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COMMUNICATION BETWEEN NURSING STAFF AND CLIENTS UNABLE TO COMMUNICATE VERBALLY

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This is an experience developed during the Master program in Nursing at UFSC. It aimed to reflect on the nursing care delivered to the patient unable to verbally communicate, based on Paterson and Zderad´s Theory and to analyze the communicational process between nursing and client. The experience was carried out in the Intensive Care Center of a private hospital in two stages: non-participating observation and three existential workshops, involving nine nursing technicians. Each participant acquired self knowledge and was known by other participants in the intuitive dialogue. Alternatives of non-verbal dialogue were suggested during the scientific dialogue. The scientific-intuitive fusion emerged when there was a need of each one to position themselves about the totality. The study on the communicational process revealed the need to enlarge the approach regarding the care to the client unable to verbally communicate, especially training the team for the interpersonal and dialogical relationship.

DESCRIPTORS: nursing care; communication; non-verbal communication

COMUNICACIÓN ENTRE LA ENFERMERÍA Y LOS CLIENTES IMPOSIBILITADOS DE COMUNICARSE VERBALMENTE

Se trata de una experiência desarrollada en la Maestría en Enfermería del UFSC. El objetivo fue refleccionar sobre el cuidado de enfermería al cliente imposibilitado de comunicarse verbalmente., bajo la Teoría de Paterson y Zderad, y analizar el proceso comunicacional enter la enfermería y el cliente. La experiencia se desarrolló en el Centro de Terapia Intensiva de un hospital privado en dos etapas: observación no participante y tres oficinas existenciales, incluyendo la participación de nueve técnicos en enfermería. En el diálogo intuitivo, cada uno de los participantes se autoconoció y fue conocido por los otros participantes. En el diálogo no científico, el equipo sugirió alternativas de diálogos no verbales. La fusión intuitiva-científica surge cuando hay necesidad de un posicionamiento de cada uno de ellos sobre el resto. El estudio sobre el proceso comunicacional reveló la necesidad de ampliar el acercamiento para el cuidado del cliente imposibilitado de comunicarse verbalmente, involucrando principalmente la preparación del equipo para la relación interpersonal y de diálogo.

DESCRIPTORES: atención de enfermería; comunicación; comunicación no verbal

COMUNICAÇÃO ENTRE A ENFERMAGEM E OS CLIENTES IMPOSSIBILITADOS DE COMUNICAÇÃO VERBAL

Trata-se de experiência desenvolvida no Mestrado em Enfermagem da Universidade Federal de Santa Catarina. O objetivo foi refletir sobre o cuidado de enfermagem ao cliente impossibilitado de comunicação verbal, sob a teoria de Paterson e Zderad, e analisar o processo comunicacional entre enfermagem e cliente. A experiência ocorreu no centro de terapia intensiva de um hospital privado, em duas etapas: observação não-participante e três oficinas existenciais, envolvendo a participação de nove técnicos de enfermagem. No Diálogo Intuitivo, cada participante se autoconheceu e foi conhecido pelos outros participantes. No diálogo científico, a equipe sugeriu alternativas de diálogo não-verbal. A fusão intuitivo-científica surgiu quando houve a necessidade de posicionamento de cada um sobre a totalidade. O estudo sobre o processo comunicacional revelou a necessidade de ampliar a abordagem acerca do cuidado ao cliente impossibilitado de comunicação verbal, envolvendo principalmente o preparo da equipe para a relação interpessoal e dialógica.

DESCRITORES: cuidados de enfermagem; comunicação; comunicação não verbal

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INTRODUCTION

Human communication was first done through gestures, images and sounds. Later, humans began using graphical signs to refer to familiar sense-perceived objects that used to be communicated through gestures. Verbal communication marked human transition from concrete animal intelligence, limited to the present, to a symbolic or mental representation of the world[1]. For nursing, appropriate communication aims to reduce conflicts and reach solutions for problems that appear during client hospitalization. The dynamics of sending and receiving messages depends on interpreting what is expressed and on the nursing team's attitude. It involves feelings, ideas, agreements, disagreements and physical proximity, and is reached through gestures, postures, facial expression, body language, somatic singularities, natural or artificial, object organization in space, and even through the distance relationship between individuals[2].

At an Intensive Care Unit (ICU), verbal communication is sometimes impaired. Therefore, clients only have gestures and looks, often anguished, to try to express themselves[3]. Weighing and acquiring knowledge about non-verbal communication permits to develop professional capacity to precisely identify feelings expressed through looks and touches and, thus, to overcome client communication difficulties. Due to its complexity and current importance, numerous studies and investigations have looked at communication. In health, and especially in nursing, communication is considered essential to meet simple human needs[4]. The team should decode and understand the meaning of the clients' message so as to offer adequate care, consistent with their real necessities. For nursing, communication is an essential instrument, a competency and a skill to be developed[5]. The ICU experience shows that most clients are unable to communicate verbally and that their conscience levels are affected, ranging from lucid and oriented to deep coma. This implies the need not only to control the equipment, but also to understand human, social, psychological and spiritual dimensions. Studies with ICU patients show that the touch from relatives, nurses and doctors, can change clients' heartbeat or reduce it by holding their hands[6]. The communication process during ICU care points at the importance of nurses' self-knowledge and self-perception. Moreover, it shows that dialogues are recreational moments for those involved in the interaction[3,7].

Paterson and Zderad's Humanistic Theory[8] proposes the approximation between nurses and clients as an existential experience in which their expressiveness and potentiality are evidenced. The authors also see nursing as a human experience, including all the possible human answers to a situation, regarding people in need as well as people helping, in which both participate according to their own way of being. This theory is also an important reference involving *encounters* (meetings between human being, expecting that there will be someone to deliver care and someone to be cared for), *presence* (the quality of being reciprocally open to the other), *relationship* (being with the other, moving towards the other, offering and enabling authentic presence), and *a calling and an answer* (interactive communication, either verbal or non-verbal)[8].

In this sense, the objectives of the present study were outlined: to reflect on nursing team care toward clients unable to communicate verbally, guided by Paterson and Zderad's theory; and to analyze the communication process between nursing team and clients unable to communicate verbally.

METHODOLOGY

This experience was carried out at the adult ICU of a private hospital located in Porto Alegre, a city in Rio Grande do Sul State, Brazil. The unit has 31 beds, arranged in individual boxes so as to guarantee the clients' tranquility and privacy with their relatives. First, the ICU nurse supervisor was informally approached, who approved the present study after getting to know its purposes*. Nine nursing technicians from the night shift agreed to participate in the meetings. They complied with the following inclusion criteria: having worked at the unit for at least one year, and agree to provide written consent. The project was analyzed and approved by the Institutional Review Board at Santa Catarina Federal University.

* This study was developed in the subject "Nursing and Health Care Projects", as part of the Nursing Masters Program at the Federal University of Santa Catarina. In this subject, students develop a health care practice with clients from their area of interest in order to implement the principles of a Nursing or Education Theory.

This study was performed in two stages: the first consisted of non-participant observation; and the second involved existential workshops. The purpose of non-participant observation of nurse staff work with ICU patients was to collect data for planning and developing the existential workshops. Hence, this stage was carried out at a different moment than data collection; that is, during morning and afternoon shifts, with a total of six hours of non-participant observation. A field journal was used to transcribe the observed context, including a description of dialogues and health care setting[9]. The day nursing team has a six-hour daily shift, while the night team has a 12-hour shift, with rest intervals of 60 hours.

The existential workshops[3] were performed before the participants' work hours, and aimed to analyze the team's activities with clients unable to communicate verbally. They also aimed to collect information for the further development of an educational process with the nursing team about delivering care to clients unable to communicate verbally, guided by Paterson and Zderad's theory. The three workshops took place in June 2005 and followed stages of sensitization, implementation, and evaluation. Each existential workshop lasted an average of 60 minutes.

The theme of **Existential Workshop #1** was **who am I?** This moment aimed to provide the group with an opportunity to reflect about themselves, experiencing their beliefs as persons and professionals. **Existential Workshop #2** was about the possible forms of communication, and was called **how do I communicate with ICU patients?** This workshop aimed to provide the group with an opportunity to reflect about the forms of communication used during nursing care, focusing on verbal and non-verbal communication, and seeking to identify, from the group's perspective, the easy and difficult aspects of communicating with ICU patients. The theme for **Existential Workshop #3** was dialogical interaction, and was called **dialogical interaction representation"**. The aim was to reflect on the dialogical interaction involved in nursing care delivery to ICU patients. In the first workshop, the participants were allowed to choose flower names for their identification. The chosen names were: **Carnation, Lilly, Tulip, Orchid, Hibiscus, Pansy, Rose, Violet and Daisy**. The established trust relationship granted participants the right to no answer, no revelation or veiled revelation, respecting appropriate revelation limits so as to preserve their privacy[9].

DETAILING THE EXPERIENCE

Intuitive dialogue was observed especially in the first workshop, with the construction of the subjects' perception of the study through dynamics that encouraged them to think about themselves and about how they communicated with clients. Thinking about **technical-scientific dialogue**, themes were organized with simple guiding questions to approach the perceptions reported by the group, ending with **intuitive-scientific fusion** by evaluating each participant though oral and written evaluations.

The first stage, non-participant observation, is the moment when the researcher was present in the situation but without interaction[9-10]. This observation method permitted information collection, such as individuals' characteristics and conditions, verbal and non-verbal communication, activities and environmental conditions, without interference from the observer in the dynamics of the setting. Two significant moments of direct patient care were noticed during the six observed hours, and are described below. The first is the description of non-care toward the client, and the second moment represents empathy and nurse-client interpersonal relationship.

The nursing technician enters the box where client *C* is, and says: *just a little prick*, referring to capillary glycemia measurement. The client gives an unsatisfied look and lowers her head (sad). The nursing technician asks: *Would you like to have lunch now?* The client nods her head, showing she agrees. After checking her watch, the nursing technician adds: *If you don't eat now, the doctor will want to use a little feeding-tube.* At this moment the patient frowns and shows she is upset, and sighs when the worker leaves the box.

This report shows the professional's lack of sensitivity and attention when performing a painful procedure. He uses irony, with a threatening tone, in case the client does not agree to eat. At this moment, non-care is manifested through professional posture and behavior, perhaps due to lack of preparation, work overload, tiredness or lack of involvement. An opposite fact was observed, in which the nurse demonstrates the methodological stages of the Humanistic Theory[8].

The nurse was sitting next to the client, holding his hand, explaining she needed his help to insert a feeding tube, and that he needed this tube due to his inability to eat regularly. The client was awake, lucid, intubated, but collaborative. The nurse started the procedure with some difficulty, because the tube kept rolling in the client's mouth, which demanded a great effort from him. Many unsuccessful attempts were made, and the nostrils were somewhat traumatized. The nurse did not want to continue. With tears in her eyes, she tried to calm the client down, holding his hands and showing affection. The client insisted through facial movements that she should continue, because he believed it was necessary and important for his treatment. After some time, the procedure was accomplished and the nurse remained by the client's side until he fell asleep. She seemed worried with the discomfort that had been caused.

The nurse sought to intuitively get to know the client, perceiving the situation through his eyes and understanding his experience, which was difficult. She transmitted security and confidence through touch, fragile facial expression and dialogue. This made the patient realize the need to perform the procedure for his treatment and health improvement. In phenomenological nursing, there is no description for a nursing plan focused on one goal, because humanistic nursing is concerned with being with the other in need, in which *being better* or *wellbeing* is achieved through *dialogue*[8]. This observation was extremely important because, from this moment, it was outlined how the Existential Workshops would be developed.

In the second stage, a reflexive process was developed about the findings from the existential workshop, based on Paterson and Zderad's theory. The existential workshops were characterized through three phases, according to the presuppositions of Paterson and Zderad's theory; that is, Intuitive Dialogue, Scientific Dialogue, and Intuitive-Scientific Fusion. In **Existential Workshop #1**, participants were asked to write, on a spiral drawn on cardboard, their expectations regarding the upcoming workshops. After all participants were done writing, the following words were read out loud:

Growth, togetherness, knowledge, growth and togetherness, to grow as a human being, getting along and learning, humanization and amusement, companionship, sincerity, more knowledge and understanding toward patients and colleagues, building skills and commitment, respect, group unity, friendship and joy.

The idea was for participants to use their intuition to determine the search for knowledge in order to enhance their interpersonal relations and everyday nursing tasks. Participants were asked to create a poster using pictures or texts from magazines, answering the following guiding questions: **Who am I? At home? At work?** They looked at magazines, some silently, others exchanging ideas and commenting about the workshop. A musical background was set to help participants think about the two proposed questions. After accomplishing the individual task, each participant hung his/her posters on the wall and read them out loud. This made it possible to relate their perception with the program content for that moment. The statement given by **Orchid** illustrates this phase:

I did some pasting, like, this one of a mother with her child. I'm a proud mother, I like my son and I enjoy playing with him. This is another picture (points at a happy, embraced couple), when my husband is home at the weekend, it is the moment I can enjoy being with him and I leave house work for the other days. I also like to spend some time alone, I like to pray, have some time to think about what I did wrong, what I could improve. Most of the time I'm home, I'm resting (picture of crossed feet, representing rest). At work, I can appear to be a serious, determined person. I try to concentrate on what I'm doing. I'm open to criticism, opinions. I'm flexible and I listen to what people have to say.

Participants created a retrospective about their *self*, which, according to Paterson and Zderad[8], is the key element for dialogical relationships, since they are associated with the understanding of beings trough their personal experiences. This increases the chance of understanding human beings in the nursing situation. The self-knowledge process occurred when nursing practice experiences were lived during the workshop. It was a moment for thinking, analyzing and interpreting one's "self", arousing personal and intimate feelings about work and colleagues. Participants paid close attention to each presentation, showing that, despite the many hours they spent working together, they did not know much about each other. Some feelings related to dialogical interactions were addressed, since they were very present in the statements, such as empathy, emotional involvement, patience and acceptance. When the time was up, each participant described the experienced moment and thanked the group's involvement in the proposed challenge.

In **Existential Workshop #2**, the ball of wool dynamics* was used. At this moment, **Violet** made the following statement.

...it's like when we move the patient in bed with a blanket. If one of us lets go of the blanket, the client might fall. Communication is essential.

It was significant to remember that any action, especially client care, should include appropriate communication and mutual understanding.

The second moment addressed the importance of communication with clients and among the group, and that communication can be verbal, non-verbal and paralinguistic (with some explanation about each). In scientific dialogue, intuitive knowledge construction was supported by the body of literature on client-nursing staff communication and interaction. The explanation about verbal and non-verbal communication gave the group chances of being *present* in the self-other relationship. This confirms the dialogue process experienced through gestures, emotions, looks, silence, body and facial expressions, voice intonation and other participant behaviors[8].

Next, participants were asked to form three small groups, so each could perform an everyday scene, representing how people communicate at work, showing the easy and difficult aspects involved. At the end, participants explained aspects that were unclear or ambiguous. Each group remembered facts that occurred with certain clients, easy and difficult aspects, empathy, beliefs, emotional attachment with client and relatives, and difficulties of working with various health care professionals. The group formed by **Tulip**, **Rose** and **Daisy** was quite prepared for the presentation, with various notes about their thoughts. **Daisy** sat in front of the desk and began saying:

First, we will talk about some things that are important for a dialogical interaction. Things that really help in communication: having a fixed client list, so I take care of that client until hospitalization is over. This helps me understand the client better, especially if he/she is unable to communicate verbally. Day by day, you start learning little things that will help you take care of your client; observing the client as a whole, not only clinical signs.

According to the group, a fixed patient list would permit closer approximation with clients and, thus, create professional-client empathy and attachment. This is expressed through attention to the client's preferences regarding sleep hours, bed positions, room temperature, toileting and others. Changing clients every shift impairs dialogical relationships and thus contributes to client dissatisfaction.

A low and tender voice transmits security and tranquility. Sometimes, one thing we see that really shocks us is when the neurosurgeon comes and enters the room yelling with the client: "Mr. So-and-so?" And pinches the client to check if there is any reaction. The client gives a jerk because of the scare, or the cold... or it could have really hurt. We know this approach is important to evaluate conscience level, but there are ways to do it. If you put yourself in the client's place, it is shocking and aggressive. (Daisy)

Attachment, as previously described, makes professionals pay attention to these occurrences. They try to protect clients from factors that could cause stress, disturb tranquility or increase clients' discomfort, especially when they cannot communicate verbally. Professionals who focus only on evaluating the patient might forget that the moment should be made into a significant encounter. Moreover, this does not involve only physical contact, in which *doing for* could be replaced by *doing to*, as proposed by the humanistic theory. Health care, in addition to zeal and concern, means solicitude, attention and dedication, which can pose agitation and a sense of responsibility on caretakers[12-13].

Observing the client's signs and reactions; and also using other resources, like a board with letters and numbers so they can use their hands and fingers to form phrases that translate their needs; also using pen and paper, a magic board; and of course family support for interpretation. We realized that another difficulty is the limitation to make decisions in nursing. We often need to make faster decisions, but we need the authorization from another professional to go through with them. The physician on duty, for instance, does not look after this client integrally, and when we request an evaluation, because the client is trying to say he/she is in pain, they doubt the team's statements and do not permit giving the patient any pain killers. (Daisy)

Using support material and family participation in the communication process favors the dialogic relationship between the staff and clients unable to communicate verbally. "People, when open or available, are understood as presence."[8] The above statement shows that the nursing technician

* In the ball of wool technique, each participant is supposed to pass the ball of wool to a colleague in the group, saying a word out loud to express their expectation about the moment and the meeting. Each person is supposed to hold the thread, thus forming a dialogical web.

identified the need, but emphasized that certain actions depend on other professionals to actually be carried out. Actions should be made visible through touch and interaction, so as to meet the needs manifested by the client. Moreover, clients' feelings should be recognized, and not judged. At the workshop, the group stated it is important to sensitize people about client care and human respect. After a few discussions, the group formed by **Violet, Orchid** and **Carnation** started its performance. **Violet** introduced the group.

Orchid will be the client (lucid and intubated), and Carnation will be the nurse technician. The client makes signs with her hands, up in the air, as if cooling herself. She has a tense look, because the nurse technician does not understand her. Carnation asks very hurriedly: *what do you need, ma'am? Do you want to cover yourself? Are you out of breath? Do you want to raise your legs?* Angry, he says: *Just a second, I'll call my colleague to see if she understands you.* Upset, the client starts slapping her hands on her legs. The other nursing technicians arrives, Violet herself, and sits next to the client. She makes the following comment: *now, try to speak very calmly, and show me what you need.* The client starts laughing and at the same time shows her frustration, pointing her hands to the orotracheal tube, trying to express that it is impossible for her to speak, since she is intubated. Violet puts her hands on her waist, defensive and showing she understands she has followed the wrong conduct (everyone laughs at the colleague's error). Orchid points at the pillow, and Violet asks: *Should we flip your pillow? Replace it with a higher one?* Orchid moves her head as to confirm her need and puts her hands together as if praying, showing she is relieved she was understood. Violet began the discussion saying she finds it difficult to understand clients who communicate through gestures, lip movements, and other signs. *It is best if, when taking care of a client, you continue taking care of him/her in the other shifts, because you already know his/her needs, habits, sleep hours, ways of feeding, toileting, promoting privacy, comfort in bed and communicating better. I don't like to switch clients every shift, because I don't know him/her as well as a colleague who has already taken care of him/her.*

Once again, the team members pointed at the need to know themselves and others in order to provide care and effective communication. This evokes the need for a fixed client list. If caretakers always paid attention to clients' callings, mostly non-verbal, they could be cared for with sensitivity and have their expectations met. The art in nursing is the ability to speak without words, care intuitively and empathically, value encounters, and transcend what is visible[14].

In **Existential Workshop #3**, participants were welcomed using the balloon dynamics*. Some instructions about the dynamics were given and the Workshop began. The participants' texts and posters, as well as the non-participant observation abstract were hung on the walls. The video of participants' performances was also shown. Next, participants exchanged the material and silently and carefully observed it for thirty minutes. Then, each participant spoke about how they perceived this collective picture production and answered the following questions: **How has communication occurred at the ICU?** And **what is each person's opinion about how the communication process should be?** Participants' observations were used to promote a reflection about dialogic interaction, and to seek associations with the reflections from previous workshops. Their comments show an analysis of the communication process between the team and clients unable to communicate verbally:

The things observed have really become automatic, and we don't notice that anymore during our practice. We don't notice that we go by without talking with our clients. We don't inform we're going to perform a procedure, like respiratory aspiration. Clients are intubated, but they are lucid. We become robots and just don't realize. We often don't introduce ourselves as their caregivers. What must they think? (Rose)

Clients often do not speak, but they are listening. Even if they are in a coma, we should talk with them. You don't know the level of the client's coma. (Pansy)

I keep trying to picture what the clients thinks, I try to put myself in their place, some can't see, others can't speak. Imagine if someone comes over and starts touching me, without my knowing what will happen. I've had the experience of being carried on a stretcher. It's horrible. When we turn the client in bed, the impression we have is that they feel they're going to fall off the bed, they hold tight on us. There are so many times we turn them without saying anything. It must be a horrible experience. (Orchid)

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* For the balloon dynamics, participants were asked to write on a piece of paper their expectations or a message to someone in the group. The notes were folded and put inside a balloon they chose. They filled the balloons and, against music a background, they walked around the room exchanging balloons. When the music stopped, each participant popped a balloon, read the message out loud and handed the note to the indicated person, as a souvenir.

The communication process moved from the trivial to a phenomenological approach, and the phenomenon was unveiled showing sensitive people thirsty for knowledge, self-knowledge and contextualization of their experience. Acquiring the power of claiming implies group cohesion, self-confidence, as well as developing exposition, argumentation and persuasion skills; which are all based on communication[3,15]. The intuitive-scientific fusion emerged when there was a need for each participant to state his/her position regarding the group of experienced situations. The confrontation between their intuition about themselves and the workshop content implied developing awareness about the possibilities regarding their practice.

Because we don't know how much they actually understand. They might be hearing everything. There are many reports of clients who had been in a coma and reported having heard voices and comments made by the health team, but they were unable to make or express any reaction. After our last meeting, I began my shift and thought a lot. I received a client that was lucid, had been through a difficult situation and had been manipulated a lot. When I entered the "Box", you know when you feel there's something wrong with the client? I greeted him and started to talk, and he started to cry. I don't know if at any other moment I would have had that behavior, of sitting next to him, holding his hand tightly, trying to give him some sense of security and confidence, without worrying about my tasks, things involving other clients and the sector. But after the reflection in the second workshop, I was very sensitive and concerned about my attitude and life reflection. (Daisy)

There is something else I noticed in the non-participant observation. We use the diminutive too much when speaking to people. I'm going to give you a little prick, a little suction, insert a little tube, mommy, granny, a little bath, a little turn, we act like children and it's disrespectful of those lying there. We want to be nice to people, be affectionate, when we are actually offending. (Lilly)

This analysis was considered the most precious moment of the experience, because it sensitized participants to self-reflection about how they think and behave in practice. A therapeutic communication requires **expression**, **clarification** and **validation**[16].

It should be clear that non-verbal communication fully covers verbal emission, since it reveals feelings and intentions. Therefore, signs should be clarified and questioned with a view to a broad comprehension about the experienced moment.

The group showed a need to continue with the meetings in order to rethink and to recycle, as some stated, as well as to sensitize about care to others and to people close to us. The meetings seemed to have been very valuable to creating the expected dialogic relationship, and the changes yielded better professionals and people. Participants were asked to individually write about how they perceived the workshops and how they felt now, at the end.

Every lesson that adds good things and allows us to evolve as people and professionals is valid and very welcome. I think these workshops reminded us of methods, techniques, tenderness, patience and the good will that is often asleep in our minds due to the everyday rush or time of profession. It showed there is no recipe telling us how to communicate and behave in every situation. There are moments when the rule does not apply to the situation, and good sense, intuition and perception of the clients' real needs should be evident and receive appropriate attention and respect. (Rose)

These moments showed a synthesis of the reality that was known, with concepts elaborated by the group, permitting new thinking about practice, and expanding nursing knowledge, especially for people who did not participate in this experience.

FINAL CONSIDERATIONS

This study contributes to a significant change in the work environment, adding a humanized look to nursing-client relationships. This shows the applicability of Paterson and Zderad's Humanistic Theory[8], since it offers support to a reflection about transforming a "robotized environment" into a "humanized environment". Non-participant observation and the workshops showed that the dialogic relationship remains impaired. Nursing technicians were able to experience the possibility of change through posture, attention, and patience, in their look or way of approaching clients, showing *presence*. It was suggested that visual resources and materials be used to interpret clients' needs, individuality and privacy, besides the voice tone, gestures, body language and even silence. It was also revealed that approaching clients promotes self-knowledge and self-perception, as well as knowing and perceiving the client, thus making dialogic relationships possible. This contradicts some health care professionals' posture of non-care, since they do not put themselves in other people's place; they

do not speak the same language and do not contemplate holistic care. The communication process, as part of nursing practice, involves transactions between individuals through which information and understandings are exchanged. This could make it easier to apprehend and understand the client's needs, making care authentic[7].

Study results indicate that the team improved and that their attitudes changed. The institution and nursing supervisors became interested in this proposal as a continuing education activity for the ICU nursing team. This activity would be a form of equipping and developing the communication process with clients unable to communicate verbally. This was a step toward understanding the complexity of this theme, permitting professionals to develop skills for a more accurate identification of feelings, doubts and difficulties when clients are unable to verbalize them.

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