COMMUNICATION BARRIERS AND FACILITATORS BETWEEN NURSES AND PATIENTS RECEIVING PALLIATIVE CARE

A LITERATURE REVIEW

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ABSTRACT
Communication is central to palliative care. It unifies all nursing practice, and plays an integral role in the operationalization of palliative care. To deliver quality palliative care, it is paramount that nurses have adequate communication skills. Positive patient outcomes are derived when communication between the nurse and patient is effective. Ineffective communication may result in inaccurate information on treatment/medication increase patient risks and may cause patient dissatisfaction with care. It is therefore necessary to be familiar with the facilitators and barriers that influence communication.

This study aimed to describe barriers and facilitators of effective communication between nurses and patients receiving palliative care.

A literature review of fifteen articles was utilized to answer the study’s aim. Searching the CINAHL Complete and MEDLINE databases performed data collection. Data was analyzed using the matrix method.

The findings were categorized into two main themes: barriers of effective communication and facilitators of effective communication. Three subthemes emerged under the barriers of effective communication and two sub themes for the facilitators. The main barrier to effective communication was the nurse’s lack of knowledge and skills.

In conclusion, the nurse-patient interaction is compounded by variables such as: nurses’ competence, patient’s attributes and environmental or care setting. All together these factors require the nurse’s ability to overcome the communication barriers and highlight the facilitators. It would be of benefit if nurses receive training in communication skills in palliative care with emphasis on transitions and how to handle them within the palliative care scope.

Key words: Palliative care, effective communication, nurse-patient
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Appendix 1- Methodologic matrix
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BACKGROUND

**Palliative Care**

The concept of palliative care according to Meghani (2004) is dynamic and with time always changing. This is because it involves understanding disease and assessing what quality of life and death encompass for persons with life threatening illnesses (Guo, Jacelon & Marquard, 2012). Thus, it’s synonymously used with terms such as end of life care, terminal care, hospice care, continuing care, comfort care and supportive care (Guo et al., 2012; Meghani, 2004; Pastrana, Jünger, Ostgathe, Elsner, & Radbruch, 2008). Generally, the World Health Organization [WHO] defines palliative care as:

An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and impeccable assessment of pain and other problems, physical, psychosocial and spiritual (Sepúlveda, Marlin, Yoshida & Ullrich, 2002, p. 94).

In light of the above definition, Sepúlveda et al., (2002) highlights the WHO’s principles and philosophy of palliative care delivery, which States that Palliative care:

- Provides relief from pain and other distressing symptoms;
- Affirms life and regards dying as a normal process;
- Intends neither to hasten nor postpone death;
- Integrates the psychological and spiritual aspects of patient care;
- Offers a support system to help patients live as actively as possible until death;
- Offers a support system to help the family cope during the patients’ illness and in their own bereavement;
- Uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated;
- Will enhance quality of life, and may also positively influence the course of illness;
- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Palliative care as a specialty is attributed to; holistic care, patient- and family-centered care, teamwork, effective communication, and collaboration (Guo et al., 2012; Meghani, 2004; Pastrana et al., 2008). Guided by its principles and philosophy, these constituents aid delivery of palliative care. In order to meet all of the patients’ needs, competence is required for effective and quality service delivery (Gamondi, Larkin & Payne, 2013). The European Association for Palliative Care (EAPC) proposes ten core competencies to this effect. These include: applying the core constituents of palliative care in settings involving patients and their families; Enhancing physical comfort throughout patients’ disease trajectories; Meeting patients’ psychological needs; Meeting patients’ social needs; Meeting patients’ spiritual needs; Responding to the needs of family care givers in relation to short-, medium- and long-term patient care goals; Responding to the challenges of clinical and ethical decision-making in palliative care; Practicing comprehensive care, co-ordination and interdisciplinary teamwork across all settings where palliative care is offered; Developing interpersonal and communication skills appropriate to palliative care and to Practice self-awareness and undergo continuous professional development (Gamondi et al., 2013).
Palliative care may be provided across primary and tertiary care settings: homes, acute care, ambulatory clinics, hospitals, hospices and long-term care facilities (Gamondi et al., 2013; Payne, Seymour & Ingleton, 2008). In these settings, palliative care can be delivered at three levels: (1) Basic palliative care - focuses on providing comfort, reinforcing personal autonomy including shared decision making and is provided alongside active treatment. (2) Specialized palliative care - provided by a multi-professional team with training in the specialty of palliative care. They assess, manage and treat complex symptoms and give advice as well as information about complex issues along the illness trajectory. (3) End-of-life care - begins in the final weeks or days of life, continuing to death and into family bereavement; palliative care services here focus on family support: physical, emotional, and spiritual comfort (Ahmedzai et al., 2004; Gamondi et al., 2013; Kristjanson, Toye & Dawson, 2003).

A life-threatening illness may have extensive ramifications that impinge on a person's physical, emotional, social, and spiritual wellbeing (Wilson & LeMay, 2007). The goal of palliative care is to relieve suffering and improve quality of life following diagnosis of life threatening illness (Guo et al., 2012; Meghani, 2004). Life threatening illnesses may be: Alzheimer’s disease and other dementia disorders, cancer, cardiovascular diseases, liver cirrhosis, chronic obstructive pulmonary diseases, diabetes, Human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS), kidney failure, multiple sclerosis, rheumatoid arthritis, drug-resistant tuberculosis (Connor & Bermudo, 2014) and neurodegenerative diseases (Kristjanson et al., 2003).

The continuum of palliative care from diagnosis of a life-threatening illness to death and bereavement seeks to clarify and identify goals of care in the perspective of the patient’s definition of meaning of life and its quality (Twaddle et al., 2007). Yet, quality of life is subjective (Pastrana et al., 2008). Therefore, the offered palliative care must be in respect to a person’s autonomy and be congruent to their values, beliefs and needs. All these should be considered in pain and symptom management, advance care planning, psychosocial and spiritual support, as well as coordination of care (Ahmedzai et al., 2004; Kuebler, Davis & Moore, 2005; Guo et al., 2012). This will help to reinforce a person’s autonomy and assists them to live an active life until death by providing them with information/advise, support and comfort through every transition in their illness (Ahmedzai et al., 2004).

Palliative care has a holistic focus that gives equal consideration of physical, emotional and spiritual aspects of a person’s life. Since all aspects of a person’s life are involved during their period of illness, palliative care uses an interdisciplinary team approach to holistically cater for the patients’ needs (Guo et al, 2012; Meghani, 2004; Pastrana et al., 2008; Zeppetella, 2012). Crawford and Price (2003) stated that palliative care teams vary but mostly comprise of the nursing, medical, and other allied health disciplines. In short, quality palliative care is attained through teamwork (Sepúlveda et al, 2002). Team members collaboratively share their expertise in line with the goal of palliative care; providing a holistic view of the needs of a patient and family (Crawford & Price, 2003). Of these team members, nurses spend the most time with patients (Clarke & Ketchell, 2011; Westbrook et al., 2011). The palliative care principles and the very essence of nursing have a close link. As a philosophy of care, palliative care is an important aspect to the nursing discipline (Fitch, Fliedner & O’Connor, 2015).

Nursing
Nursing encompasses collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. It includes the promotion of health, prevention
of illness, and the care of ill, disabled and dying people (International Council of Nursing [ICN], 2002). Lugton and McIntyre (2005) maintain that nursing, as a discipline is a complex activity based on practice. Its principles are concerned with human nature, skillful caring and creating therapeutic relationships. Furthermore, the nursing practice also involves processes of complex decision-making. In nursing, a nurse is a person who has undergone training of a completed program of basic/generalized nursing education and is authorized by the appropriate regulatory authority to practice nursing in his/her country (ICN, 2016).

The discipline of nursing is both an art and a science with unique perspectives for providing care. Nurses have a charge: to promote health, prevent illness, to restore health and alleviate suffering (ICN, 2012). Meleis (2012) describes four perspectives that govern nursing care including nursing as a human science –concerned with providing care that has a holistic focus of human experience, meaning and its significance. Nursing as a practice-oriented discipline encompasses application of the nursing knowledge (science) in all practices performed by nurses. Nursing as a caring discipline can be referred to as an art, as it concerns connecting with people using skills such as communication to determine a course of action in a moral fashion. Lastly, nursing as a health care-oriented discipline denotes its focus on the health promoting practices that assist sick persons to lead active lives. A health perspective defines the basis for assessing, planning, evaluating and managing a person’s illness.

The nursing domain’s central focus is the recipient of care (i.e. nursing client) and their transitions in health status. This also extends to: relationships formed through the interaction with patients and the nursing process, healing environment conducive to promote health and all practices intended to provide care for patients (Meleis, 2012).

Nursing in palliative care
In palliative care nursing, transitions of curative to palliative and end of life care may evoke feelings of anxiety and fear about the impending death and its process for involved persons (Malloy et al, 2010). The role of nurses in palliative care is crucial as nurses spend considerable time with the patients helping them interpret medical information and listen to their emotional responses (Johnston & Smith, 2006). The responsibility of nurses here is to prepare patients and their families for informed decision making, symptom management and act as advocates in representing patients’ and families’ needs and preferences for quality-of-life when implementing/planning a treatment plan with other team members (Lyn Ceronsky, 2009). Furthermore, the role of nurses encompasses promotion of comfort, hope and support to the patient and the families, helping them to cope with the psychological, spiritual, social and physical effects of the illness (Lugton & McIntyre, 2005). Implementing nursing practices as mentioned above demands skill and knowledge from the nurse. All of which is not possible without effective communication as communication is the central unifying focus of all nursing practices (Kourkouta & Papatheodoriou, 2014).

Communication
Communication is a process of sharing information and feelings between people verbally or non-verbally in order to achieve a common understanding or meaning (Dunne, 2005; Wallace, 2001). Non-verbal communication denotes behaviors that do not carry any verbal content including eye contact, hand gestures, facial expressions, nodding of head, touch etc., these behaviors are imperative in the communication process as they accentuate verbal communication adding meaning to the interaction (Merriam Webster dictionary, 2016; Roter et al., 2006). Communication serves the purpose of: commencing actions, creating understanding, information sharing of ideas, beliefs and values. It helps to create, build and
maintain relationships. Communication is therefore imperative in health care delivery (Thomas, 2006). Collaboration, role allocation and Information sharing amongst or/and between palliative care team members, as well as with the client, is highly dependent on effective communication (Crawford & Price 2003).

Effective communication
The desirable outcome of a verbal interaction process is effective communication, where the receiver understands the sender’s message as it was intended (Lunenburg, 2010). Effective communication is a two-way process, which allows patients to express their anxieties or emotions and in which patients are well informed of the nature of their disease (Payne, Seymour & Ingleton, 2008). Effective communication fosters therapeutic relationships between the nurse and the patient, creating a trusting environment where the patients are free to convey their needs, preferences, fears and emotions (Luker et al., 2000). Zeppetella (2012) ascertained that effective communication should be consistent and the information sharing has to be clear, correct, complete, courteous and constructive.

The communication process involves various elements to take effect. According to Steinberg, (1995) these include: context, medium, people, message, and feedback. Context relates to the environment or situation in which communication takes place and the medium is the channel through which communication is carried. The people involved in a communication process are referred to as a sender (the person sending the message) and a receiver (the recipient of the sent message). The role of the sender is to send purposeful messages with the intention of sharing thoughts or feelings; the receiver carefully interprets the message with the aim of understanding the sender’s intent. Messages in a communication transaction contain meaning, which must be understood, this could be in form of facts, feelings or ideas. The participants’ response to each other’s messages during this interaction is called feedback, which may be verbal or non-verbal and allows the sender to determine whether the message sent has been received and understood (Kourkouta & Papathanasiou, 2014; Steinberg, 1995).

Any stimulus that interferes with the transfer and receipt of messages is perceived as a barrier (Steinberg, 1995). A barrier to communication is something that distorts what is implied from what is meant (Howe, 1963). These could arise from something in the environment that distracts attention during a conversation e.g. a cold room, offensive odor, uncomfortable chair, ringing cell phone etc., or circumstances that make retaining information difficult such as hearing impairment, fatigue, physiological illness etc. Others still relate to personal attributes such as mood, beliefs, values and skills that can include the way words are used [i.e. their meaning] (Payne, Seymour & Ingleton, 2008). On the contrary facilitators to communication are those factors that makes communication easier and clearly understood (American Heritage Dictionary, 2016).

Nurse -Patient Communication
Communication is an essential aspect of palliative care nursing and is viewed as its primary intervention (Norton et al., 2013). For examples, for nurses to achieve symptom management, impeccable assessment is required to gain a clear understanding into the patient’s condition. Under such circumstances, effective communication is key (Buckman, 2001; Kourkouta & Papathanasiou, 2014). According to Dahlin and Giansiracusa (2006), nurses have the prospect of communicating with patients at three levels. First, customary interactions surrounding caring tasks like activities of daily living, treatment discussion etc. Second, communication involving patient’s treatment evaluation to understand a patient’s distress, pain or quality of
life and lastly communication regarding existential issues, this level of communication embodies aspects of end of life, including a search for meaning, and suffering.

In palliative care, communication is centered on conveying information that discuss treatment outcomes and prognosis relative to the goals, values, circumstance and expectations of the patient and family (Lugton & McIntyre, 2005; Norton et al., 2013). Effective communication contributes to patient satisfaction with care delivered. Patient satisfaction in palliative care is of utmost importance because the desirable health status outcome may not be attained after a palliative diagnosis. Moreover, care is considered incomplete if it is not harmonized with communication interventions that address physical and emotional situations (Heyland et al., 2002). Some studies have reported positive outcomes when communication is effective, consequently leading to adherence to treatment and patient involvement in their own care (Kullberg, Sharp, Johansson & Bergenmar 2015; Norton et al., 2013). On the other hand, poor/ineffective communication has been shown to result in dissatisfaction, frustration and uncertainty for both the nurse and patient (Kirk & Kristjanson 2004; Tsutsum, Sekido & Tanioka, 2014). Satisfaction here entails the degree to which health care experiences match individual’s expectations (Bredart, 2005). Ineffective communication may also negatively impact patient safety risks such as medication errors and risk for falls, which consequently affects patients’ quality of life (Kullberg et al., 2014).

PROBLEM STATEMENT
As highlighted herein, communication is one of the core competencies of quality and effective palliative care delivery. It is central in unifying all activities in nursing and contributes to patient satisfaction when it is effective. Ineffective nurse-patient communication may result in: risk to patient safety, dissatisfaction with care, uncertainty and frustration for both the nurse and the patient. Therefore, knowledge about communication barriers and facilitators is necessary to identify possible nurse-patient communication challenges and how to overcome them and promote effective communication. This can contribute to the guidelines or structured training in communication skills in palliative care.

AIM
To describe barriers and facilitators of effective communication between nurses and patients receiving palliative care

METHOD
Design
The design of a study entails the process in which it was created to develop evidence that is accurate and interpretable (Polit & Beck, 2012). This paper presents a literature review of extant studies, published between 2006 and 2016, with key elements on barriers and facilitators of communication between nurses and patients. A literature review is a critical summary of research on a topic of interest, often prepared to put a research problem in context (Polit & Beck, 2012). It requires the reviewer to carefully analyze research studies evaluating their purpose, appropriateness and quality of the scientific methods as well as analysis of the question and answers posed by the authors. A summary of the findings across the studies is written as an objective synthesis of the findings (Garrard, 2011). This method design was appropriate because it gave the researcher an overview of the current state of knowledge from various perspectives on the research topic in focus (Polit & Beck, 2012). Moreover, it provided grounds for critical appraisal of the research studies on a wider base. This facilitated a more objective synthesis of the description required to attain the study’s aim.
In accordance with the standard procedure of conducting a literature review, the following were done: (1) a research question to be addressed was formulated; (2) search for data was performed in the relevant electronic databases using the inclusion and exclusion criteria; (3) data was extracted; (4) appraised for methodological quality plus appropriateness, and (5) the findings were analyzed and synthesized systematically and presented in a matrix [see Appendix I] (Garrard, 2011; Polit & Beck, 2012).

Data collection
A search for data was performed in the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and PubMed to access the MEDLINE database (Polit & Beck, 2012). To guarantee that relevant and up-to-date literature was reviewed in this study, a time frame of 2006-2016 was used. Using controlled vocabulary MeSH (medical subject headings) and free text; search words representing the key elements of interest in the articles were combined in different ways. Boolean operators AND/OR were used to expand or delimit a search as shown in Table 1.

The ancestry approach is a method of data collection that uses citations from relevant studies to track previous research upon which the study is grounded (Polit & Beck, 2012). This method was also employed to find articles related to the aim by manually searching for articles in the reference list of the chosen articles. Four of the included articles were retrieved using this method.

Upon completion of the data search, fifteen articles were chosen for this review as they met the inclusion criteria.

Table 1: Database search results

<table>
<thead>
<tr>
<th>Database Reviewed</th>
<th>Search Dates</th>
<th>Key Words</th>
<th>Identified articles (hits)</th>
<th>Abstracts Reviewed</th>
<th>Articles Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>CINAHL</td>
<td>20160412</td>
<td>Effective communication AND hospice palliative care nursing OR</td>
<td>16</td>
<td>9</td>
<td>9</td>
</tr>
</tbody>
</table>
Inclusion and exclusion criteria
Articles were included in the review if they were of primary source. Primary source articles are original studies performed by researchers who were directly involved in conducting the study (Garrard, 2011; Polit and Beck 2012). Furthermore, only articles related to nurse–patient communication in palliative care and written in English were included. A description of communication had to be eminent not only a mention of the term communication. Other inclusion features of the articles were publication date of 2006-2016, studies that involved adult participants, were peer reviewed and those graded (I) or High quality and (II) or moderate quality according to the Sophiahemmet university classification guide of academic articles (refer Appendix II).

Exclusion criteria
Articles about physician’s communication were excluded. This extended to include Grey literature i.e. “literature presented at scientific meetings such as preliminary reports, technical reports or government document” (Garrard, 2011). Low quality or grade (III) articles in accordance with the Sophiahemmet university classification guide of academic articles were also excluded, and all secondary source articles. Secondary source literature is that which was written as an analysis of the primary source these include literature reviews (Garrard, 2011; Polit & Beck, 2012).

Data analysis
In order to systematically extract applicable information from the publications in review, the classification guide from Berg, Dencker, & Skärsäter, (1999) and Willman, Stoltz, & Bahtsevani, (2006) modified by Sophiahemmet University was utilized; for assessing quality of academic articles in both qualitative and quantitative research. To assess the credibility and validity of the extracted articles various aspects of the studies were analyzed. This was in terms of adequacy of the sample size used to answer the study’s aim, methodology used e.g., was it suitable for the study and was there adequate description of protocols provided including materials (see appendix I).

The classification guide used herein classified articles on a three level scale: high quality (1) moderate quality (II) and low quality (III). Grade I or II meant the studies satisfied the various aspects in appraisal and these were included articles.

With focus on the results section of the chosen articles, results were read carefully. A summary of all results was organized into the methodologic matrix (Garrard, 2014; Polit & Beck, 2012). Following a chronological order, the characteristics of the studies were recorded including the Author(s) name, Year of publication, Country of publication, title, aim, method of the study, participant’s attrition rate and a summary of the results in the study. This was done with a view of evaluating common themes/patterns, discrepancies, gaps and
consistencies in the data presented in the matrix. Thus providing basis for synthesis of the data required to answer the aim of this review study (Polit & Beck, 2012). The common themes observed were categorized into barriers and facilitators. After reading and re-reading the two themes were further analyzed for patterns and themes. Three sub-themes were made from the barriers and two sub-themes from the facilitators.

**Ethical Considerations**
Ethic is defined as a system of moral values that is concerned with the degree to which the research procedures adhere to professional, legal and social obligation to the study participants (Polit & Beck, 2012). To preserve the integrity of the research as well as trustworthiness and credibility while performing a review the researcher was careful not to omit any results in the articles under study and not to fabricate, falsify or plagiarize data. All selected studies meeting the inclusion criteria were ethically approved this was to assess that the studies were performed in line with ethical principles of justice, beneficence, non-maleficence and patient autonomy (World Medical Association, 2013).

**RESULTS**

The results are presented in two main categories: barriers to effective communication and facilitators of effective communication each of which contain sub-themes as described in details below.

**Barriers of effective communication**

**Competencies of the nurse**
This category concerns the competencies of the nurse that affected the nurse-patient communication. Effective communication between nurses and their patients was multidimensional. Nurse’s lack of knowledge and skill was a perceived barrier to effective communication. Studies revealed nurse’s lack of knowledge in addressing specific topics about: prognosis (Aslakson et al., 2012; Hjelmfors et al., 2014; Helft, Chamness, Terry & Uhrich, 2014), existential issues (Keall, Clayton & Butow, 2014; Strang et al., 2014) and end of life as barriers to effective communication (Zheng, Guo, Dong & Owens, 2014).

Lack of knowledge and skill affected nurse’s confidence in discussing issues such as the above (Hjelmfors et al., 2014; Wilkinson, Perry, Blanchard & Linsell, 2008). Zamanzadeh et al., (2014) described self-confidence, holistic view, and expert knowledge as characteristic of effective communication in oncology nursing. Self-confidence showed the extent nurses were familiar with their roles and influence in consequences of cancer treatment. Lack of confidence caused them to regard technical aspects more important than communication, hence preventing effective communication.

According to studies by Keall et al., (2014), Hjelmfors et al, (2014) and Tay Ang and Hegney (2012), other barriers to effective communication emanated from the nurses’ own fears. Nurses, who feared they’d be asked questions they did not have answers to or fear that the might make a bad situation worse did not communicate effectively. Still, Tay et al., (2012) in their study related that the nurses’ personal discomfort in addressing topics that made them uncomfortable e.g. talking about male patients’ sexuality or death prevented effective communication. This was because of the nurse’s negative emotions towards the subjects due to their beliefs and values.
Characteristics of the patients
This category relates to the specific characteristics of the patient and those related to their disease/health. These characteristics made communication with patients particularly challenging. Changes imposed by the disease trajectory led patients to have a closed disposition to communication. Zamanzadeh et al., (2014), highlights this in a study they conducted which showed that in initial phase cancer, patients with poor prognosis along the course of treatment became depressed, angry and aggressive towards the nurses. These conditions caused nurses to limit verbal communication. In another study Tay et al., (2012) maintained, newly diagnosed end stage palliative cancer patients were filled with grief and denial. This consequently affected nurse-patient communication as they were closed up. Characteristics of the patient such as response to disease trajectory, lack of trust in the nurse, language and culture can hinder effective communication between the nurse and the patient. These characteristics can make communication with patients particularly challenging.

Hjelmfors et al., (2014) found that patient’s general lack of interest in communication provided challenges in communication. This extended to include the circumstances that made retaining information particularly challenging for the patient like: fatigue or cognitive impairment. On the other hand, Zamanzadeh et al., (2014) reported that the patient’s lack of trust/respect in the nurse’s skills and expert knowledge were a barrier to communication. For example, patients with high education levels had increased awareness and increased self-care recommendations. Such patients were skeptical with information provided by the nurse.

Other specific characteristics like patient temperament can also hinder communication. Tay et al., (2012) found that difficult/needy patients who demanded more of the nurse without fully considering/understanding the nurse’s workload also obstructed effective communication.

Language differences
Language differences between the patient and the nurse were another preventive factor in effective communication. When the nurse and the patient did not share a common language, interaction between them was strained and very limited. ( Kai, Beavan & Faull, 2012; McCarthy, Cassidy, Graham & Tuohy, 2013; Richardson, Thomas & Richardson, 2006; Tay, Ang, & Hegney, 2012;Zamanzadeh et al., 2014). In such cases, using interpreters to mediate communication resulted in filtered information provided to the patients. For example, Kai et al. (2011) found that interpreters did not translate all or inaccurately translated medical terminologies spoken by the nurse. Richardson, Thomas and Richardson (2006) found that patients were uncomfortable relaying their fears/concerns with a third person (the interpreter) as it made them feel vulnerable to gossip and ridicule.

Cultural differences
Culture was another hindrance found in the reviewed literature. In the review, the patient’s culture blocked effective nurse-patient interactions because perceptions on health and death were different between patients (Aslakson et al., 2012; Helft et al., 2011; Richardson et al., 2006; Tay et al., 2012; Zheng et al., 2015). For example, in China talking about death is taboo. Zheng et al. (2015) reported that nurses avoided conversations about prognosis and end of life because it would have led to discussions about death. In USA, one study reported that nurses avoided end of life conversations in the intensive care unit because of the patient’s culture (Aslakson et al., 2012). Dilemmas arose about involving patients in the discussions about end of life with family members. Another study in Singapore showed most Asian cultures were reserved about communicating their needs/concerns, it was even considered disrespectful to discuss issues such as sexuality openly (Tay et al., 2012).
Setting in which care was provided

The factors in care setting led to reduction in quality of nurse-patient communication. Increased workload and time constraints restricted nurses from discussing their patients concerns effectively (Helft et al., 2011; Keall et al., 2014; Zamanzadeh et al., 2014). Lack of collaboration between the nurses and the doctors in information sharing also hindered effective communication. This led to inconsistencies in the information given to patients making comprehension difficult for the patient and their families (Wittenberg-Lyles, Goldsmith, & Ferrell, 2013). In discussing existential issues it was noted that a lack of privacy was a barrier to effective existential communication; the presence of family and team members contributed to ineffective nurse-patient interactions about existential issues (Keall et al., 2014).

Facilitators of effective communication

Nurses’ knowledge and skills

Communication skills that displayed behaviors denoting compassion, active listening, using open ended questions, being aware of the patients nonverbal cues and communicating honestly with patients facilitated effective communication (Periyakoil et al., 2013; Strang et al., 2014; Wittenberg-Lyles et al., 2013). Moreover nurses who had received training in communication skills communicated effectively and showed increased confidence to address complex issues within palliative care (Wilkinson, Perry, Blanchard, & Linsell, 2008).

In the study about communicating existential issues with patients, Strang et al., (2014) and Keall et al., (2014) ascertained that creating a patient relationship founded on trust facilitated effective communication. Additionally, assessing patient’s emotional situation before engaging in communication about existential issues and being open-minded were found to promote effective communication. Similarly, Stajduhar, Thorne, McGuinness, & Kim-Sing, (2010) found that demonstrating caring practices such as expressing empathy or gestures of physical contact evidenced caring and support for patient with cancer. Such acts were perceived as facilitators of communication.

Using complimentary strategies

Using interpreters facilitated effective communication where language barriers existed. These were in form skilled or unskilled (family members or bilingual colleagues) interpreters (Alasiry et al., 2012; Kai et al., 2011; McCarthy, Cassidy, Margaret & Tuohy, 2013; Richardson et al., 2006). McCarthy et al., (2013) in their study on nurses’ experiences of language barriers, found that tactics like: using simple language and using nonverbal communication in conjunction with isolated words promoted communication where language was a barrier.

In relation to conversation about prognosis and end of life Hjelmfors et al., (2014) found standardization of end-of-life conversations in the organization as facilitator of effective prognosis communication. Furthermore, discussing prognosis was made easier when patients had prior break-point conversation with the physician as well as having an open attitude towards the patient.

DISCUSSION

Method discussion
The objective of this study was to review the current state of knowledge on the barriers and facilitators of effective communication between nurses and patients receiving palliative care. For this reason, a literature review was the appropriate method of choice because it helps to analyze literature coherently (Garrard, 2011; Polit & Beck, 2012). The study presented here draws on systematically collecting, analyzing and arranging data on barriers and facilitators of effective communication for patients receiving palliative care.

Strategies used to collect data included a search in the electronic database CINHAL and MEDLINE. An appointment with a librarian was made for a research consultation to aid this process. This was perceived as an effective way of collecting data as the databases contained a vast amount of articles to choose from. There was a risk that not all recent articles were displayed during the data search. This is because it takes time for new articles to be indexed into the database. Some of the articles were not available in full text. Alternative searches were made using the Google scholar search engine for those particular articles and were retrieved there if present in full text. Also, using the University of Gävles library to access articles which were not available on system through Sophiahemmet University was also helpful.

Another strategy this approach have similar themes. Moreover, it would limit the themes of the study employed to collected data was the ancestry approach “tracking down earlier studies cited in a reference list of a report (Polit & Beck, 2012 p124)”. This strategy helped to make up for the four articles in this study. Upon reflection it might seem like researcher’s bias as the articles retrieved using had there been more articles retrieved in this manner. This would consequently influence the study’s results as the articles would be inclined towards a similar theme, hence restricting the analysis from general perspective or limiting the themes of the literature review, resulting in a study that is not comprehensive and unreflective of the current state of knowledge on the topic.

Fifteen articles were included as per Sophiahemmet university requirement of conducting a literature review. Both qualitative and quantitative studies were included. Articles were assessed for quality using the Sophiahemmet standardized classification guide; see Appendix I, modified from Berg, Dencker and Skårsäter (1999) and Willman, Stoltz and Bahtsevani (2006). The guide was essential to ensure quality articles only with grades 1 and 2 were included in the study. This was done to enhance the credibility of the study.

Fourteen of the literature reviewed here were qualitative in nature. This gave a good description of the study’s aim. However, since qualitative studies tend to have small sample sizes, their studies cannot be representative of the entire study population (Dworkin, 2012). One of the studies here had a sample size of 7 another study had 10. Transferability of these results would have proved challenging as the sample sizes were not sufficient to represent the study population. However, considering a literature review is a method used to analyze various studies, the findings collectively may enhance credibility as they echo the voice of various authors on a similar subject and study population (Garrard, 2011; Polit & Beck, 2012).

Ethical consideration was also considered in relation to research misconduct (Polit & Beck, 2012). This included plagiarism; accrediting all information that was not the authors own. Being truthful when recording data helped the author to avoid fabrication (making data up) and falsification (modifying data). Having ethical approval implied that the rights of the participants were respected and protected (Polit & Beck, 2012). For example in a study
about Chinese oncology nurses’ experience of caring for dying cancer patients, Zheng et al., (2015) sought approval from the Human Research Ethics Board at the research governance department of Tianjin Medical University Cancer Institute and Hospital prior to their study. They then sought informed consent from the participants and informed them of their rights to withdraw from the study at any point during the study. Participants were given subject codes for each interview. All recordings and documents were kept in a locked cabinet until the interview. The researcher’s actions demonstrated person’s autonomous right as they informed their participants of their rights to withdraw from the study through informed consent. Additionally, they protected the participant’s right to privacy by ensuring anonymity of their study participants; all interviews were in a locked cabinet and participants were assigned codes. This study took measures to protect the rights of the study participants and highlights ethical principles (The World Medical Association, 2013). Additionally, the literature review process was guided through a peer review (teachers and fellow students reviewing the work and giving comments) at Sophiahemmet University. This encouraged transparency and established internal validity of the study.

The literature presented in the study came from various countries: USA, UK, Australia, Canada, China, Iran, Sweden, Singapore, Ireland and Saudi Arabia. Each country contributed a unique perspective to the study’s research area. While this gave broad perspective of the research area in magnitude and effect, generalizability and transferability of the results would seem compromised. The results aimed to present the current state of knowledge of different countries irrespective of their cultural contexts. Furthermore, the results do not portray a global outlook. Communication styles vary, although there are general principles that are universal. To illustrate: in non-verbal communication, eye contact denotes interest and gaze shifts convey speech turns. In certain cultures, eye contact is considered rude (Caris-Verhallen et al., 1999), this is also particularly true in the author’s own culture: “the Zambian culture”.

Data analysis was performed using the matrix method (Garrard, 2011). The studies were analyzed through reading and re-reading to avoid misinterpretations. Studies revealed communication barriers and facilitators in relation to topics within the palliative care context. For instance; two studies described barriers to effective communication in relation to existential issues in patients receiving palliative care (Keall et al., 2014; Strang et al., 2014) and four studies related to communication about prognosis (Aslakson et al., 2012; Helft et al., 2011; Hjelmfors et al., 2014; Kai et al., 2011). Initially the author intended to present results according to the order/topics (prognosis, existential issues and end of life care) addressed in patients receiving palliative care. However, presenting the results in this order proved challenging because the author did not have enough articles to represent this style. This would have given a clear perspective of the barriers and facilitators under each topic since palliative care is dynamic and communication topics follow this order of topics (Meghani, 2004)

Results Discussion
Communication is imperative in palliative care and is central to unifying all nursing practices therein (Kourkouta & Papathanasiou, 2014). Thus, it is important for nurses to be aware of the barriers and the facilitators of effective communication to improve patient outcome. This however is not an easy task as communication is a complex transaction. The presented results herein revealed various barriers and facilitators to effective communication. These barriers and facilitators need to be addressed so as to meet the conditions for effective communication. For example, in a nurse-patient interaction, outcome of communication will be determined by
variables such as patient attributes, nurse communication skills and the environment/care setting.

Knowledge and skill deficit among nurses was a prominent result in the studies considered (Aslakson et al., 2012; Chamness, Terry & Uhrich, 2014; Hjelmfors et al., 2014; Helft, Chamness, Terry & Keall, Clayton & Butow, 2014; Strang et al., 2014; Uhrich, 2014; Zheng, Guo, Dong & Owens, 2014). It was commonly observed that nurses avoided entangling in issues such as addressing prognosis, end of life and existential issues when caring for patients receiving palliative care. This was because the nurses lacked knowledge and skill on how to handle such topics/situation. Lack of knowledge can influence behavior and reaction to situations. Zamanzadeh et al., (2014) had some interesting results, which show that patients lose confidence and respect in cases where nurses show a lack of knowledge and skill. Although the studies did not mention whether the nurses were specialist or general palliative care nurses.

Nurses comfortable and skilled in communicating about prognosis, existential issues and end of life care may improve patients’ quality of life and their general satisfaction with care (Moir et al., 2015). Smooth transitions from curative to palliative and end of life care are dependent on the kind of information, communication and education patients receive from nurses doctors and other allied health workers. According to Meleis (2012), transitions in health status are part of nursing domain. The nurse should demonstrate knowledge in the various phases of the disease trajectory including transitions so as to effectively communicate, explain, give medical instructions and provide support to the patient. Central to palliative care is prognosis, end of life and existential issues (Lugton & McIntyre, 2005; Norton et al., 2013).

As shown in the reviewed studies, lack of knowledge and skills in addressing these was projected into fear and reduced self-confidence when addressing patient’s palliative care needs (Zamanzadeh et al., 2014). Developing communication skills is a prerequisite to delivering quality palliative care; and nurses are responsible to ensure this development (Gamondi et al., 2012). Wilkinson et al., (2008) showed that training nurses in communication skills and how to handle different patients increased the nurses’ confidence levels and awareness of how to communicate and handle different patient cases. Here recommendation given is that nurses need to be trained in communication skills and how to handle various cases and/or types of patients. Enacting scenario’s and role-playing may be helpful in demonstrating how to handle common difficult situations and types of patients.

Patient characteristics can include interest in conversation or situations that make retaining information challenging like fatigue or cognitive impairment (Hjelmfors et al., 2014). These factors influence communication and determine its quality, length and effectiveness (Payne, Seymour and Ingleton, 2008). It is essential for nurses to recognize, improve or optimize one’s own personal attributes as these may hinder or foster communication. To illustrate, it can be perplexing to deal with difficult patients or patients whose social status is high or have more knowledge about their condition. These patients may show lack of trust and respect for nurses (Tay et al., 2012; Zamanzadeh et al., 2014). Consequently, instituting conflicts/hindrances to effective communication.

Some behaviors could also be perpetuated by patients attitudes like: lack of respect for the nurse’s skills and knowledge (Tay et al., 2012). This is mirrored in the author’s home country where social attitudes elevate doctors to be “all knowing” while nurses are considered less knowledgeable and as “supportive staff”. In a case with palliative care where a nurse is very
critical in the deliverance of care, such social attitudes will prove problematic especially during communication, as patients will show lack of interest to listen to the nurses. Such stereotypes demands nurses be holistic and evolved as the nursing profession has with both perspective and domain. The nurses must be able to reflect this change to command respect that the profession deserves (Meleis, 2012). Additionally, training nurses on how to handle cases like these will surely improve communication.

In the results it was shown that culture played an obstructive role to effective communication (Aslakson et al., 2012; Helft et al., 2011; Richardson et al., 2006; Tay et al., 2012; Zheng et al., 2015). In order for communication to be effective there must be a shared meaning between the nurse and the patient (Steinberg, 1995). It is important for nurses to be aware of the cultural differences of their patients as culture affects how patients perceive death and illness. Communication will be impaired without this knowledge as there will be no shared meaning in what death or health entails from the patients’ perspective. In this instance care provided should be congruent to the patients’ culture (Crawley, Marshall, Lo & Koenig, 2002). This requires nurses to be culturally sensitive when interacting with patients. Cultural sensitivity necessitates awareness of how culture influences the patients’ values, beliefs, and worldviews. Recognizing that differences exist and respecting these differences will booster communication (Crawley et al., 2002). While it is not mandatory for the nurse to learn every patients culture simply affirming and respecting the difference will ensure nurses are meeting the patient’s needs. Additionally, since palliative care involves dealing with problems like existential issues professionally building competences like cultural awareness is to a large extent an important part of nurses’ job. This is in agreement with the ten core professional competencies in palliative care presented by EAPC (Gamondi et al., 2013).

The environment or care setting in which care is delivered should promote teamwork. According to the principles of palliative care, a team approach to address the needs of the patients is an effective way of delivering palliative care (Sepúlveda et al., 2002). However, collaboration and communication is key to derive positive outcome of the team’s goals. Wittenberg-Lyles et al, (2013) in their study found that lack of consensus between the team members led to inconsistencies in information shared with patients which as a result confused and made comprehension of the information given difficult. Consequentially, communication to patients was ineffective and made patients more confused with differing information given.

The results presented here revealed fewer facilitators than there were barriers. This could have been because there has not been much research on facilitator or perhaps the author needed more articles. It would have been interesting to have a balanced outlook on both barriers and facilitators to effective communication. In light of facilitators, an interesting facilitator of effective communication was reported in a study by (Kai et al., 2011). This study described the facilitators of effective communication where language barriers existed. Using interpreters to mediate communication was both a barrier and a facilitator. Using interpreter seemed an effective way of overcoming language barrier. However, instead of enhancing the communication process, it instead reduced communication. This was because patients were not comfortable relaying concerns to a third person. It is seen here that effective communication is a two-way process (Payne, Seymour & Ingleton, 2008; Zeppetella, 2012). It would be useful to have this in mind when dealing with interpreters. Perhaps establishing an interpreter- patient relationship where possible may aid this process.

Nurses must strive to create a good relationship with patient regardless of patients’ personal attributes or culture. Of key importance is that this relationship is founded on trust; the nurse
must be honest in their communication (Periyakoil et al., 2013). Developing trusting relationships encourages the patient to verbalize their fears, needs, or concern. In so doing, a therapeutic environment is established which can be used as a basis for assessing, planning, evaluating, and managing patients’ illness (Meleis, 2012).

**Conclusion**

Nurse-patient interaction is compounded by many competing variables. These variables are presented herein as barriers and facilitators of effective communication. Barriers were mainly attributed to: competencies of the nurse and patient’s attributes. Environmental care settings were also a barrier if they did not meet or promote patient privacy and if the organization structures did not promote sharing of information and effective communication between coworkers. The facilitators found here center more trained nurses in communication skills and being tactful by following the patient’s pace when handling prognosis and existential issues. Also, use of family caregivers or professional interpreters were language barriers, facilitating effective communication. All together, the nurse’s ability to overcome communication barriers and highlight the facilitators is key to effective communication. It is the author’s conclusion that it would be of benefit if nurses received training in communication skills and how to handle sensitive cases and different types of patients within the palliative care scope.

**Clinical application**

- This paper can be applied in clinical improvement programs in quality assurance to enhance knowledge about how to communicate with patients effectively to derive positive patient outcomes.
- It can be utilized in team building, as communication is critical in team collaboration and function.
- It can also further be used as a basis for further research or
- As a guide to structure a communication skills training in palliative care.
REFERENCES


Kirk, P., Kirk, I., & Kristjanson, L. J. (2004). What do patients receiving palliative care for
cancer and their families want to be told? A Canadian and Australian qualitative study. Bmj, 328(7452), 1343.


Moir, C., Roberts, R., Martz, K., Perry, J., & Tivis, L. J. (2015). Communicating with Patients


<table>
<thead>
<tr>
<th>Author(s) (Year), Country</th>
<th>Title</th>
<th>Aim/Objective</th>
<th>Method</th>
<th>Participants (attrition rate)</th>
<th>Result</th>
<th>Design (Quality)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alasiry. S, Alshehri. H, Medin. J and Hagelin C .L (2012) .Saudi Arabia</td>
<td>Nurses experience of providing palliative care in intensive care units in Saudi Arabia</td>
<td>To explore the nurses’ experiences of providing palliative care for critically ill patients in an intensive care unit in Saudi Arabia.</td>
<td>A qualitative study design was used by using semi structured interviews. The interviews were recorded and analyzed using qualitative content analysis</td>
<td>n=9 (0)</td>
<td>Language was reported as a barrier to effective communication. Nurses used interpreters to facilitate communication</td>
<td>P (II)</td>
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<tr>
<td>Aslakson, R., Wyskiel A., Thornton R., Copley I., Shaffer C., Zyra D., Nelson M., Pronovost J., and Peter J., (2012) USA</td>
<td>Nurse-Perceived Barriers to Effective Communication Regarding Prognosis and Optimal End of Life Care for Surgical ICU Patients: A Qualitative Exploration</td>
<td>To explore the barriers to optimal communication and end-of-life care in SICUs as perceived by the bedside nurse</td>
<td>A focus group guided developed to identify barriers to two key components of palliative care—optimal communication regarding prognosis and optimal end-of-life care—and used the tool to conduct focus groups of nurses providing bedside care. Responses were analyzed into thematic domains and validated by independent observers.</td>
<td>n=32 (0)</td>
<td>Barriers included: Discomfort with discussing patients’ prognosis, Fear of causing conflict amongst all involved parties, Inadequate competence and training of how best to provide end-of-life care Cultural differences concerning end-of-life care</td>
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<td>A national survey including nurses from outpatient clinics and primary health care centers was performed. Data was collected using a questionnaire on communication with HF patients about prognosis and end-of-life care.</td>
<td>n=111 (0)</td>
<td>Barriers of communicating prognosis to encompassed; lack of communication interest from the patient, patient’s general impaired condition e.g. fatigue or cognitive impairment, Fear of taking away the patient’s hope, lack of confidence, Insufficient time for communication, and Lack of communication skills and knowledge. Facilitators included; Standardization of end of life conversation, training communication and prior break-point conversation with the patient from the physician aided nurse patient communication. The patient’s own open attitude and asking questions about the future, functioned as a facilitator for discussion.</td>
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<td>Author(s)</td>
<td>Title</td>
<td>Summary</td>
<td>Methodology</td>
<td>Sample Size</td>
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<tr>
<td>Kai J., Beavan J., and Faull C., (2012) UK</td>
<td>Challenges of mediated communication, disclosure and patient autonomy in cross-cultural cancer care</td>
<td>To explore health professionals’ experiences of caring for patients with cancer from diverse ethnic communities to inform practice and quality of care interventions.</td>
<td>Cross sectional study. Data collected from interviews of nursing home professional staff most familiar with the resident and interviews with family.</td>
<td>n=106 (0)</td>
<td>Language differences and cultural differences were reported barriers to communication and although interpreters helped to facilitate communication they too became barriers to effective communication when they went unprepared for a session. Involvement of the patient’s family had consequences for obtaining informed consent and open discussion of treatment options or end of life plans.</td>
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<tr>
<td>Keall R., Clayton J.M., and Butow P., (2014) Australia</td>
<td>How do Australian palliative care nurses address existential and spiritual concerns? Facilitators, barriers and strategies.</td>
<td>To investigate the facilitators, barriers and strategies that Australian palliative care nurses identify in providing existential and spiritual care for patients with life-limiting illnesses.</td>
<td>Interviews of palliative care nurses from a cross section of area of work, place of work, years of experience, spiritual beliefs and importance of those beliefs within their lives. Questions focused on their current practices of existential and spiritual care, identification of facilitators of, barriers to and strategies for</td>
<td>n=20 (0)</td>
<td>Development of a nurse patient relationship, patient’s openness, communication skills, having compassion, being aware of patients non verbal behaviors and being confident were seen as factors that helped nurses to discuss</td>
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<td>Study</td>
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<td>Sample Size</td>
<td>Findings</td>
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<td>McCarthy, J., Cassidy I., Graham. M.M., and Tuohy. D., (2013), Ireland.</td>
<td>Conversations through barriers of language and interpretation</td>
<td>To describe nurses' experiences of language barriers and the use of interpreters within the context of an evolving healthcare environment in Ireland</td>
<td>n=7</td>
<td>Existential and spiritual concerns moreover it was reported that differences of beliefs, insufficient time, fear of worsening the situation, lack of appropriate skills and lack of privacy prevented nurses discussion of existential and spiritual needs</td>
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<tr>
<td>Helft. P.R, Chamness .A, Terry .C, and Uhrich .M, (2014) USA</td>
<td>Oncology Nurses’ Attitudes Toward Prognosis-Related Communication: A Pilot Mailed Survey of</td>
<td>To assess oncology nurses’ attitudes toward prognosis-related communication and experiences of the</td>
<td>n=394</td>
<td>Language and cultural differences were reported as barriers to communication. Participants found the use of non-verbal communication and isolated words, simplified conversations and promoted understanding where language barriers existed. Interpreters were also used to facilitate communication</td>
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Barriers to prognosis related communication included nurses lack of awareness of their role, attitude-uncomfortable to talk about prognosis,
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<tr>
<th>Study</th>
<th>Participants</th>
<th>Methods</th>
<th>Findings</th>
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<tr>
<td>Oncology Nursing Society Members</td>
<td>quality of such communication among physicians.</td>
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<td>culture, lack of knowledge, lack of time and fear of taking away patients’ hope, respectively, were barriers to prognosis related communication.</td>
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<tr>
<td>Reduced to nods and smiles”: Experiences of professionals caring for people with cancer from black and ethnic minority groups</td>
<td>To explore the views of professionals currently working in health and social care and to consider their needs for training.</td>
<td>Focus groups created to enable participant’s to talk through their experiences in working with cancer patients who were from ethnic minority groups</td>
<td>Barriers to communication arose from a lack of common language between the nurse and the patients as well as differences in cultures — not knowing a patients beliefs about death or coping styles proved to be a barrier to communication, however having interpreters facilitated communication and the use of family members also proved effective in the absence of professional interpreters.</td>
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<tr>
<td>Patient perceptions of helpful communication in the context of advanced cancer</td>
<td>To gain a better understanding of what patients identify as helpful to them in their communication</td>
<td>Individual interviews and focus group were done on participants, with advanced cancer in the palliative phase of care. Interpretive description</td>
<td>Demonstrating caring and being honest in the provision of information, were found to be helpful behaviors in</td>
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<tr>
<td>Strang S., Henoch I., Danielson E., Browall M., and Melin-Johansson C., (2014) Sweden</td>
<td>Communication about existential issues with patients close to death—nurses’ reflections on content, process and meaning</td>
<td>To describe the nurses’ reflections on existential issues in their communication with patients close to death</td>
<td>Nurses were recruited from hospital, hospices and homecare teams. Each nurse participated in five group reflection sessions that were recorded, transcribed and analyzed using qualitative content analysis</td>
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<tr>
<td>Tay L.H., Ang E., and Hegney D., (2012) Singapore</td>
<td>Nurses’ perceptions of the barriers in effective communication with inpatient cancer adults in Singapore</td>
<td>To identify the factors that promote, inhibit or both promote and inhibit effective communication between inpatient oncology adults and Singaporean</td>
<td>Interviewed nurses from oncology wards. Data were transcribed verbatim and thematically analyzed.</td>
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<td>Study</td>
<td>Design</td>
<td>Population</td>
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<td>Vyjeyanthi, S. P, M and Helena, K. (2014) USA.</td>
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<td>Multi-Cultural Long Term Care Nurses’ Perceptions of Factors Influencing Patient Dignity at the End of Life</td>
<td>To characterize the perceptions of multi-cultural long-term care nurses about patient dignity at the end-of-life (EOL)</td>
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<tr>
<td>Wilkinson, S., Perry, R., Blanchard, K., and Linsell, L. (2008) UK</td>
<td></td>
<td>Effectiveness of a three-day communication skills course in changing nurses’ communication skills with cancer/palliative care</td>
<td>To evaluate the effectiveness of the 3-day Wilkinson communication skills course in its ability to change UK nurses’</td>
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<tr>
<td>Authors</td>
<td>Title</td>
<td>Study Details</td>
<td>Results/Findings</td>
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<tr>
<td>Wittenberg-Lyles, E, Goldsmith, J, and Ferrell, B. (2013) USA</td>
<td>Palliative care Communication in Oncology Nursing</td>
<td>To examine perceived communication barriers and patient-centered communication from the perspective of nurse managers. Research questions: (a) What do nurse managers identify as communication barriers to patient-centered care? and (b) What do nurse managers identify as patient-centered communication skills needed by oncology nurses?</td>
<td>Focus groups were held using semi-structured guide designed to focus the discussion on nurse communication barriers and training needs. n=7 (0) Barriers to communication related to inconsistencies in communication making comprehension difficult for patients and family members. It was also reported that nurse’s lack of knowledge about patient history including clinical visits and specialized oncologists hindered communication. Moreover, lack of time, lack of physician–nurse collaboration in information sharing was also viewed as a barrier to communication. It was recommended that: patient centered communication, nurses use of simple language when communicating with patients and being</td>
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<td>Authors</td>
<td>Title</td>
<td>Study Object</td>
<td>Method</td>
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<td>Zamanzadeh .V., Rassouli .M., Abbaszadeh .A., Nikanfar. A., Alavi-Majd .H., Ghahramanian A., (2014), Iran.</td>
<td>Factors Influencing Communication Between the Patients with Cancer and their Nurses in Oncology Wards.</td>
<td>To demonstrate the factors influencing nurse-patient communication in cancer care in Iran.</td>
<td>Semi-structured interviews</td>
</tr>
<tr>
<td>Zheng. S, Guo.H, Dong.F and Owens R.G, (2014) China.</td>
<td>Chinese oncology nurses’ experience on caring for dying patients who are on their final days: A qualitative study</td>
<td>To elucidate Chinese oncology nurses’ experience of caring for dying cancer patients.</td>
<td>Semi-structured interviews were utilized to explore views of purposive sample of 28 nurses who took care of terminally ill patients in a cancer hospital in Tianjin, mainland China. Qualitative thematic analysis was used to analyze the data for significant statements and phrases that in turn were organized into themes and sub-themes.</td>
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APPENDIX II:

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<tr>
<th>CLASSIFICATION</th>
<th>1 = High quality</th>
<th>2 = Moderate</th>
<th>3 = Low quality</th>
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<tbody>
<tr>
<td>Randomized controlled trial (RCT)</td>
<td>Large, well planned and well executed multicenter study with an adequate description of protocol, material and methods including treatment techniques. The number of patients/participants is large enough to answer the research question. Adequate statistical methods.</td>
<td>* Randomized study with few patients/participants and/or too many partial studies with insufficient statistical strength. Insufficient number of patients/participants, inadequately described method or large attrition rate (participant drop out rate).</td>
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<tr>
<td>Clinical controlled trial (CCT)</td>
<td>Large, well planned and well executed study with an adequate description of protocol, material and methods including treatment techniques. The number of patients/participants is large enough to answer the research question. Adequate statistical methods.</td>
<td>* Limited number of patients/participants, method inadequately described, failure or lacking in protocol and insufficient statistical strength.</td>
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<tr>
<td>Non-controlled study Q</td>
<td>Well defined research questions, sufficient number of patients/participants and adequate statistical methods.</td>
<td>* Limited number of patients/participants, method inadequately described, errors in protocol and insufficient statistical strength.</td>
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<tr>
<td>Retrospective study (R)</td>
<td>Number of patients/participants sufficient to answer the research question. Well planned and well executed study with an adequate description of protocol, material and methods.</td>
<td>* Limited number of patients/participants, method inadequately described, errors in protocol and insufficient statistical strength.</td>
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<tr>
<td>Qualitative study (Q)</td>
<td>Context clearly described. Selection of participants described. Clearly described selection criteria, data collection, transcription process and method of analysis. Credibility and reliability described. Relation between data and interpretation evident. Critique of method.</td>
<td>* Poorly formulated research questions. Patient/participant group inadequately described. Method and analysis not sufficiently described. Presentation of results incomplete.</td>
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</table>

* Some of the criteria for level 1 are not met, but the academic quality is deemed higher than level 3 = Low quality.