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Original Article

Experiences of Being in an Intensive Care Unit: A Qualitative Phenomenological Study

Azmat Bano[1], **Mandeep Kumar Jangra**[2], **Akanksha Saxena**[3*]

[1]Maharishi Markandeshwar Institute of Physiotherapy and Rehabilitation, Department of Musculoskeletal Physiotherapy, Maharishi Markandeshwar (Deemed to be University), Mullana, India
[2]Department of Physiotherapy, Maharishi Markandeshwar Medical College and Hospital, Kumarhatti- Solan, India
[3]Maharishi Markandeshwar Institute of Physiotherapy and Rehabilitation, Department of Neurological Physiotherapy, Maharishi Markandeshwar (Deemed to be University), Mullana, India

***Corresponding Author:** Akanksha Saxena, Email: akankshasaxena623@gmail.com

Abstract

Introduction: Recovery among individuals discharged from Intensive Care Units (ICUs) is often prolonged and suboptimal. Many patients experience significant physical, emotional, and cognitive complications. Enhancing patient involvement in decision-making has become a contemporary priority and is expected to further improve the quality of ICU care. This study aimed to explore the experiences of individuals admitted to the ICU.

Methods: This qualitative study employed a hermeneutic phenomenological approach and recruited 12 participants with varied diagnoses who had stayed in different ICUs for a minimum of four days. In-depth, face-to-face, semi-structured interviews were conducted using a content-validated interview guide to explore participants' detailed experiences. Data were collected until saturation was reached, meaning no new codes or themes emerged. All interviews were audio-recorded and lasted 30–45 minutes; recordings were transcribed verbatim into English and subsequently imported into QDA Miner Lite software for analysis.

Results: Analysis yielded eight themes and 22 subthemes. The identified themes were: Overall Experience; Food, Hygiene, and Cleanliness; Communication with Staff; Transition from ICU to Ward; Sleep Disturbances; Emotions Experienced and Perceptions; Obstacles to Recovery; and Suggestions for Improving Care.

Conclusion: The study found that most patients were satisfied with the overall ICU care they received. However, they reported issues such as inadequate sleep, hygiene concerns, and encounters with uncooperative or rude staff, which further complicated their transition to other wards. Participants recommended increasing the number of qualified, empathetic, and respectful staff in ICUs to make patients' ICU stays more comfortable.

Keywords: Intensive care units, Patient satisfaction, Patient participation, Communication

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Introduction

In recent years, advancements in pharmacological and surgical technologies have significantly improved patient survival, resulting in a reduced mortality rate of approximately 5.6%–19.1% (1,2). Each year, nearly 270,000 individuals are admitted to ICUs in the United Kingdom (3). Despite these improvements, the recovery phase for many patients discharged from ICUs remains prolonged and suboptimal, with most individuals experiencing substantial physical, emotional, and cognitive impairments (4).

Rapid muscle wasting, functional decline, and delirium are among the most common problems experienced by individuals during their ICU stay (5). These issues not only delay the patient's recovery process but also lead to a wide range of complications, including weakness, fatigue, decreased endurance, shortness of breath, reduced mobility, anxiety, depression, loss of appetite, memory impairments, difficulties with attention and concentration, nightmares, hallucinations, and flashbacks (4,5). In addition to these complications, ICU patients face an increased risk of malnutrition, which can result in a 10–30% loss of total body mass, with an estimated daily loss of approximately 2% (6,7). These complications contribute to the development of a constellation of physical, neurological, and emotional sequelae following discharge from intensive care, collectively known as Post-Intensive Care Syndrome (PICS) (2,8). The prevalence of PICS ranges from 15% to 50%, with associated mental, physical, and cognitive impairments persisting for 5–15

years (8). Patients frequently report negative memories of their ICU stay for various reasons, including fear of death, pain, sleep disturbances, and the presence of tubes and drains (9).

Healthcare professionals and family members often evaluate improvements in ICU patients using quantitative measures, while paying insufficient attention to complications and PICS, factors that may hinder recovery after discharge and provide little insight into the underlying causes of these numerical outcomes (10). Therefore, client or patient involvement should be regarded as a high priority for both healthcare staff and family members (4). According to Lindberg et al. (2015), individuals admitted to ICUs expressed a desire to be active participants in their own decision-making processes (11).

Moreover, qualitative research, in comparison to quantitative approaches, is better suited to identifying the underlying factors that disrupt patients' ICU experiences and serve as barriers to their recovery (10,12). In particular, phenomenological methods allow researchers to explore the precise lived experiences of individuals regarding a specific phenomenon, illness, or event, without imposing preconceived ideas or theoretical assumptions, as may occur in grounded theory approaches. Such research designs can reveal issues related to organizational structure and patient care, and can address the actual needs and concerns of patients, thereby facilitating a smoother pathway to recovery (13,14). However, only a limited number of studies have investigated patients' experiences during their stay in the ICU.

Most existing studies have focused on the transition from ICU to ward (6,15), patient well-being within the ICU (16), stressors encountered in the ICU (17), PICS following ICU discharge (18), or the experiences of patients undergoing cardiovascular surgeries (9,13,19). Studies examining direct ICU experiences have reported diverse findings, ranging from poor staff communication and inadequate nursing care to descriptions of satisfactory or even ideal ICU stays (20–24). However, the majority of studies highlight predominantly negative experiences (19–22), and several report that longer ICU stays are associated with more adverse perceptions (23,24). A recent study by Flahault et al. (2022) investigated long-term PICS-related sequelae among ICU survivors (18). The study found that maintaining an ICU diary helped identify stressors and demonstrated that support from healthcare staff played a significant role in managing these symptoms (18). While most prior research has centered on identifying stressors, surgical experiences, or communication with staff, none have comprehensively examined all dimensions of the ICU experience, such as involvement in decision-making, explanations of prognosis, and clarity regarding treatment, factors that could help facilitate a smoother ICU journey for patients. Furthermore, the majority of studies exploring ICU experiences have been conducted in developed countries with advanced medical facilities. There is a marked need for similar research in developing countries such as India to identify existing gaps and inform future improvements. Therefore, the present study aimed to explore the experiences of individuals admitted to Intensive Care Units (ICUs).

Methods

A qualitative phenomenological design using a hermeneutic approach was selected to capture the lived experiences of individuals. This approach was chosen because it reveals aspects of experience that are often taken for granted and provides rich textual descriptions when a deeper understanding of meaning is sought. Ethical approval was obtained from the Institutional Ethical Committee, and all procedures were conducted in accordance with the Declaration of Helsinki. Data were collected through in-depth, face-to-face, semi-structured interviews using a 17-item interview guide (Table 1). The guide was content-validated by experienced professionals with a minimum of five years of ICU experience. Following expert feedback, several modifications were incorporated, after which the item-level and scale-level Content Validity Indexes (25) were calculated as 0.83–1.00 and 0.83, respectively. A total of 12 participants were recruited using purposive sampling (12) from various ICUs at Maharishi Markandeshwar Institute of Medical Sciences and Research, Mullana-Ambala, India. Interviews were conducted only after participants were fully conscious, oriented to their surroundings, and had stable vital signs (21,23). Eligible participants were those who had stayed in the ICU for at least 5–7 days, were above 18 years of age (15), and had no communication, psychological, or cognitive impairments. Informed consent was obtained from all participants before the interviews. Interviews were scheduled according to participants' preferred timing and conducted by the primary researcher. Initial general questions were asked to build rapport and gain the participants' trust. Each interview lasted approximately 30–45 minutes and took place in the wards where participants were admitted. All interviews were transcribed verbatim into English and then imported into QDA Miner Lite software for qualitative analysis. Coding was carried out by the primary researcher and subsequently reviewed and finalized by all three researchers. Research rigor was ensured through member checking, wherein participants reviewed their interview transcripts, and through maintaining a detailed thick description of the entire research process. Furthermore, an audit trail was conducted periodically by fellow researchers to minimize potential bias.

Results

Data saturation was achieved after the 12th interview, as no new themes or subthemes emerged. Participant characteristics are presented in Table 2. Initial themes and subthemes were identified by the primary researcher, and through multiple rounds of discussion among all three researchers, eight themes and 22 subthemes were finalized. The subthemes, arranged according to their

Table 1. Interview guide

No.	Questions
1	How would you describe your overall experience in the ICU? Can you elaborate on specific comforts and discomforts you encountered during your stay?
2	What aspects of the ICU staff did you find unsatisfactory? Probes: Did this involve nurses, doctors, or support staff?
3	How would you describe your experience of communication with the ICU staff? Probes: Were there differences before and after intubation?
4	How was your experience with the meals provided during your ICU stay? Probes: Were meals served on time, hygienically prepared, and sufficient? How was your experience if you received RT feeding?
5	How would you describe the hygiene and cleanliness maintained during your stay? Probes: Were bed sheets and dressings changed on time? Were the washrooms and surroundings clean? Was oral hygiene maintained daily?
6	Were you intubated during your ICU stay? How did you experience being on mechanical ventilation? Probes: Did you face any discomfort after extubation?
7	How was your experience transitioning from mechanical ventilation to normal breathing?
8	Can you provide an example of a time when you found it difficult to make yourself understood or explain what you were trying to communicate?
9	Did you experience any difficulty sleeping while in the ICU? Probes: Consider factors such as lighting, stress, dyspnea, alarms, machine sounds, or other disturbances.
10	How was your experience transitioning from the ICU to the ward?
11	What do you consider your greatest strengths while being admitted to the ICU? Did you experience any loss of attention, confidence, or optimism? Probes: During your ICU stay or after transition to the ward?
12	Did you encounter any difficulties in decision-making or changes in your behavior? Probes: Consider lack of attention, disinterest, or irritability in performing activities.
13	What was the most significant problem you faced as a patient in the ICU?
14	Can you describe a time you were under significant pressure? What difficulties did you encounter, and how did you manage or overcome them? Probes:Consider anxiety, palpitations, or stress.
15	Did you experience any difficulties in understanding instructions from nursing or other medical staff?
16	Were you satisfied with the ICU environment? Probes: If not, what suggestions would you make to improve patient experience?
17	What were your expectations regarding your recovery?

Table 2. Demographic characteristics of the recruited Participants

Demographic Variables	n (Percentage of sample)
Sex	Male: 5(41.67%) Female: 7(58.33%)
Mean Age at the time of interview	45
Diagnosis	• Acute CVA of right temporo-occipital region (P1) • Seizure, with high-grade fever (P2) • Laminectomy (P3) • Dilated Cardiomyopathy (P4) • Ovarian tumor (P5) • Abdominal mass and Gastric outlet obstruction (P6) • Right Carcinoma breast (P7) • Carcinoma Ovary(P8) • Caesarean Section (P9) • Block Colon (P10) • Intestinal perforation with Exploratory laparotomy with Ileostomy (P11). • Biliary Peritonitis (P12)
Stay in ICU /CCU	4 patients stayed in ICU for 4 days 41.6%. 5 patients stayed in ICU for 5 days 33.3% 3 patients stayed in ICU for 8 days 25%

frequency across all interview transcripts, are illustrated in the word cloud (Figure 1). The themes and subthemes, along with representative participant quotations, are presented below.

Overall Experience

Satisfaction with the Care

This subtheme reflects patients' satisfaction with the care provided in the ICU. One participant stated, "*I knew about the hospital but never got a chance to review it; however, from what I observed, it is not as I had imagined… the hospital environment is very nice, and the staff are very helpful. I am satisfied with the environment of the ICU*" (Participant 4). Another participant noted, "*I am comfortable with the environment and with the staff too*"(Participant 2).

Better Recovery

This subtheme captures patients' perceptions of their recovery process and its progression. One participant shared, "*On the very first day of admission, my health and rate of recovery were poor, but after medication, treatment, and the cooperation of the staff, my recovery rate increased, and I am feeling good about it*" (Participant 3). Another participant stated, "*My recovery took some time due to my condition… the doctors informed me accordingly. My family constantly asked the staff how long it would take for me to recover, but my recovery progressed according to my medication. It took approximately 10 to 12 days for me to return to my normal, basic life. According to the staff and doctors, I did pretty well based on my prognosis*" (Participant 1). Another participant noted, "*My care was managed very well in both the ICU and the ward. It was done so effectively that I could recover so well; otherwise, I*

Figure 1. Word cloud of all participants

wasn't even able to speak properly"(Participant 6).

Food, Hygiene, and Cleanliness

Taste Variation

This subtheme reflects patients' perceptions of the quality, quantity, and taste of the food provided in the ICU. The study found that while patients were generally satisfied with the food's quality and quantity, they often did not enjoy its taste, which affected their appetite. One participant stated, "*Food was good and sufficient, but the problem is I don't feel like eating because of my illness. Although hospital food cannot be compared with homemade food, there were still taste variations*" (Participant 1). Another participant shared, "*I was on a liquid diet, but since yesterday, I have had an apple, tea, and biscuits. I didn't eat the food provided to me. I felt like vomiting when I saw it, but I consumed some on the doctor's instructions. I didn't like the taste of the meal, so I avoided having it*" (Participant 4).

Hygienically Prepared & Served

This subtheme captures patients' perceptions regarding the hygiene and presentation of food in the ICU. Participants generally reported satisfaction with the hygienic preparation and serving of meals. One participant noted, "*Meals were good. I was on a liquid diet, so the juice provided to me was sufficient and served hygienically. I was on RT feed, but even then, I did not face any difficulty while being fed through it*" (Participant 2). Another participant shared, "*I was given food by the hospital four to five times a day. Although the portions were small and the taste was not particularly appealing, the presentation was beautiful, which encouraged me to try it. The food was also properly wrapped and served hygienically every time*" (Participant 10).

Lack of Cleanliness/ Hygiene

This subtheme addresses patients' experiences with hygiene and cleanliness during their ICU stay. One participant stated, "*On my call, bed sheets were changed, but my personal care was not attended to at all; personal hygiene was also not maintained. The washrooms were acceptable, and sweepers came to clean the surroundings, but after some time, the area became filthy again*" (Participant 9).

Communication with Staff

Need for More Trained Staff

This subtheme highlights patients' concerns regarding interactions with ICU personnel, particularly the need for adequately trained staff. One participant emphasized, "*More trained and more qualified staff are required for the ICU, as patients here are critically ill and require greater support and care*" (Participant 1).

Difficulty in Two-Way Communication

This subtheme reflects the difficulties patients experienced when communicating with nursing staff and doctors. One participant shared, "*On the very first day of admission, I faced difficulty in understanding and making people understand. Besides, two days before admission, I faced the same issue… perhaps the problem is on my end, as I cannot explain myself properly*" (Participant 4). Another participant noted, "*Communication with doctors was good, but with some nursing staff it was smooth and acceptable, while with others it was very poor*" (Participant 9).

Ignorant and Rude Staff

This subtheme highlights patients' experiences of perceived indifference and unprofessional behavior by ICU staff. One participant remarked, "*One thing I did not like was the attitude of the staff. They were very rude and kept moving me from one bed to another. It was quite uncomfortable, and no one explained why I was being moved or whose orders were responsible for it*" (Participant 10).

Good Communication

This subtheme highlights patients' appreciation for effective communication and timely assistance provided by ICU staff. One participant stated, "*In the ICU, there were nurses, caretakers, and a cleaner. Overall, communication was good, and they performed their duties on time, helping me in and out of bed many times a day without being rude*" (Participant 1). Another participant shared, "*I did not experience any difficulty understanding the nurses' instructions. I was very satisfied with the nurse's behavior and appreciated her cooperation and patience*" (Participant 2).

Doctors as Heroes

For some patients, doctors were perceived as heroic figures, providing reassurance and support during a

difficult time. One participant expressed, "*When I learned about my disease, I was really in trouble and worried a lot about my condition and my children. I was trembling, but the doctors supported me and helped me realize that everything would be fine*" (Participant 8).

Being Ventilated

This subtheme highlights the difficulties patients experienced in communicating while on mechanical ventilation. One participant stated, "*I was on ventilation for a full day, and while being ventilated, I was not aware of what was happening around me. All medications were administered through machines, but after being removed from ventilation, I did not experience any discomfort and felt that I had recovered*"(Participant 4). Another participant shared, "*While on ventilation, you are not aware of anything, but after the transition, you feel much better. However, it does create difficulties in speaking and communicating*" (Participant 5).

Transition from ICU to Ward

Staff Difference

This subtheme reflects patients' perceptions of differences in staff behavior and care between the ICU and general wards. One participant stated, "*The ICU has better staff compared to the ward*" (Participant 1). Another participant noted, "*My experience in the ICU and the ward was almost the same, but in terms of staff, the ICU had more caring and empathetic personnel. In the ward, they seemed less attentive and less interested in what was happening with me*" (Participant 2).

Temperature Variation

This subtheme highlights patients' experiences with environmental differences during the transition from ICU to the ward, particularly regarding temperature. One participant stated, "*During the transition from the ICU to the ward, I noticed a temperature difference… It was cold in the ICU, while the ward felt hot in comparison. The ward had more facilities than the ICU, and the staff there were even more caring*" (Participant 3).

Sleep Disturbances

In the present study, five out of twelve patients reported difficulty sleeping, which they attributed to the attachment of probes and drainage tubes, as well as the continuous sounds of medical machines. Some participants also experienced dizziness and persistent headaches during their ICU stay.

Sounds of Equipment

This subtheme highlights patients' difficulties in sleeping due to the sounds of medical equipment. One participant stated, "*There were sounds of machines that made it impossible for me to sleep. Also, I was unwell, so I could not get much rest*" (Participant 1). Another participant noted, "I *did not have trouble sleeping because of the light, but I was greatly affected by the sounds of the machines and often had headaches because of them*"(Participant 4). Another participant shared, "*It was very uncomfortable; the lights disturbed me, and so did the noises, although I understand they are for the benefit of the patients*" (Participant 10).

Attachments

This subtheme highlights how medical devices, such as tubes, drains, and attached leads, contribute to patients' sleep disturbances. One participant shared, "*I couldn't sleep at all because of the bright lights and the drainage tubes attached to me. Turning was very difficult, and I could not get even an hour of sound sleep at night*" (Participant 10).

Physical Discomfort

This subtheme reflects patients' experiences of sleep disruption caused by physical weakness and pain. One participant stated, "*I had difficulty sleeping… I was on medication and also experienced other problems, such as dizziness and constant headaches. I was especially unable to sleep at night*" (Participant 2). Another participant noted, "*Due to my weakness, I was unable to sleep; otherwise, I did not face any difficulty in the ICU*" (Participant 6).

Emotions Experienced and Perceptions

Anxiety/Stress

Patients reported experiencing a range of emotions during their ICU stay, with anxiety and stress being the most common. One participant shared, "*I was feeling anxious and initially had palpitations too, but this gradually normalized with time and the surrounding environment*" (Participant 1). Another participant noted, "*During my treatment and ICU stay, and even in the ward, I felt extremely stressed. My mind kept imagining the worst-case scenarios, and my heart raced. All I wanted was to be free from this and sit outside*" (Participant 3).

Loss of Patience and Confidence

This subtheme highlights patients' experiences of reduced confidence and patience during ICU admission, which is also common among PICS patients. One participant stated, "*I did not experience any loss of attention, but I felt like I was losing my confidence. I am a NET aspirant, and I worried that after this, I might not be able to continue my preparation. At that time, my father encouraged me, boosting my confidence and assuring me that I could do it. His optimism towards my recovery and return home really helped*" (Participant 2).

Emotional Instability

Managing one's emotions is crucial for better and faster recovery. Participants described fluctuations in their behavior and emotional stability during ICU admission. One participant noted, "*Yes, there were alterations in my behavior. I used to get irritated easily and often got angry at every little thing happening around me*"(Participant 8). Another participant shared, "*I did not experience alterations in my behavior, but I was emotionally unstable. I used to think… I am not getting anything I want. I felt*

I could neither pamper my child nor take care of him, which made me both sad and angry, yet I was completely helpless"(Participant 9).

Positive Attitude

A positive attitude, combined with determination to recover, helped patients overcome challenges. One participant stated, *"I didn't feel weak or discouraged; I was brave and still feel brave. I fought and won against the most dangerous disease"*(Participant 7). Another participant added, *"During my ICU stay, other patients around me were tense about their health. I was also anxious about whether I would recover, but seeing them gave me strength and courage to get better"*(Participant 1).

Obstacles to Recovery

Post-Surgical Pain

Pain was identified as a major barrier to recovery. One participant reported, *"There was no pressure on me, but on the first day after admission, I experienced extreme pain. I had to take two injections of painkillers. Although the pain is gone now, I think that was the worst experience after admission"*(Participant 5).

Thirst

Thirst was also cited as a hindrance to recovery. One participant stated, *"There was a time I felt really thirsty. I kept asking for water, but no one gave it to me. Maybe the doctors had instructed otherwise, but thinking about it makes me feel bad about myself"*(Participant 6).

Suggestions forImproving Care

Patients offered practical suggestions to enhance ICU care:

- *"More trained and qualified staff are needed in the ICU"*(Participant 12).
- *"Maintaining hygiene and cleanliness is crucial, as it increases patients' confidence in treatment and encourages more people to trust the hospital"*(Participant 8).
- *"Patients in critical condition should be placed in a separate room in the ICU, as their panic can affect other patients and interfere with staff care"*(Participant 2).
- *"Guards outside the ICU must know doctors' schedules and treat family members respectfully so they can communicate with the doctors"*(Participant 7).
- *"Nurses must be cooperative and responsive to patients' needs"*(Participant 9).

Discussion

The experiences of ICU patients varied widely, emphasizing the importance of qualitative research in understanding individual patient perspectives.

Theme 1: Overall Experience

Participants reported mixed experiences. Some faced obstacles during the transition from ICU to the ward or had communication challenges with staff, while others described ICU staff as calm and supportive. A review on ICU well-being similarly found that while barriers often outweighed facilitators, a few studies reported positive ICU experiences where physical needs were met despite emotional challenges (16). Choi et al. also reported positive ICU experiences, which may reflect their use of quantitative methods (26).

Theme 2: Food, Hygiene, and Cleanliness

Variations in food taste led to loss of appetite, consistent with Merriweather et al. (2014), who reported physiological changes in appetite and taste in critically ill patients, sometimes resulting in food aversion (7). Sleep disturbances further contributed to nutritional deficiencies (7).

Theme 3: Communication with Staff

Effective and honest communication fosters trust and understanding between nurses, patients, and families (27). Lack of communication due to staff ignorance can generate fear and distress (28), as observed in studies from Australia and England (29,30). Staff were often perceived as lacking empathy and as indifferent to patients' needs for personal space and privacy (4). Poor communication was reported not only by patients and their families, but also by nursing students and nurses, who described instances in which staff were rude or inattentive to patients' needs, potentially a consequence of staff fatigue or dialect-related misunderstandings (31–33). Nevertheless, positive experiences with staff were also noted, consistent with several studies reporting effective and supportive communication by ICU personnel (5, 10, 34).

Theme 4: Transition from ICU to Ward

Patients noted differences in staff, facilities, and environment during ICU-to-ward transition. Similar studies reported stress caused by inadequate ward facilities and incompetent staff (6,12), resulting in psychological disorders (8–57%) and physical limitations (25–80%) (28).

Theme 5: Sleep Disturbances

Disruptions in sleep patterns may be explained in part by patients' abnormal daytime sleep patterns, which can cause them to miss nutritional supplements and snacks, and consequently experience weakness. Moreover, the ICU environment itself is highly disruptive, with unnecessary alarms and equipment noise frequently disturbing patients' sleep. These disturbances affect not only patients; nurses and nursing students also report finding the excessive light and noise both frightening and irritating, often referring to the phenomenon as "alarm fatigue" (2, 31, 35).

Theme 6: Emotions Experienced and Perceptions

Patients reported a range of psychological symptoms, including nightmares, palpitations, anxiety, behavioral changes, and an overall loss of confidence. Similar findings have been described in other studies, where

patients characterized these reactions as negative emotional experiences (4, 9, 12, 36). These psychological issues may persist even after discharge, as patients often suppress their emotions in an effort to remain strong for their families. This suppression can contribute to changes in body image and self-esteem (7).

Theme 7: Obstacles to Recovery

Our findings highlight several obstacles that patients face during recovery, including difficulty adjusting to the ICU environment, uncooperative staff, and restricted family visitation hours. These results align with those of Zengin et al., who identified similar stressors, such as loneliness, machine noise, pain, and separation from family, among ICU patients, and noted that these stressors were negatively correlated with satisfaction with care (17).

Theme 8: Suggestions for Improving Care

Patients also offered valuable suggestions for improving their ICU experience. Some emphasized the need for more qualified personnel, while others recommended that staff adopt more cooperative and respectful behaviors. Additional suggestions included providing isolation for critically ill patients and prioritizing hygiene within the ICU.

This was the first qualitative study conducted in India to explore the experiences of ICU patients. It not only identified shortcomings in care but also highlighted the positive aspects of patients' experiences. The issues reported by patients may contribute to improving healthcare services in India. One major concern was the lack of adequately trained staff in the wards; to address this, regular training sessions and mock drills could be implemented for nurses. In addition, mandatory training programs or support groups, led by psychologists and social workers, could be established in hospitals to help ICU and ward staff manage patients with psychological issues and cope with work-related stress, ultimately fostering greater empathy toward patients. Ensuring designated family visitation hours and providing opportunities for stable patients to mobilize in corridors or outdoor areas should also be mandated across ICUs to help prevent emotional distress.

The strength of this study lies in the diversity of the sample and the range of ICU stays across different specialized units, which offered a rich, detailed account of patient experiences from all major specialty departments within the hospital. However, data were collected from only one multi-specialty hospital, and repeat interviews were not conducted. Therefore, the small sample size limits the generalizability of the findings to other hospitals or to national and international contexts. Nevertheless, by providing a detailed account of data collection, analysis, and results, this study enables readers to assess the transferability of the findings to other settings

Conclusion

The study found that most patients were satisfied with the overall ICU care. However, several issues were reported, including sleep disturbances, hygiene concerns, and encounters with uncooperative or rude staff, which further complicated their transition to the wards. Patients also experienced considerable emotional turmoil during their ICU stay, which was exacerbated by fixed and limited family visiting hours. To address these challenges, regular staff training on emergency protocols and periodic mock drills are recommended to ensure preparedness in critical situations. Moreover, hospital hygiene should be closely monitored, with cleaning personnel available overnight to maintain consistent cleanliness standards.

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Authors' Contribution

Conceptualization: Akanksha Saxena.
Data Curation: Azmat Bano.
Formal Analysis: Azmat Bano.
Investigation: Azmat Bano.
Methodology: Akanksha Saxena, Mandeep Kumar Jangra.
Project Administration: Akanksha Saxena.
Resources: Akanksha Saxena, Mandeep Kumar Jangra.
Software: Akanksha Saxena, Azmat Bano.
Supervision: Akanksha Saxena, Mandeep Kumar Jangra.
Validation: Akanksha Saxena, Mandeep Kumar Jangra.
Visualization: Azmat Bano, Akanksha Saxena, Mandeep Kumar Jangra.
Writing–Original Draft: Azmat Bano, Akanksha Saxena.

Competing Interests

All the authors declare no conflict of interest.

Ethical Approval

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