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BARREIRAS À COMUNICAÇÃO COM OS DOENTES EM CONTEXTO DE URGÊNCIA: PERCEÇÃO DOS ENFERMEIROS E ESTRATÉGIAS DE SUPERAÇÃO

BARRIERS TO COMMUNICATION WITH PATIENTS IN AN EMERGENCY CONTEXT: NURSES' PERCEPTION AND STRATEGIES TO OVERCOME THEM

BARRERAS EN LA COMUNICACIÓN CON LOS PACIENTES EN UN CONTEXTO DE URGENCIAS: PERCEPCION DE LOS ENFERMEROS Y ESTRATEGIAS PARA SUPERARLAS

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RESUMO

Introdução: A comunicação entre enfermeiros e doentes constitui um elemento fundamental da qualidade, segurança e humanização dos cuidados de saúde, assumindo particular relevância no contexto do Serviço de Urgência, caracterizado por elevada pressão assistencial e complexidade clínica.

Objetivo: Explorar as barreiras à comunicação percecionadas pelos enfermeiros que exercem funções no Serviço de Urgência, bem como as estratégias utilizadas para a sua superação.

Métodos: Estudo transversal, descritivo, de abordagem mista, realizado num Serviço de Urgência de um hospital do Norte de Portugal. A componente quantitativa incluiu 78 enfermeiros, que responderam a um questionário estruturado, sendo os dados analisados por estatística descritiva e inferencial. A componente qualitativa compreendeu entrevistas semiestruturadas a 7 enfermeiros, submetidas a análise temática com recurso ao software NVivo.

Resultados: Os resultados evidenciaram barreiras predominantemente organizacionais (elevada carga de trabalho, limitação temporal e interrupções frequentes), fatores ambientais (ruído e a ausência de privacidade), bem como fatores profissionais e clínicos (uso de linguagem técnica, o stress e a falta de formação específica em comunicação clínica). Identificaram-se diferenças estatisticamente significativas na perceção de determinadas barreiras entre enfermeiros com e sem formação específica em comunicação clínica, sendo que os enfermeiros com formação específica atribuem maior impacto às interrupções na troca de informação e os enfermeiros sem formação revelam maior dificuldade em manter uma comunicação clara e objetiva sob stress. Os dados qualitativos corroboraram os resultados quantitativos, evidenciando o impacto das dificuldades comunicacionais na prestação de cuidados.

Conclusão: A comunicação em contexto de urgência é condicionada por múltiplas barreiras interligadas, sendo necessário investir em intervenções organizacionais e na formação em competências comunicacionais para promover cuidados de enfermagem de qualidade.

Palavras-chave: comunicação; serviço de urgência; relação enfermeiro-paciente; capacitação em Serviço; Equipa de Enfermagem.

ABSTRACT

Introduction: Communication between nurses and patients constitutes a fundamental element of the quality, safety, and humanization of healthcare, assuming relevance in the context of the Emergency Department, characterized by high care pressure and clinical complexity.

Objective: To explore the barriers to communication perceived by nurses working in the Emergency Department, as well as the strategies used to overcome them.

Methods: Cross-sectional, descriptive, mixed-methods study conducted in the Emergency Department of a hospital in Northern Portugal. The quantitative component included 78 nurses who completed a structured questionnaire, with data analyzed using descriptive and inferential statistics. The qualitative component comprised semi-structured interviews with 7 nurses, which were subjected to thematic analysis using NVivo software.

Results: The results revealed predominantly organizational barriers (high workload, time constraints, and frequent interruptions), environmental factors (noise and lack of privacy), as well as professional and clinical factors (use of technical language, stress, and lack of specific training in clinical communication). Statistically significant differences were identified in the perception of certain barriers between nurses with and without specific training in clinical communication, with nurses with specific training attributing a greater impact to interruptions in information exchange and nurses without training revealing greater difficulty in maintaining clear and objective communication under stress. The qualitative data corroborated the quantitative findings, highlighting the impact of communication difficulties on care delivery.

Conclusion: Communication in the emergency context is conditioned by multiple interrelated barriers, making it necessary to invest in organizational interventions and training in communication skills to promote high-quality nursing care.

Keywords: communication; emergency service; nurse-patient relations; inservice training; nursing staff

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RESUMEN

Introducción: La comunicación entre enfermeros y pacientes constituye un elemento fundamental de la calidad, la seguridad y la humanización de la atención sanitaria, adquiriendo especial relevancia en el contexto del Servicio de Urgencias, caracterizado por una elevada presión asistencial y complejidad clínica.
Objetivo: Explorar las barreras de comunicación percibidas por los enfermeros que trabajan en el Servicio de Urgencias, así como las estrategias utilizadas para su superación.
Métodos: Estudio transversal, descriptivo, de enfoque mixto, realizado en el Servicio de Urgencias de un hospital del norte de Portugal. La componente cuantitativa incluyó a 78 enfermeros que respondieron a un cuestionario estructurado, cuyos datos fueron analizados mediante estadística descriptiva e inferencial. La componente cualitativa comprendió entrevistas semiestructuradas a 7 enfermeros, sometidas a análisis temático con el uso del software NVivo.
Resultados: Los resultados evidenciaron barreras organizativas (elevada carga de trabajo, limitación temporal e interrupciones), ambientales (ruido y falta de privacidad) y profesionales/clínicas (lenguaje técnico, estrés y falta de formación en comunicación). Se identificaron diferencias estadísticamente significativas en la percepción de determinadas barreras entre enfermeros con y sin formación específica en comunicación clínica, atribuendo los enfermeros con formación específica un mayor impacto a las interrupciones en el intercambio de información y revelando los enfermeros sin formación mayor dificultad para mantener una comunicación clara y objetiva bajo estrés. Los datos cualitativos confirmaron el impacto de estas dificultades en la prestación de cuidados.
Conclusión: La comunicación en el contexto de urgencias está condicionada por múltiples barreras interrelacionadas, siendo necesario invertir en intervenciones organizativas y en la formación en competencias comunicativas para promover cuidados de enfermería de calidad.

Palabras clave: comunicación; servicios médicos de urgencia; relaciones enfermero- paciente; capacitación en servicio; personal de enfermería

INTRODUCTION

Communication is a central element in the delivery of high-quality healthcare and is embedded in nurses' fundamental professional responsibilities. In clinical practice, the ability to establish effective communication is particularly important in building the therapeutic relationship, especially in situations of greater clinical complexity. In the Emergency Department, nurses are responsible for managing interpersonal communication intentionally and appropriately, demonstrating knowledge of communication techniques and facilitative strategies that promote understanding, trust, and informed decision-making by critically ill patients. As a therapeutic tool, communication contributes to reducing pain and suffering, promoting comfort, well-being, and safety in care, and is recognized as an essential component of safe, high-quality healthcare (Babaii, Mohammadi, & Sadooghiasl, 2021). In the Emergency Department (ED), communication faces additional challenges arising from patients' clinical instability, high patient volumes, and the time pressure characteristic of this setting. These conditions may compromise the quality, efficiency, and effectiveness of nursing care, making communication more complex than in other healthcare settings (Bozorgzad et al., 2021). Accordingly, this study aimed to explore the communication barriers perceived by nurses working in the Emergency Department, as well as the strategies used to overcome them, thereby supporting the relevance of the topic and the development of the present research study. The following specific objectives were defined:

- To identify the organizational, environmental, clinical, and professional factors that hinder communication between nurses and patients in the emergency setting;
- To analyze nurses' perceptions of barriers to communication with patients in the emergency setting, comparing them according to specific training in clinical communication;
- To explore, through a qualitative approach, nurses' experiences and perceptions regarding communication difficulties in the emergency setting;
- To systematize the strategies used or suggested by nurses to promote effective communication with patients in the emergency setting.

1. THERAPEUTIC COMMUNICATION IN NURSING IN THE EMERGENCY DEPARTMENT SETTING

Therapeutic communication is an essential, intentional professional process that enables the identification of patients' needs and the provision of holistic care (Pavlova, 2024). When patient-centred, it promotes individualized care, treatment adherence, trust, and therapeutic outcomes (Kwame & Petrucka, 2021). It encompasses emotional dimensions—such as empathy, respect, and trust—as well as informational dimensions, including patient education and expectation management (Pavlova, 2024). According to Alharazi et al. (2025) and Pavlova (2024), effective and interactive communication is directly associated with patient satisfaction and strengthens the nurse–patient relationship. Nurses should therefore base their practice on effective communication,

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overcoming barriers and understanding facilitating factors in order to optimize nursing care (Alharazi et al., 2025; Kwame & Petrucka, 2021; Lacerda, 2021).

1.1 Communication characteristics, barriers, and strategies

In the Emergency Department (ED), the effectiveness of nurse–patient communication is frequently compromised by time pressure and high patient volumes (Lacerda, 2021; Lacerda et al., 2021). Nevertheless, effective communication is crucial to the quality of care, increasing treatment adherence and reducing patient anxiety (Bahari et al., 2024; Lacerda, 2021).

According to Kordkolaee et al. (2024), the main obstacles to effective nurse–patient communication are shortages of nursing staff and workload in the ED, which is consistent with the findings reported by Al-Kalaldeh (2020). Moreira et al. (2022), Gheshlagh et al. (2024), and Zaman et al. (2025) also identify these barriers and add excessive working hours among the most important and frequent barriers to communication between nurses and patients in emergency settings. Lack of knowledge and training in communication skills were variables identified in the findings of Al-Kalaldeh et al. (2020) and Souza et al. (2021). Kordkolaee et al. (2024) and Gheshlagh et al. (2024) likewise describe inadequate knowledge among nurses regarding communication skills. Other authors have identified patients' lack of recognition of the nursing profession, roles, and responsibilities as barriers in EDs (Kordkolaee et al.; Gheshlagh et al., 2024). Patient-related barriers described in the literature mainly include the presence of accompanying persons and inappropriate or aggressive behavior towards healthcare professionals (Kordkolaee et al.; Gheshlagh et al., 2024). Other important, although less frequent, barriers include a shortage of physical spaces that ensure privacy for effective communication (Souza et al., 2021; Gheshlagh et al., 2024) and nurses' dissatisfaction with the profession (Gheshlagh et al., 2024). Zaman et al. (2025) further report that the use of medical terminology may hinder effective communication.

Effective communication in emergency settings requires structured strategies grounded in scientific evidence. The use of clear language adapted to the patient's level of understanding, combined with environmental management—namely reducing noise and interruptions—helps minimize errors, reduce professional stress, and improve patient safety (Tuohy & Wallace, 2024). Strategies such as active listening, empathy, and promotion of patient autonomy strengthen trust and emotional support, thereby improving care and treatment adherence (Sequeira, 2016; Lacerda, 2021). Structured education and continuous training in communication skills, including clarity, empathy, and mutual respect, are key to improving nurses' competencies (Chen et al., 2023; Tuohy & Wallace, 2024; Alghamdi et al., 2023).

2. METHODS

This study adopted mixed-methods, cross-sectional, descriptive design and aimed to explore communication barriers perceived by nurses in the Emergency Department and the strategies used to overcome them.

The quantitative component constituted the central strand of the study and, through a questionnaire administered at a single point in time, enabled objective identification and measurement of the most prevalent barriers in actual clinical practice. Complementarily, the qualitative component provided greater interpretative depth by exploring participants' meanings and experiences. This methodological integration made it possible to clarify and expand the quantitative findings, combining objectivity with interpretative depth to enhance the robustness, validity, and consistency of the results.

The cross-sectional nature of the design involved data collection at a single point in time, without manipulation of variables, allowing participants' perceptions to be described as they occurred in the real clinical practice setting.

2.1. Sample

The target population comprised 97 nurses working in the Emergency Department of a hospital in Northern Portugal. A non-probability sample was used, consisting of nurses from this department who met the inclusion criteria and agreed to participate in the study. No formal sample size calculation was performed, as this was an exploratory study using a convenience sample.

The use of convenience sampling and the absence of a formal sample size calculation were justified by the exploratory nature of the study and the specific characteristics of the Emergency Department setting. This strategy made it possible to overcome logistical and organizational constraints and enabled timely, feasible data collection adapted to the unpredictability of nurses' routines. As the primary aim was to achieve an initial understanding of the phenomenon in its real-world context—rather than statistical generalization—the study sought to include as many voluntary participants as possible in order to enrich and diversify the perspectives analyzed. Nevertheless, the non-probability approach limits extrapolation of the findings to other settings or populations and therefore requires caution in their interpretation. Although restricted to a specific context, these contributions provide a useful starting point for future research using larger samples and probability-based methods to strengthen the external validity of the conclusions.

The inclusion criteria were nurses working in the ED who provided direct patient care and had at least 6 months of experience in the department. Nurses performing exclusively management functions were excluded. After applying these criteria, 2 nurses were excluded because they held exclusively management roles, and 17 chose not to complete the questionnaire, resulting in a final questionnaire sample of 78 respondents.

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2.2. Data Collection Instruments

The data collection instrument included a structured questionnaire developed by the author to assess nurses' perceptions of barriers to communication.

Questionnaire items were organized into five conceptual dimensions defined a priori on the basis of the literature: organizational, environmental, clinical, professional, and strategies/perceptions. Each dimension comprised the corresponding items, and its score was calculated as the arithmetic mean of responses on a 5-point Likert scale.

The questionnaire was organized into two distinct parts: the first addressed participants' sociodemographic and professional characteristics (sex, age, professional experience, and training), and the second focused on perceptions of communication barriers, encompassing organizational, environmental, emotional, and clinical factors operationalized through 13 statements. No formal psychometric validation was performed; however, the internal consistency of the dimensions was examined using Cronbach's alpha and correlation coefficients, allowing the reliability of the instrument to be assessed within the context of the study.

In addition, semi-structured interviews were conducted using an interview guide comprising 9 open-ended questions, allowing participants to freely express their experiences and opinions regarding the topic under study. The interviews were conducted individually and face to face with a small subsample of 7 participants, all of whom had also taken part in the quantitative phase. This approach was intended to provide a deeper qualitative understanding of the perceptions identified.

Data were collected in September 2025 by making the questionnaire available and sending it to the institutional email addresses of nurses working in the Emergency Department. Participants were duly informed of the study objectives and the voluntary nature of their participation, and the data were stored digitally by the researcher. The study reported no conflicts of interest and received a favorable opinion from the institution's Ethics Committee (opinion no. 0058/CES/JAS, 11 July 2025).

The data collection instrument was structured around five conceptual dimensions supported by the literature: organizational, environmental, clinical, professional, and strategies/perceptions. The score for each dimension was calculated as the arithmetic mean of the respective items, measured on a 5-point Likert scale (ranging from 1 – Strongly disagree to 5 – Strongly agree). Higher mean values indicate a greater perception of the presence of a barrier or greater agreement with the strategies assessed.

Table 1 presents the description and reliability of the questionnaire dimensions. Internal reliability was assessed using Cronbach's alpha, applying the following interpretative ranges: < 0.5 – Unacceptable; 0.5 to 0.6 – Poor; 0.6 to 0.7 – Questionable; 0.7 to 0.8 – Acceptable; 0.8 to 0.9 – Good; > 0.9 – Excellent (George & Mallery, 2003). For dimensions comprising only two items, Spearman's correlation coefficient and its statistical significance were examined. The Organisational ($\alpha = 0.778$) and Environmental ($r = 0.530$; $p < 0.001$) dimensions showed good reliability, high mean scores (4.4), and low variability, indicating greater consistency and homogeneity of responses. The Professional dimension showed acceptable reliability ($\alpha = 0.689$) and an equally high mean score (4.3). In contrast, the Clinical dimension showed lower reliability ($r = 0.269$; $p < 0.001$), a lower mean score (3.6), and greater dispersion, indicating greater heterogeneity in responses. The Strategies/Perceptions dimension showed the weakest reliability ($\alpha = 0.610$), an intermediate mean score (3.9), and relatively high variability. Overall, the Organisational and Environmental dimensions showed the greatest consistency and homogeneity of responses, whereas the Clinical and Strategies/Perceptions dimensions showed greater variability and lower reliability.

Table 1 – Descriptive and reliability analysis of the dimensions

	Nº of items	Reliability analysis	Mean	SD
Organisational	3	Cronbach's alpha = 0.778 (good reliability)	4,4	0,7
Environmental	2	Spearman's correlation coefficient = 0.530 (p < 0.001) (good reliability)	4,4	0,5
Clinical	2	Spearman's correlation coefficient = 0.269 (p < 0.001) (fair reliability)	3,6	0,9
Professional	3	Cronbach's alpha = 0.689 (acceptable reliability)	4,3	0,7
Strategies/Perceptions	3	Cronbach's alpha = 0.610 (poor reliability)	3,9	0,8

2.3. Statistical Analysis

Statistical analysis of the quantitative data was performed using IBM SPSS Statistics (v. 30.0). The sample and variables were characterized using descriptive statistics, with absolute and relative frequencies for nominal variables and measures of central tendency and dispersion (mean, standard deviation, minimum, and maximum) for quantitative variables, such as Likert-scale items addressing barriers to communication with critically ill patients. To detect statistically significant differences in perceptions of communication barriers according to specific training in clinical communication, Student's t-tests for two independent samples were used. The normality assumption was assessed using complementary criteria, including normality tests (Kolmogorov–Smirnov test). When the assumption of population normality was not met, the non-parametric Mann–Whitney test was used. For the sample without specific training in clinical communication ($n = 67$), the central limit theorem was applied to support the use of parametric tests, based on the principle that, for sufficiently large samples (typically $n \geq 30$), the sampling distribution of the mean tends to approximate normality, allowing parametric tests to be used with some robustness even in the presence of moderate deviations from normality. The significance level adopted for rejection of the null hypothesis was 5% (0.05).

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The qualitative analysis of the interviews with nurses was based on an inductive thematic approach, in which categories were not predefined but emerged directly from participants' accounts. The process involved initial coding of text segments into broad categories, followed by focused coding of the most relevant excerpts. The thematic categories were not established in advance; rather, they emerged from the data through an inductive approach, with codes assigned as the researcher analyzed each response. Frequency distributions (n) referred to the number of themes (nodes) mentioned and their percentage coverage of the total themes for each question; quotations and context units were included to facilitate understanding of the themes identified. Qualitative analysis was conducted using NVivo 15.0, which enabled source organization, data coding, and the creation of tree nodes, allowing the discourse to be labeled and hierarchically organized and absolute frequencies to be counted.

3. RESULTS

The sample (N = 78 nurses) had a mean age of 36.9 years (range: 23–59), was predominantly female (74.4%), and showed a low level of specific training in clinical communication (85.9%), highlighting a gap in therapeutic interaction. Participants had substantial professional experience, with a mean of 13.6 years of clinical practice and 10.3 years of experience in the Emergency Department.

Regarding barriers to communication with critically ill patients (Table 2), organized into five dimensions, organizational barriers were perceived as having the greatest impact (interruptions, workload, and lack of time), followed by environmental barriers (noise and lack of privacy), clinical barriers (severity of illness and altered level of consciousness), and professional barriers (technical language, insufficient training, and stress). In the strategies domain, although communication was individually valued as a priority, lower scores were observed for the promotion of a collective communication culture within the team, revealing institutional weaknesses.

Table 2 – Barriers to communication with critically ill patients in the emergency/emergency care setting

	Dimension	Mean	SD	Minimum	Maximum
High workload hinders communicative interaction with the patient.	Organizacional	4.3	0.8	2	5
Lack of time prevents effective communication in the emergency setting.	Organizacional	4.3	0.7	2	5
Constant interruptions compromise information exchange with the patient.	Organizacional	4.6	0.5	3	5
Noise and constant movement make it difficult to concentrate during communication.	Environmental	4.6	0.5	3	5
Lack of privacy inhibits clear and empathetic communication with the patient.	Environmental	4.2	0.8	1	5
The patient's clinical severity makes obtaining informed consent difficult.	Clinical	3.2	1.0	1	5
The patient's altered level of consciousness limits effective communication.	Clinical	3.9	0.8	2	5
I feel that I do not have sufficient training in clinical communication for emergency settings.	Professional	4.2	0.8	1	5
Under stress, it becomes difficult to maintain clear and objective communication.	Professional	3.9	0.8	2	5
Technical language may make it difficult for the patient to understand.	Professional	4.6	0.6	2	5
I use strategies to adapt my communication to the patient's condition.	Strategies/ Perceptions	4.2	0.8	1	5
I consider communication with the patient a priority, even in critical situations.	Strategies/ Perceptions	4.3	0.8	2	5
My team promotes a culture of patient-centred communication.	Strategies/ Perceptions	3.4	0.8	2	5

Table 3 shows statistically significant differences in two communication barriers when nurses with and without specific training in clinical communication were compared. Professionals with training attributed a greater impact to constant interruptions in information exchange. Conversely, professionals without communication training reported greater difficulty maintaining clear and objective communication under stress, suggesting that training may contribute to better emotional management in stressful situations.

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Table 3 – Barriers to communication with critically ill patients in the emergency/emergency care setting according to specific training in clinical communication

	Specific Training in Clinical Communication						
	YES			NO			
	Mean	SD	Mean rank	Mean	SD	Mean rank	*P*
High workload hinders communicative interaction with the patient.	4.3	0.8	38.1	4.6	0.5	48.0	0.142**
Lack of time prevents effective communication in the emergency setting.	4.3	0.7	38.9	4.4	0.9	43.2	0.518**
Constant interruptions compromise information exchange with the patient.	4.5	0.6	38.0	4.8	0.4	48.6	<0.05**
Noise and constant movement make it difficult to concentrate during communication.	4.5	0.5	38.4	4.7	0.5	46.0	0.234**
Lack of privacy inhibits clear and empathetic communication with the patient.	4.2	0.9	40.6	4.0	0.8	32.6	0.415*
The patient's clinical severity makes obtaining informed consent difficult.	3.3	1.0	40.1	3.1	0.8	36.1	0.613*
The patient's altered level of consciousness limits effective communication.	3.9	0.9	39.9	3.9	0.3	37.1	0.670**
I feel that I do not have sufficient training in clinical communication for emergency settings.	4.2	0.9	39.8	4.2	0.8	37.9	0.965*
Under stress, it becomes difficult to maintain clear and objective communication.	4.0	0.7	41.7	3.3	1.0	26.2	<0.05*
Technical language may make it difficult for the patient to understand.	4.6	0.6	38.8	4.7	0.5	43.5	0.452**
I use strategies to adapt my communication to the patient's condition.	4.2	0.8	38.5	4.5	0.7	45.5	0.298**
I consider communication with the patient a priority, even in critical situations	4.3	0.8	40.0	4.3	0.6	36.2	0.564**
My team promotes a culture of patient-centred communication.	3.4	0.9	40.6	3.1	0.7	32.7	0.251**

Note: *Student's t-test for two independent samples; **Mann–Whitney test

The results of the interviews conducted with 7 nurses across the different domains are presented below. In the qualitative analysis, the interviews were coded by identifying meaning units, which were counted according to thematic frequency. Thus, the "n" values presented in the tables refer to the number of occurrences of emerging themes rather than the number of participants (n = 7), as the same interviewee could contribute to several categories. The node hierarchy therefore supports both a macro- and micro-level reading of the data, strengthening the analytical robustness and interpretative clarity of the coding process (Richards, 2009).

Nurses' communication experience in the Emergency Department

Overall, nurses described communication in this setting as a challenging, frequently ineffective process influenced both by the patient's clinical and emotional condition (22.2%) and by characteristics of the department. The environment was described as dynamic, noisy, and characterized by lack of time (11.1%), which hampers the establishment of clear and empathetic communication. In addition, the use of technical language (11.1%) and patients' physical or psychological limitations contribute to making the interaction more complex.

"Based on your experience, how would you describe communication with patients in emergency/emergency care situations?"
High patient volume (20%) and stress management (20%) emerged as the most prominent challenges identified by interviewees. Work overload and noise, although reported at lower percentages (13.3%), reinforce the perception of a demanding work environment characterised by multiple simultaneous demands and adverse environmental conditions. Challenges related to low health literacy (13.3%), the use of plain language (6.7%), and the presence of patients' family members (6.7%) were also mentioned.

Main communication barriers identified by nurses

"Which factors do you consider most likely to hinder communication (time, environment, the patient's clinical condition, etc.)?" (n = 14)
The main barriers identified were a noisy environment (28.6%), high workload (14.3%), the patient's clinical and emotional condition (14.3%), lack of privacy (14.3%), and lack of time (7.1%).

"Are there times when you feel communication fails? Why?" (n = 7)
All participants (100%) acknowledged situations in which communication fails, and the most frequently reported cause was low health literacy among patients and/or family members (57.1%), which hinders and compromises the effectiveness of the communication process. Other factors mentioned, such as prioritizing patient stabilization (14.3%), communicating bad news (14.3%), and lack of privacy (14.3%), reflect the pressures and constraints of the clinical setting.
Impact of communication difficulties on patient care

"Do you believe communication difficulties influence the patient's clinical outcome or well-being?" (n = 7)
All interviewees believed that communication difficulties have an impact on clinical outcomes or patient well-being (57.1%), although not all were able or willing to clearly articulate this relationship. The main consequences concerned patient adherence

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to treatment and care delivery ("Yes, of course. These difficulties can interfere with care delivery and the patient's adherence to treatment.").

"Have you witnessed situations in which communication failure had consequences?" (n = 7)
When asked, almost all interviewees (85.7%) reported having witnessed situations in which communication failure had consequences. Examples included failure to understand treatment (28.6%), hostility (aggressive behavior) on the part of the patient, and other misunderstandings in general (14.3%).

Strategies and proposals for improving communication
"What strategies do you use to try to improve communication?" (n = 13)
The most frequently reported strategy was to communicate in a calm, low-noise environment (23.1%), followed by adapting clinical language to everyday language (15.4%), highlighting the importance of the physical context for effective communication. Both verbal and non-verbal aspects were identified: adapting clinical language (15.4%), using an appropriate and calm tone of voice (15.4%), adopting an empathetic attitude (15.4%), and providing information in advance about procedures (7.7%).

"Does the institution where you work promote good communication practices? Is training provided?" (n = 7)
There was a predominantly negative perception regarding institutional promotion of good communication practices, with participants reporting the absence of specific training and structured initiatives in this area within the institution.

"What suggestions would you make to improve this aspect in your own practice and within the team?" (n = 11)
At the end of the interview, nurses were asked to suggest ways to improve good communication practices. The main suggestions focused on greater investment in training in this area (45.5%) ("I suggest promoting regular training sessions for all members of the emergency team") and creating a dedicated room for communicating bad news (36.4%) ("…creating a more private room to provide greater privacy when communicating with patients/family members, particularly in difficult contexts such as bereavement or end-of-life situations"). Suggestions were also made to minimize noise and improve the environment and context for communication with patients.

4. DISCUSSION

The analysis of the results addressed the general objective of the study by identifying barriers to communication between nurses and critically ill patients in the emergency setting, as well as the corresponding strategies used to overcome them. Methodological triangulation (quantitative and qualitative) provided an in-depth understanding of the phenomenon by combining quantification of the barriers with a detailed analysis of their impact on clinical practice.
The results showed that organizational barriers were the most prominent, particularly constant interruptions, high workload, and time constraints. These findings are consistent with the studies by Al-Kalaldeh (2020), Moreira et al. (2022), Gheshlagh et al. (2024), and Zaman et al. (2025), which identify work overload and shortages of human resources as central factors that compromise communication in emergency settings. However, rather than being merely structural constraints, the qualitative data suggest that these barriers are perceived as intrinsic features of Emergency Department functioning, contributing to the normalization of interruptions and care-related pressure. This finding, which has received less emphasis in the literature, suggests a process of cultural adaptation among professionals to the setting, potentially leading to the normalization of suboptimal practices and making structural and organizational change more difficult to implement.
Within the environmental dimension, noise, constant movement, and lack of privacy showed high mean scores and were also reported in the interviews as factors that compromise concentration and communicative empathy. These findings are consistent with Souza et al. (2021) and Gheshlagh et al. (2024), who highlight the lack of suitable spaces for communication as a significant barrier. Data triangulation indicates that the physical environment is not merely a contextual factor but directly influences the quality of therapeutic interaction, affecting both information clarity and patients' perception of safety.
Regarding professional and clinical barriers, the use of technical language, the impact of stress, and the perception of insufficient training were particularly prominent. These findings are consistent with Al-Kalaldeh et al. (2020), Souza et al. (2021), Gheshlagh et al. (2024), and Kordkolaee et al. (2024), who identify deficits in communication skills as a factor limiting practice. Importantly, in this study, nurses without specific training showed greater difficulty maintaining clear communication under stress, suggesting that training may act as a protective factor in emotional regulation and message structuring in critical situations, in line with Chen et al. (2023).
A particularly relevant finding that partly diverges from the literature concerns the perception of patient aggression. Whereas studies such as Kordkolaee et al. (2024) and Gheshlagh et al. (2024) predominantly describe aggression as a barrier to communication, in this study it also emerged as a possible consequence of communication failures, suggesting a bidirectional relationship between ineffective communication and relational tension. This perspective broadens understanding of the phenomenon by partially shifting the focus from external factors to relational processes and implies that improving communication skills may affect not only information exchange but also conflict prevention.
With regard to improvement strategies, nurses reported adapting language, creating more private environments, and adopting an empathetic attitude and active listening, in line with Tuohy and Wallace (2024), Sequeira (2016), and Lacerda (2021). In addition, Alghamdi et al. (2023) emphasise that structured communication practices promote greater patient satisfaction and

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safety. Despite the individual value placed on communication, the findings indicate institutional weaknesses, particularly in the provision of structured training and in promoting an organizational culture based on therapeutic communication, consistent with Kwame and Petrucka (2021).

Overall, the mixed-methods approach proved essential for capturing both the quantitative dimension and the subjective meaning of communication barriers. The convergence of the data strengthens the conclusions, confirming that communication in the Emergency Department is a complex phenomenon shaped by structural, environmental, and individual factors that require integrated, multidimensional interventions.

Study limitations

Several limitations of this study should be acknowledged, particularly those related to the size and nature of the sample. The use of a convenience sample comprising 78 questionnaire respondents and 7 interview participants may affect the representativeness of the findings and consequently limit their generalisability to other populations or healthcare settings. The study was conducted in a single Emergency Department, which may further limit extrapolation of the findings to other institutional contexts. In addition, the use of an author-developed questionnaire without extensive psychometric validation constitutes a methodological limitation, although the mixed-methods approach allowed the findings to be explored in greater depth and triangulated. Finally, the use of self-reported data may be associated with social desirability bias.

Implications for practice

The study findings support the need to optimize organizational and environmental conditions in the Emergency Department, particularly through workload management, reduction of interruptions, and the creation of spaces that provide greater privacy for communication. In addition, the limited availability of specific training supports the implementation of clinical communication training programmes tailored to the emergency care setting. Finally, it is important to consolidate an institutional culture based on therapeutic communication, thereby promoting the quality, safety, and humanization of nursing care.

CONCLUSION

This study explored communication barriers perceived by nurses in the Emergency Department and the corresponding strategies used to overcome them, identifying multiple organizational, environmental, clinical, and professional barriers that affect the effectiveness of communication in this setting. Strategies to mitigate these limitations include adapting language, using a calm tone of voice, adopting an empathetic attitude, and seeking more favorable communication environments. The findings show that communication between nurses and patients in this demanding and dynamic context is a competence that extends beyond the technical dimension and requires institutional support and continuous investment in communication-skills training in response to challenges such as time pressure, unpredictability, and high patient volumes. Gaps in institutional support were also identified, reinforcing that the adoption of appropriate communication practices is essential to ensure the quality, safety, and humanization of care and to preserve the therapeutic relationship.

This study makes an original contribution to scientific knowledge by providing an integrated exploration of nurses' perceptions of barriers to communication with critically ill patients in emergency/emergency care settings, combining quantitative and qualitative approaches and providing relevant empirical evidence on a topic that remains underexplored.

Future research should further investigate this topic by replicating the study in other Emergency Department settings, including basic, medical-surgical, and multipurpose emergency departments, as well as in hospital institutions located in different regions of the country, in order to provide a broader and comparative understanding of communication barriers across different care contexts.

AUTHOR´S CONTRIBUTION

Conceptualization, S.M. and G.B.; data curation, S.M.; formal analysis, S.M. and G.B.; investigation, S.M.; methodology, S.M. and G.B.; project administration, S.M.; resources, S.M. and G.B.; software, S.M.; supervision, G.B.; validation, G.B.; visualization, S.M. and G.B.; writing – original draft, S.M.; writing – review & editing, S.M. and G.B.

CONFLICT OF INTERESTS

The authors declare no conflict of interests.

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