's policies.

4.2.4.1. Strategies for improving the physical structure. Strategies to improve the physical structure include humanised architecture and infrastructure and material resources.

The need for **humanised architecture and infrastructure** was related as follows:

"(…) To have a unit with a good architectural structure that allows you to have enough space and work with tranquillity" (Nurse 2).

"(…) We have a newly refurbished, circular ICU that allows us to see all patients from anywhere. This is also important for their care" (Nurse 9).

"(…) The structure of the ICU undoubtedly results in better or worse care for the patient" (Nurse 10).

"(…) They put up photos to encourage me" (Patient 12).

Regarding the strategies related to material resources, the participants stated the following:

"(…) *Dynamic mattresses have come a long way and nowadays, it's much more difficult for patients to develop pressure ulcers. Having quality resources greatly benefits daily care (…)*" (Nurse 4).

"*(…) I believe that the material aspect is important, having state-of-the-art beds that allow you to move on your own and avoid getting bedsores (…)*" (Patient 11).

4.2.4.2. Strategies for improving human resources. Strategies to improve human resources involve continuous training; sufficient staffing and rotation; the incorporation of psychologists, physiotherapists, and a nurse of reference; and caring for the professionals.

In relation to strategies to improve human resources, the need for **continuous training** was detailed as follows:

"(…) Continuous training means that the whole team has the same knowledge about a subject, which helps the team and improves care a lot" (Nurse 14).

"(…) Good continuous training of all staff, both new and veteran" (Nurse 3).

In the same way, **staffing and rotation** were mentioned:

"(…) What I see is that there are too few people for the number of patients, (…) to be able to attend to all of them properly" (Patient 1).

"(…) There's a need for more personnel resources. We have more and more work, but the staff is always the same, and if we want to ensure humanised care and give a more humane service to our patients, sometimes we're overwhelmed with our workload (…)" (Nurse 1).

Participants mentioned the **need to incorporate psychologists, physiotherapists, and a nurse of reference**:

"(…) Including professionals who would work with us and be part of the team. Having a physiotherapist in the ICU would allow patients to be discharged faster; they would be up and moving earlier, and in the end, the health system would save money (…)" (Nurse 7).

"(…) Now we have a psychologist who has been put in the ICU, and the truth is that he comes to see patients who are going through a very difficult stage and encourages them and tries to give them tools to cope with their stay in the ICU (…)" (Nurse 12).

"Yeah, I mean they give it to you, they put your cream on when they bathe you, but what I mean is something more professional, something more like a physiotherapist" (Patient 9).

Some mentioned the need for a **nurse of reference** in the ICU:

"(…) It's important for there to be a reference person to ensure that quality care is provided (…)" (Nurse 2).

"In my case, I logically had the nurse assigned to each shift, and I always had the same one from each shift, so the experience was very positive" (Patient 7).

Finally, the importance of **caring for the professionals** who provide care was emphasised**:**

"(…) They should also take care of the staff, which is very important, the schedule, making it easy to take a day off if possible, or making it easy to change shifts, those things should also be taken into account" (Nurse 5).

4.2.4.3. Strategies to improve unit policies. Strategies to improve the unit's policies include the open-door ICU, technology, pets, and outings.

As for **open-door ICUs**

"(…) It is essential to have doors open 24 hours a day, so a family member is there 24 hours a day, regardless of whether the patient is conscious or not (…)" (Nurse 9).

"There is only one visiting hour in the afternoon, and barely that (…) There should be more" (Patient 8).

The **use of technology** during the pandemic in ICUs was emphasised:

"When I couldn't speak, they themselves helped me communicate with my family through video calls. These are things that really help with recovery; for me, it was one of the best things" (Patient 5).

"(…) Trying to make video calls every day with family members and those moments was very hard for the nursing staff, but very rewarding for the patient" (Nurse 4).

Another nurse highlighted the **use of pets** during ICU stays:

"(…) Their pets could come, some kind of pet, right? A dog or a bird if they're in a closed bay, since there are lots of patients who wake up and ask us about their dog, how is their dog and be able to pet them (…)" (Nurse 3).

Finally, both nurses and patients mentioned the importance of **patient outings** so that patients who have been admitted for weeks or months can leave the hospital for a few minutes.

"(…) So they can breathe a little bit of fresh air, see light, and have the feeling of normal air, just being on the street after having spent 3 or 4 months locked up in an ICU makes them feel alive, and that helps a lot (…)" (Nurse 1).

"(…) I spent 105 days in the ICU, intubated for 75 days. They used several strategies, especially in the last phase, like taking me out to see the sea, so that you can feel the breeze. That gives you a lot of energy (…)" (Patient 7).

5. Discussion

In our study, both nurses and patients identified strategies for improving satisfaction with ICU nursing care that encompass physical, psychoemotional, and spiritual aspects. Some of the strategies identified to improve physical care align with other published studies[21,34] that refer to the relationship between pain management and satisfaction. Darawad[34] also emphasises the need to inform patients about the importance of expressing pain when they experience it so that it can be addressed as quickly as possible.

Additionally, the nurse is in a position to promote the patient's privacy, autonomy, and participation in care, as well as conduct a comprehensive assessment of the patient during washing and hydration procedures. The fact that nurses identified these moments as

important aligns with what has been reported by other studies.[7,24] Finally, nurses and patients agreed, as in other studies, that grouping nursing care, reducing light or noise intensity, and using medication or earplugs are strategies that promote rest and sleep.[17,21,22]

Responding promptly to patients' subjective needs—those tied to their experiences, values, beliefs, and culture—and showing interest when patients try to express themselves helps patients perceive nurses as truly caring and attentive. Several studies find that listening attentively to patients is a key element in nursing care.[17,20,23,24] However, the strategy of considering patients' recreational needs is not identified in any of the studies analysed. These aspects highlight the need to provide psychoemotional and spiritual care.

In this sense, satisfaction necessarily includes a holistic approach to the care of the person. Both patients and nurses highlighted that care is characterised by a combination of human and technical elements. In this sense, professionals are experts in the use of machines and various techniques, but they also simultaneously provide a sense of safety to the patient through more psychosocial care. This combination has been described as essential for the satisfaction of critically ill patients.[5,20,35] Moreover, care should be individualised and comprehensive, addressing all possible needs of the patient during their stay, whether physical, psychological, spiritual, or social.[11,24] However, two studies show that patients place greater importance on human skills than on technical ones.[21,24]

The strategies identified by patients and nurses to foster patient satisfaction with nursing care include verbal and nonverbal communication. Communication, whether verbal or nonverbal, allows interaction that involves human sensitivity and creates a connection between the emotions of the patient and those of the nurse.[22]

Specifically, in verbal communication, nurses and patients agreed on the importance of nurses introducing themselves, providing information before any care procedure, and using alternative communication methods (alphabet boards, whiteboards, and speaking valves, among others). Additionally, nurses emphasised encouraging patients to express themselves, using simple language, leveraging technology, and enhancing communication training. The use of technology in ICUs during periods of visitor restrictions, as noted in our findings, has been described as a fundamental pillar during the most challenging months of the COVID-19 pandemic.[36] Finally, communication training is a key aspect in improving how nurses communicate with patients, their families, and other professionals. Kerr[37] highlights the need to train nurses in communication skills to provide effective, safe, and patient-centred nursing care.

With respect to nonverbal communication, both patients and nurses highlighted the importance of eye contact. Through eye contact, people can discern a smile, a sad expression, or a concern, even when someone is wearing a mask.[25,38] Our findings align with those of other studies, which also emphasise the significance of actions such as eye contact and active listening.[7,11,24]

Nurses and patients identified strategies to enhance patient satisfaction related to professional behaviours, such as interdisciplinary communication, addressing the patient as a person, and exercising clinical judgement. However, the continuous rotation of interdisciplinary ICU staff makes the implementation of some of these strategies challenging.[39] Regarding nurses, joint nurse—physician rounds, training in teamwork, and maintaining a positive attitude were highlighted as strategies. Turning to the published literature in this area, Ervin[39] identifies joint visits, interdisciplinary communication, and teamwork training as three essential strategies for teamwork. The need for good training in teamwork in units as large as ICUs is indisputable for professionals. The continuous rotation of interdisciplinary staff in ICUs hinders any type of strategy that can be implemented in these large units.[39] Instead, our study details a broader set of strategies for improving professional behaviours. Two studies highlight clinical judgement and nurses' attitude as strategies for improving patient satisfaction.[22,40] The vulnerability and dependency in which critical patients find themselves make it particularly important to treat the patient like a person, not like a disease.[41] Rapid action, together with good technical and human skills, produces a sense of security and comfort in the patient.[5,20]

Strategies for improving physical infrastructure, enhancing human resources, and improving unit policies have likely emerged due to an increased recognition of the indisputable role of nurses in hospital management, as evidenced in recent years. In the context of the pandemic, nurses identified the need for increased staffing and supportive structures that ease their workload and aid patient recovery as key factors linked directly to patient satisfaction.[42]

Furthermore, to increase patient satisfaction with care, nurses and patients noted that ICU policies should humanise intensive care. In this regard, nurses emphasised the importance of an open-door ICU, where family members could play a much more active role in patient care, as well as enabling patients to walk in the hospital's garden (see also Igeño-Cano[43]).

5.1. Strengths and limitations

The study results identify strategies to enhance critical patient satisfaction with nursing care. These strategies largely align with the dimensions of the instrument used in phase I, the Nursing Intensive Care-Satisfaction Scale.[6,44,45] Consequently, the use of mixed methods provides a deeper understanding of complex concepts such as satisfaction. Incorporating the perspectives of both nurses and patients is crucial to ensure their voices are heard and to propose meaningful improvements in health care.

The patient recruitment time was longer than expected due to hospital constraints related to the COVID-19 pandemic. There may be survival bias, in the sense that patients who participated are the ones who survived their stay in the ICU. It may also be the case that dissatisfied patients did not want to participate in the focus groups. While the nurses were well distributed across the participating hospitals, most patients were from a single hospital, which could have affected the results. A larger study with a more diverse sample should be conducted to confirm them. The hospitals studied had a nurse-to-patient ratio of 1:2; care must be used in extrapolating the results to health systems where a 1:1 ratio is the norm.

5.2. Recommendations for further research

It is essential to continue advancing in the study of satisfaction by carrying out experimental designs to evaluate the reported strategies, which would allow continuous improvements in the quality of the service provided.

5.3. Implications for policy and practice

The strategies identified by patients and nurses can guide professionals, managers, and administrators in the development of a plan to increase the quality of humanised care by modifying, changing, or strengthening behaviours, skills, or attitudes that intervene in care and health care in general.

6. Conclusion

We have shown that intensive care nurses and patients identified similar strategies to improve satisfaction with the nursing care received during an ICU stay. Satisfactory nursing care involves

both technical expertise and human connection. This balance becomes especially important during admissions under restrictive measures. In such circumstances, patients placed greater value on the human aspects of care, particularly when visits from family and friends were limited.

The strategies identified allow the patient to reduce moments of fragility or uncertainty, providing a more satisfactory stay. The development of tools and technologies aimed at humanising the ICU environment is increasingly recognised as an important part of patient satisfaction. Reviewing ICU staffing models and training nurses and physicians in empathy and communication skills are important strategies to create a positive ICU climate and effective teamwork.

Data availability statement

The data supporting the findings of this study are available upon reasonable request from the corresponding author.

CRediT authorship contribution statement

Marta Romero- García: Conceptualisation, Methodology, Formal analysis, Investigation, Writing-original draft, Writing-review and editing, Supervision, Project administration,

Pilar Delgado-Hito: Conceptualisation, Methodology, Formal analysis, Investigation, Writing-original draft, Writing-review and editing, Supervision, Funding acquisition, Project administration,

Llúcia Benito-Aracil: Writing-original draft, Writing, review and editing.

Elisabet Gallart Vivé: Writing-original draft, Writing, review and editing.

Rocío Tabernero-Gallego: Writing-original draft, Writing, review and editing.

M. Pilar Muñoz-Rey: Writing-original draft, Writing, review and editing.

Laura Martinez Rodríguez: Writing-original draft, Writing, review and editing.

Isidro Alcalá-Jiménez: Conceptualisation, Methodology, Formal analysis, Investigation, Writing-original draft, Writing-review and editing.

Acknowledgements

To each of the participants of the focus groups, who, thanks to their contributions in relation to their perceptions of the care they have received and given in the intensive care unit, have allowed us to delve into this topic and increase key knowledge for the improvement of care in intensive care units. Susan Frekko provided feedback on the manuscript and translated it into English.

Declaration of competing interests

The authors declare no conflict of interest.

Funding

This work is part of the project: “National validation of the Scale of Nursing and Society Foundation Care Satisfaction from the Perspective of the Critically Ill Patient”, funded by the Fundación Enfermería y Sociedad (PR-282/2018) and the Carlos III Health Institute (Ministry of Science and Innovation), and cofinanced by the European National Development Fund whose motto is “A way to build Europe”, Health Research Funding (FIS) (PI18/00935). We thank Research centers in Catalonia (CERCA) Programme/Generalitat de Catalunya for institutional support.

References

[1] Otani K, Waterman B, Faulkner KM, Boslaugh S, Burroughs TE, Dunagan CW. Patient satisfaction: focusing on “excellent”. J Healthc Manag 2009;54(2):93e103.
[2] Schmidt LA. Patients' perceptions of nursing care in the hospital setting. J Adv Nurs 2003;44(4):393e9.
[3] Wagner D, Bear M. Patient satisfaction with nursing care: a concept analysis within a nursing framework. J Adv Nurs 2009;65(3):69d2e701. https://doi.org/10.1111/j.1365-2648.2008.04866.x.
[4] Berkowitz B. The patient experience and patient satisfaction: measurement of a complex dynamic. Online J Issues Nurs 2016;21(1):1. https://doi.org/10.3912/OJIN.Vol21No01Man01.
[5] Romero-García M, de la Cueva-Ariza L, Jover-Sancho C, Delgado-Hito P, Acosta-Mejuto B, Sola-Ribo M, et al. The critical patient's perception of nursing care: an approach to the concept of satisfaction. Enfermería Intensiva 2013;24:51–62. https://doi.org/10.1016/j.enfi.2012.09.003.
[6] Delgado-Hito P, Alcalá-Jiménez I, Martínez-Momblan MA, Cueva-Ariza L, Adamuz-Tomás J, Cuzco C, et al. Satisfaction of intensive care unit patients linked to clinical and organisational factors: a cross-sectional multicentre study. Aust Crit Care 2023;36(5):716–22. https://doi.org/10.1016/j.aucc.2022.10.013.
[7] Latour J, Kentish-Barnes N, Jacques T, Wysocki M, Azoulay E. Improving the intensive care experience from the perspective of different stakeholders. Crit Care 2022;26:218. https://doi.org/10.1186/s13054-022-04094-x.
[8] Ng J, Luk B. Patient satisfaction: concept analysis in the healthcare context. Patient Educ Counsel 2019;102:790–6. https://doi.org/10.1016/j.pec.2018.11.013.
[9] Rojas V. Humanization of intensive care. Rev Med Clin Condes 2019;30:120–5. https://doi.org/10.1016/j.rmclc.2019.03.005.
[10] Delgado-Hito P, Sola-Prado A, Mirabete-Rodríguez I, Torrents-Ros R, Blasco-Afonso M, Barrero-Pedraza R, et al. Modification of nursing practice through reflection: a participatory action research. Intensive Care Nurs 2001;12:110–26. https://doi.org/10.1016/S1130-2399(01)78029-7.
[11] Batbaatar E, Dorjdagva J, Luvsannyam A, Savino M, Amenta P. Determinants of patient satisfaction: a systematic review. Perspect Public Health 2017;137:89–101. https://doi.org/10.1177/1757913916634136.
[12] The Beryl Institute. Human experience. https://theberylinstitute.org/defining-patient-experience/.
[13] Kitson AL. The fundamentals of care framework as a point-of-care nursing theory. Nurs Res 2018;67(2):99–107. https://doi.org/10.1097/NNR.0000000000000271.
[14] Australian Commission of Safety and Quality in Health. Person-centred care. https://www.safetyandquality.gov.au/our-work/partnering-consumers/person-centred-care.
[15] Suhonen R, Valimaki M, Katajisto J, Leino-Kilpi H. Provision of individualized care improves hospital patient outcomes: an explanatory model using LISREL. Int J Nurs Stud 2007;44:197–207.
[16] Guerra-Martín MD, González-Fernández P. Satisfaction of patients and family caregivers in adult intensive care units: literature review. Enfermería Intensiva 2021;32(4):207–19. https://doi.org/10.1016/j.enfi.2020.07.002.
[17] Büsra C, Koç Z. Quality of life and satisfaction affect individualized nursing care perceptions in intensive care. Psychol Health Med 2020;25:148–59. https://doi.org/10.1080/13548506.2019.1654110.
[18] Hummel K, Ou Z, Latchireddi A, Presson A, Tonna J. Analyzing clinical and system drivers of satisfaction in the intensive care unit as a component of high-quality care. Heart Lung 2021;50:277–83. https://doi.org/10.1016/j.hrtlng.2020.12.015.
[19] Antonio I, Stephens K, Peters J, Swanson-Bierman B, Whitman K. Evidence-based communication strategies to improve patient satisfaction: a quality improvement project. Nurse Lead 2022;20(6):560–4. https://doi.org/10.1016/j.mnl.2022.08.004.
[20] Jover-Sancho C, Romero-García M, Delgado-Hito P, de la Cueva-Ariza L, Solà-Solé N, Acosta-Mejuto B, et al. Perception of ICU nurses in relation to satisfactory care: convergences and divergences with the perception of critically ill patients. Enfermería Intensiva 2015;26:3–14. https://doi.org/10.1016/j.enfi.2014.12.002.
[21] Goudarzi F, Jafari-Pour F, Hasanvand S, Ebrahimzadeh F, Kvist T. Patients' satisfaction with humane care in critical care units. Iran J Nurs Midwifery Res 2021;26:455–61. https://doi.org/10.4103/ijnmr.IJNMR8820.
[22] Hernández R, Lozano A, Navarro A, Fortea M, Martín R, García L. Nursing professionals' perceptions of geriatric patient care. Gerokomos 2021;32:142–8. https://doi.org/10.1177/089431841988179.
[23] Dikmen Y. Patient's perceptions of nursing Care-A descriptive study from Turkey. Ann Nurs Pract 2020;3(10). https://doi.org/10.1177/2050312121097270. 20503121221097270.
[24] Ahmed N, Mohammad I, Jasline M. How nursing care influence patient's satisfaction: a literature based narrative review. Int J Adv Sci Res 2019;4:21–5. https://doi.org/10.1186/s12912-019-0348-9.
[25] Mehta S, Dodek P, Kayitesi J, LeBlanc D. The impact of the COVID-19 pandemic on intensive care unit workers: a nationwide survey. Can J Anaesth 2022;69:472–84. https://doi.org/10.1007/s12630-021-02175-z.
[26] Kydonaki K, Kean S, Tocher J. Family INvolvement in inTensive care: a qualitative exploration of critically ill patients, their families and critical care

nurses (INpuT study). J Clin Nurs 2020;29(7–8):1115–28. https://doi.org/10.1111/jocn.15175.
[27] Cypress BS. The lived ICU experience of nurses, patients and family members: a phenomenological study with Merleau-Pontian perspective. Intensive Crit Care Nurs 2011;27(5):273–80. https://doi.org/10.1016/j.iccn.2011.08.001.
[28] Gelinas C, Arbour C, Michaud C, Robar L, Côté J. Patients and ICU nurses' perspectives of non-pharmacological interventions for pain management. Nurs Crit Care 2013;18(6):307–18. https://doi.org/10.1111/j.1478-5153.2012.00531.x.
[29] Creswell J, Plano V. Designing and conducting mixed methods research. 3rd ed. Thousand Oaks; 2007.
[30] Thorne S, Kirkham R, O'Flynn-Magee K. The analytic challenge in interpretive description. Int J Qual Methods 2004;3:1–11. https://doi.org/10.1177/160940690400300101.
[31] Guba E, Lincoln Y. Paradigmatic controversies, contradictions, and emerging confluences. Sage; 2000.
[32] Halliday M, Mill D, Johnson J, Lee K. Let's talk virtually! Online focus group facilitation for the modern researcher. Res Soc Adm Pharm 2021;17:2145–50. https://doi.org/10.1016/j.sapharm.2021.02.003.
[33] Morgan DL, Scannell AU. Planning focus groups. Focus group kit2. London: SAGE Publications; 1998.
[34] Darawad M, Al-Hussami M, Saleh A, Al-Sutari M. Predictors of ICU patients' pain management satisfaction: a descriptive cross-sectional survey. Aust Crit Care 2015;28:129–33. https://doi.org/10.1016/j.aucc.2014.07.003.
[35] Andersson M, Nordin A, Engström A. Critical care nurses' perception of moral distress in intensive care during the COVID-19 pandemic – a pilot study. Intensive Crit Care Nurs 2022;72:103279. https://doi.org/10.1016/j.iccn.2022.103279.
[36] Fritz C, Claude LA, Hamada S, Trosdorf M, Barre H, Yavchitz A, et al. Daily telephone call during the COVID-19 pandemic: perceptions of families and providers. Am J Crit Care 2022;31:77–81. https://doi.org/10.4037/ajcc2022797.
[37] Kerr D, Martin P, Furber L, Winterburn S, Milnes S, Nielsen A, et al. Communication skills training for nurses: is it time for a standardized nursing model? Patient Educ Counsel 2022;105:1970–5. https://doi.org/10.1016/j.pec.2022.03.008.
[38] Analuisa E. Assertive communication and its nurse-patient relationship due to the constant use of the mask. Ciencia Latina 2022;6. https://doi.org/10.37811/cl_rcm.v6i1.1633.
[39] Ervin J, Kahn J, Wingart L. Teamwork in the intensive care unit. Am J Psychol 2018;73:468–73. https://doi.org/10.1037/amp0000247.
[40] Joven ZM, Parada SG. Critical patient perception of humanized nursing care behaviors. Adv Nurs 2019;37:66–74. https://doi.org/10.15446/av.enferm.v37n1.65646.
[41] Basile M, Rubin E, Wilson M, Polo J, Jacome S, Brown S, et al. Humanizing the ICU patient: a qualitative exploration of behaviors experienced by patients, caregivers and ICU staff. Crit Care Explorations 2021;3(6):e0463. https://doi.org/10.1097/cce.0000000000000463.
[42] Silva T, Fernandes A, O'Silva C, Xavier S, Macedo E. The impact of the pandemic on the role of disease: a narrative review of the literature. Glob Nurs 2021;20. https://doi.org/10.6018/eglobal.454061.
[43] Igeño-Cano JC. Benefits of walks through the hospital's outdoor gardens for critical patients, families and professionals. Intensive Care Med 2020;44:446–8. https://doi.org/10.1016/j.medin.2019.09.007.
[44] Romero-García M, de la Cueva-Ariza L, Benito-Aracil L, Lluch-Canut T, Trujols-Albet J, Martínez-Momblan, et al. Nursing intensive-care satisfaction scale [NICSS]: development and validation of a patient-centered instrument. J Adv Nurs 2018;74:1423–35. https://doi.org/10.1111/jan.13546.
[45] Romero-García M, Alcalá-Jiménez I, Martínez-Momblan MA, de la Cueva-Ariza L, Cuzco C, Delgado-Hito P. Psychometric properties of the nursing intensive care satisfaction scale: a multicentre cross-sectional study. Aust Crit Care 2023;36(4):550–7. https://doi.org/10.1016/j.aucc.2022.03.012.