

Literature review of nurses experience of communication nursing essay



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Background

Intensive care units (ICUs) offer critical care, which is often accomplished with complex or multiple interventions. Some of these patients are in end-of-life situations requiring the patient's family to act on their behalf. At the forefront of serving this group of patients is ICU or critical care nurses who have to provide quality care. In order to achieve this kind of care, it is essential that nurses communicate effectively with members of the patient's family. The experiences of nurses communicating with relatives of patients coming from multicultural and religious backgrounds and their experiences when explaining end-of-life issues to families are worth investigating as this would help inform the current practice of ICU nurses.

Intensive Care Unit

A Critical Care Unit (CCU) or Intensive Care Unit (ICU) is designed to meet the special needs of acutely and critically ill patients in a hospital setting. In many acute care settings, the concept of ICU care has expanded from delivering care in a standard unit to bringing ICU care to patients wherever they might be. Electronic or virtual ICU is designed to augment the bedside ICU team and monitor the patient from a remote location. ICU staff includes critical care physicians, a respiratory therapist team, critical care nurses and advanced practice nurses (APN). The capability exists to continuously monitor the ECG, blood pressure, oxygenation saturation, mechanical ventilation, cardiac output, intracranial pressure and temperature of a patient. More advanced monitoring devices allow the measurement of cardiac index, stroke volume, ejection fraction, end-tidal carbon dioxide (CO₂) and tissue oxygen consumption (Lewis et al., 2007).

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Intensive care settings are designed to assist and care for patients with complex, multiple or life-threatening health problems. Many patients are ventilated and/or chemically paralyzed and sedated. The emphasis in ICUs is on technology and short stays. The environment is often noisy, technical and fear inducing for many patients (Usher & Monkley, 2001).

An ICU is a place where technology is used to save or enhance patients' lives. It is staffed by clinicians who are skilled in managing physiology and responding to the rapidly changing status of their patients. The clinicians who work in an ICU are able to multitask, set priorities, and constantly assess and manipulate an array of medical machines and vital signs in order to help improve the patient's functional status. These clinicians are focused on helping patients get their life back to how it was before the injury or illness. Patients are transferred to an ICU to receive an aggressive level of treatment that is not available in other hospital units (Treece, 2007).

Communication

Communication refers to an organized patterned system of behaviour that may be verbal or non-verbal. Verbal communication includes not only language or dialect, but also tone of voice, volume, timing and one's ability to share thoughts and feelings. Non-verbal communication may take the form of writing, gestures, body movements, posture and facial expressions. Non-verbal communication also includes eye contact, the use of touch, body language, and style of greeting. Other variables to consider include the roles of gender, age, acculturation, status or position on what is considered to be appropriate eye contact. For example, Muslim Arab women exhibit modesty

when avoiding eye contact with men other than their husbands and when in public situations (Lewis et al., 2007).

Communication regarding end-of-life issues with patients and families has been recognized as complex and not always done well, as judged from all those involved. From a family's perspective, their members have indicated that when they are involved in making decisions about the end of life, they feel a sense of comfort and support when they might otherwise feel helpless.

A number of studies have identified what families report to be helpful when making end-of-life decisions for their loved ones. These factors included timely communication, supporting families, an advanced directive that provides honour and access to the patient before and after death (Liaschenko, J., O'Conner-Von, S. & Peden-McAlpine, C., 2009).

The importance of effective communication in intensive care settings is well established. However, anecdotal and research evidence suggests that many patients recover from episodes of critical illness that result in admission to an ICU with a less than favourable view of nurses' ability to communicate effectively. Patients often describe how they felt frustrated and alienated by the apparent lack of communication in these settings. Further, just because patients are unconscious, we can never assume that they do not perceive attempts to communicate with them (Usher & Monkley, 2001).

With an increasing focus on improving care in the ICU, authors run the risk of forgetting the families of patients who survive their ICU stay. There are several reasons why we should focus on communication with the families of all critically-ill patients. First, it is generally not clear whether critically ill
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patients will survive at a time when clinician-family communication should be occurring. Second, although the patient's death in the ICU is a risk factor for psychological symptoms among family members, even the family of patients who survive are at increased risk of these symptoms when compared to the general population. Finally, there is evidence that family members of patients who survive are actually less satisfied with the communication with ICU clinicians than the families of patients who die. If we are to be truly effective in improving clinician-family communication, we must attempt to improve this communication for the families of all critically-ill patients (Curtis & White, 2008).

Role of the ICU nurse

Nurses who work in critical care units are responsible for providing care to patients who are experiencing or are at risk of experiencing life-threatening conditions. Patients typically cared for in a critical care unit include patients who have had undergone invasive surgery, accident and trauma patients, or patients with multiple organ failure. Nurses who work in critical care units must assess and monitor the patient closely in order to identify subtle changes in a patient's condition that warrant immediate intervention. Patients who are admitted to a critical care unit need intensive care in order to maintain their condition, monitoring, and continuous adjustment of treatment, such as changing the doses of multiple intravenous medications, and changes in ventilator support. Critical care nurses must be able to interpret, integrate and respond to a wide array of clinical information because of the critical nature of patients' conditions (Kozier, Erb & Berman, 2008).

Critical care nurse cares for patients and the families of patients with acute and unstable physiological problems in an environment equipped for technically advanced methods of assessing and managing patient problems. The American Association of Critical Care Nurses (AACN) defines critical care nursing as that nursing specially dealing with human responses to life-threatening problems (Lewis et al., 2007).

Nursing staff in ICUs are important facilitators of communication because they provide a link between the patient and the outside world. Nurses are said to provide a conduit for initiating and maintaining a modicum of normality in an otherwise alien environment. This is important when many of the patients are unconscious, as is frequently the case in these settings (Usher & Monkley, 2001).

Critically-ill patients

A patient is generally admitted to an ICU for one of three reasons. First, the patient may be physiologically unstable, requiring advanced clinical judgements by a nurse or physician. Secondly, the patient may be at risk of serious complications and require frequent, often intensive, assessment. Thirdly, the patient may require intensive and complicated nursing support related to the use of intravenous (IV) polypharmacy, such as sedation and thrombolytic drugs. Patient may be admitted to an ICU because of a number of serious conditions, such as respiratory distress, major cardiac surgery, and myocardial or ischemic infarction (Lewis et al., 2007).

Severe sepsis with associated multisystem organ dysfunction is a leading cause of death in patients hospitalized in an ICU. The gastrointestinal tract

plays an important role in the pathogenesis of multiorgan dysfunction owing to the breakdown of the intestinal barrier function and the increased translocation of bacteria and bacterial components into the systemic circulation, and all those factors can lead to the patient becoming critically ill (Jacobi, C. A., Schulz, C. & Malfertheiner, P., 2011).

For many patients, a stay in an ICU can be very frightening and confusing. Some patients may have been prepared for such an eventuality, while others may have been admitted unexpectedly. In either case, the intensity of the environment and the level of staffing required can be very daunting. In these settings, many patients will have a period of being either intubated or requiring the use of a tracheostomy, leading to them being unable to talk and ask questions about their health, care or prognosis. The lack of control over their environment can have a significant number of counter-effects on the individual's cognitive and psychological status and can potentially result in misunderstandings. Many studies have demonstrated that the promotion of a suitable means of communication for an individual can improve well-being, which may therefore increase compliance with rehabilitation therapies and reduce the length of stay (Batty, S., 2009).

Ninety per cent of deaths in an ICU involve withdrawing or withholding care, but less than five per cent of critically-ill patients are able to participate in a decision-making process leading to treatment limitation (LeClaire, Oakes & Weinert, 2005).

Most critically-ill patients do not have a decision-making capacity, so family members frequently become involved with clinicians in discussions about the

goals of care and must represent the patients' values and treatment preferences in these discussions. Therefore, clinician-family communication is a central component of good medical decision-making in the ICU. Previous studies suggest that family members view clinicians' communication skills as more important than their clinical skills (Curtis & White, 2008).

Family

The family is a basic unit of society. It consists of those individuals, male or female, young or old, legally or not legally related, who are considered by others (such as close friends) to represent their significant persons. A family consists of persons (structure) and their responsibilities within family roles (Kozier, Erb & Berman, 2008). The definition of a family member is a direct family person or significant one who is identified as a "close relative" (Henderson & Knapp, 2005).

A patient's family members in the ICU are exposed to considerable stress. To better help relatives in this situation it is important to gather information about how they experience the information provided and supported by medical staff. The staff may underestimate relatives' needs (Myhern, Ekeberg, Langen & Stokland, 2004).

Communication between families and providers in the ICU includes sharing information about illness and prognoses, engaging families in treatment decision-making, and offering support. Treatment decisions are complex and so communication is essential for designing treatments that incorporate patient values. Communication also affects patient and family outcomes (Scheunemann, McDevitt, Carson & Hanson, 2010).

However, communication is complicated by time constraints, lack of training in communication skills, unclear goals and processes, and challenging family dynamics. Nurses must possess good communication skills in order to provide humane, complete and comprehensive care. Such abilities imply: listening well, honesty, avoiding a conspiracy of silence, fake cheerfulness, never dismissing hope and providing pain relief. The guidelines of the American Association of Colleges of Nursing state that a nurse must have certain skills in order to be able to provide high quality assistance and to be able to, for example, communicate with dying patients and their families, such as effective and compassionate communication ability, when death issues are concerned, along with other skills (Trovo de Araujo, M. M. & Paes da Silva, M. J., 2004).

Family members are increasingly part of care-giving to seriously ill patients, whether this is informal support and care in the home or surrogate decision-making in the ICU. The informal care and decision-making provided by family, partners and friends constitute a growing portion of the healthcare provided to seriously ill patients.

Furthermore, approximately 20% of deaths in the United States occur in an ICU, and most of these deaths involve family members acting as surrogates for the patient. In the ICU setting, there is an additional reason to focus on the needs of the family. Since family members are often serving as surrogate decision-makers, then decisions about patients will depend in part on the family.

To the extent that family members' distress affects their ability to make substituted judgement, these burdens on family members can interfere with patient care. Therefore, effective communication with family members that minimizes the stress on the family and provides support to them will improve not only family outcomes but also medical decision-making for the critically-ill patient (Curtis & White, 2008).

AIM

The aim is to describe nurses' experiences of communicating with the family members of critically-ill patients in an ICU setting.

Research questions

What are nurses' experiences of communicating with family members with different cultural and religious backgrounds?

What are nurses' experiences of communicating with family members in end-of-life situations?

METHOD

The method chosen for this study is a literature review. A literature review is defined as a written summary of the state of evidence on a research problem (Polit & Beck, 2008). A literature review discusses information about a particular subject within a certain time period. A literature review can be just a simple summary of sources, though it will have an organizational pattern and combine both a summary and synthesis and entail gathering information (Polit & Beck, 2008). In this study, a total of 15 original academic articles have been chosen.

Data collection

The data collection of literature was carried out using PubMed. PubMed is a lifelong resource regardless of institutional affiliation; it means that anyone, anywhere in the world with access to the Internet can search for journal articles (Polit & Beck, 2008, p. 114). MeSH terms are created by the National Center for Biotechnology Information (NCBI). PubMed works by searching the National Library of Medicine's (NLM) website; it helps researchers to obtain the full texts of articles in the biomedical literature and helps to access further links to selected life science journals not covered by MEDLINE (National Center for Biotechnology Information, 2010). In this study, the search strategy was devised by combining MeSH terms in PubMed and the results of this database search are shown in Table 1. In order to obtain articles relevant to this literature review, the authors have used Mesh terms and limited the research to papers published within the last 10 years, i. e. 2001-2011, in English, on humans of any age.

MeSH terminology provides a consistent way to retrieve information that may use different terminology for the same concepts (Polit & Beck, 2008). The authors searched for scientific articles by using the PubMed database. The key search words are as follows: “ Communication”[Mesh]) AND “ Family”[Mesh]) AND “ Nursing Methodology Research”[Mesh], ((“ Patients”[Mesh]) AND “ Critical Illness”[Mesh]) AND “ Intensive Care Units”[Mesh].

Original articles identified had to be published in peer-reviewed journals with an abstract available, and had to focus on nurses' experiences relating to communication with family members of critically-ill patients in ICU settings.

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The primary search yielded eleven original articles of interest and four original articles via a manual search. In addition, bibliographic searches revealed other articles. The articles are presented in a matrix (Table 1). The selected articles were assessed independently by the authors using

Appendix 1 the Sophiahemmet University College classification guide to academic articles and studies regarding quality in both quantitative and qualitative research (Appendix 1). The scientific quality of the studies was assessed on a three-grade scale: high (I), moderate (II) or low (III) quality.

Inclusion criteria and limits: PubMed is used in this study to search for academic articles. PubMed comprises biomedical literature; it is a resource for nursing and allied health literature. The inclusion criteria for articles are: English language, nursing specialty, original scientific article, setting is a Critical Care Unit (CCU) or an Intensive Care Unit (ICU). The study is concerned with studies on human beings; in addition, only primary sources have been used. The main concern was to consider nursing attitudes and experiences though any study including professions other than nursing was considered.

Exclusion criteria: any research not done in the English language was excluded. If a study was more than ten years it was excluded, unless it was unique and no other study was available with the same concern.

Data analysis

The articles were all read and analyzed manually and documented in the Office Word program on computer. The main concepts were highlighted in different colours and documented in different files. All different aspects were <https://assignbuster.com/literature-review-of-nurses-experience-of-communication-nursing-essay/>

taken into consideration and scheduled according to information correspondence and differences. The studies' conclusions were read by the authors and are included as supportive points in the conclusion of the study.

Table 1: Search process in PubMed

Database

Date of search

Keywords

Number of hits

Abstracts reviewed

Articles examined

Included

articles

PubMed

30032011

“ Patients”[Mesh]) AND “ Critical Illness”[Mesh]) AND “ Intensive Care Units”[Mesh].

17

17

10

5

PubMed

30032011

“ Communication”[Mesh]) AND “ Family”[Mesh]) AND “ Nursing Methodology
Research”[Mesh]

129

20

6

6

Database

Date of search

Keywords

Numbers of hits

Abstracts reviewed

Articles examined

Included

articles

PubMed

22032011

“ Patients”[Mesh]) AND “ Critical Illness”[Mesh]) AND “ Intensive Care Units”[Mesh].

17

17

10

2

PubMed

22032011

“ Communication”[Mesh]) AND “ Family”[Mesh]) AND “ Nursing Methodology Research”[Mesh]

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2

Database

Date of search

Keywords

Numbers of hits

Abstracts reviewed

Articles examined

Included

articles

PubMed

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“ Patients”[Mesh]) AND “ Critical Illness”[Mesh]) AND “ Intensive Care Units”[Mesh].

17

17

10

2

PubMed

30032011

“ Communication”[Mesh]) AND “ Family”[Mesh]) AND “ Nursing Methodology Research”[Mesh]

129

20

6

2

ETHICAL CONSIDERATIONS:

The authors were intent on dealing with the results in an honest way and no changes have been made to the facts or findings. The articles used are all ethically approved. The results include both information that will support the authors' thoughts and those that will not (Polit & Beck, 2008).

RESULTS

A total of fifteen articles met the inclusion criteria set for this study. The results are presented in two categories. First, findings from articles on nurses' experience of communicating with family members with different cultural and religious backgrounds are presented, followed by nurses' experience of communicating with family members in end-of-life situations.

Nurses' experience of communicating with family members with different cultural and religious backgrounds

Five articles were retrieved on the communication experiences of nurses with family members who represent different cultural or religious backgrounds. The study conducted by Høye and Severinsson (2009) reveals that families belonging to non-Western ethnic backgrounds will experience significant challenges when dealing with a complex ICU system. Among these challenges is that of communicating effectively with ICU nurses. A <https://assignbuster.com/literature-review-of-nurses-experience-of-communication-nursing-essay/>

main theme that surfaced in the study is the struggle of such families to preserve their culture whilst also trying to find their place in the healthcare system. To meet this challenge, families have to filter information they receive from their healthcare workers in order to reduce their concerns. Complex information has to be dissected and understood from their perspective. Hence, it was important for ICU nurses to be sensitive to the needs of these family members and clarify any complex information. Second, family members felt that it was important for them to understand the nurses or healthcare staff and also to be understood for their differences. Finally, family members felt that when relatives were undergoing treatment, their cultural traditions should be respected and roles, rules and expectations should be clearly defined.

Meanwhile, the study by Söderström et al. (2006) shows the importance of family members being able to understand both implicit and explicit messages. The depth of their understanding will determine how open the communication is between them and the critical-care nurses. The level of understanding will also predict their level of adjustment to the system. Nurses, on the other hand, also felt that lines of communication are better when they and family members understand each other. If the system is explained well to family members, then adjustment is also quicker and more effective. An important finding of Söderström et al.'s (2006) study was the complaint by family members that when they have little understanding of implicit and explicit messages, then they perceive that they are insulted by staff, as compared to respondents who understood both types of messages.

When communicating with family members who have a different cultural or religious background, the experiences of nurses are suggested as being a 'constant battle', as described in the study by Halligan (2005). While religion and family were vital factors in the kind of care received by ICU patients, critical-care nurses felt that caring for patients with different religious backgrounds was stressful. It is the aim of nurses to provide only quality care, but the difficulty in communicating with family members adds to the stress of caring for the patients. The challenges of dealing with multicultural families in intensive care units in Norwegian hospitals were studied by Høye and Severinsson (2008). The results of the study reveal that one of the workplace stressors was the challenge of communicating with multicultural families. While the study also revealed other categories of workplace stressors, such as the impact on work patterns, professional status and gender, and responses to crises, the study emphasized the importance of communicating effectively with multicultural families so as to avoid misunderstandings. The cultural diversity of their patient's families is seen as an important factor in determining whether positive and effective communication takes place between ICU nurses and patients' families.

Finally, a study by Høye and Severinsson (2010) reveals the challenges of communicating with families with diverse cultural backgrounds. The findings of this study reveal that there is a conflict between the cultural traditions of families and professional nursing practice. For instance, the nurses felt that there is a conflict between the perceptions of nurses as total providers versus the belief of families to be able to contribute to the process of caring for their family members as patients. There is also a conflict between how

families respond to illness and communicate to the nurses versus the perception of nurses to provide comprehensive information. And there is a different conflict between the perception of nurses to assume professional responsibility in the clinical environment as opposed to the needs of families to follow cultural norms and self-determination. These conflicts can only add to the perceived difficulties in communicating effectively with patients in order to determine what is appropriate or best for the patient. Hence, Høye and Severinsson (2010) suggest that there is a need for nurses “ to negotiate with culturally diverse family members to address conflicts” (p. 858). The authors also suggest that there is a need for nurses to practise cultural sensitivity and eliminate ethnocentrism. Hence, it is also suggested that nurses be assessed on their competence in assessing the diversity of patients’ families.

An evaluation of the quality of the studies retrieved about nurses’ experience in communicating with multicultural families or those with different religious backgrounds shows that only two studies were of high quality or earned a grade of I, while the rest were of moderate quality. The studies by Söderström et al. (2006) and Høye and Severinsson (2010) were graded as being of high quality, which means that the context is clearly described. The selection of the participants was well explained and the inclusion criteria were well established by the authors of the study. Data collection and analysis were clearly explained. How credibility and reliability were achieved in the data analysis and presentation of results were also explained in a transparent manner. There was also a clear relationship between data gleaned in the study and their interpretation. A critique method was also well

employed by the researchers. The rest of the studies were deemed as being level II studies, or having higher quality than low-quality studies. These types of studies have certain criteria for level 1, which were not met.

Despite the limitations of the other studies reviewed in this paper, the results of all the studies included in this section are important, as they show the importance of effective communication when giving quality care to ICU patients. They also show that difficulty in communication has the potential to be a significant stressor in the workplace. Hence, it is suggested that clear communication channels should be established to ensure that there is mutual understanding between ICU nurses and patients' families. However, the methods used, which were all examples of qualitative methodology, limit the applicability of the findings to the sample populations only.

Generalisation to a larger and more heterogeneous population is not possible.

Nurses' experience of communicating with family members in end-of-life situations

Eleven of the studies retrieved in this study all related to the communication experiences of ICU nurses in end-of-life situations. A review of the findings of the different studies included in this review reveals that communication with family members is often accompanied by feelings of grief (Shorter and Stayt, 2009). Nurses remarked that it was difficult to communicate with family members, especially if they had developed a meaningful relationship with the patient's relatives. Other themes revealed by the studies included nurses reporting that the death of a patient is less traumatic if the patient and his or her family are prepared. The experience also becomes less traumatic if the

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patient has experienced good nursing care (Shorter and Stayt, 2009).

Another theme that emerged from the study by Shorter and Stayt (2009) was the coping mechanism of nurses when dealing with end-of-life situations. They reported talking to their colleagues to alleviate feelings of grief or sadness. Others dissociated themselves emotionally from their dying patients.

In another study by Fridh et al. (2009), it was found that communicating with the family of a dying patient would involve leaving them with an enduring memory of their loved ones by ensuring that patients experienced a calm and dignified death. Meanwhile, Calvin et al. (2009) explained that nurses' experience of communicating with a patient's family in an end-of-life situation involved talking with the patient's family and exhausting all possible treatments for the patient. The intensity of care is also discussed by talking with the family and patient together to increase their presence.

Nurses in the study also perceived that they walk a fine line when communicating with a patient's family. The implications of this study include the need for sensitivity when communicating with the family of a patient during end-of-life care. In a newborn intensive care setting, Epstein (2008) suggested that nurses perceive their roles as practitioners who create a good experience for the relatives or family of a child when administering end-of-life care. Communicating with families is also seen as challenging as nurses express that it should be done with sensitivity. There is a need to inform parents or families about end-of-life care and to ready them for the eventual demise of their patient. All this experience is thought to be distressing on the part of the nurses as they face the grief of families.

Meanwhile, Ronayne (2008) suggests that nurses have difficulties in explaining brainstem death to a patient's family. In the study, nurses talk of experiencing cognitive dissonance that fuels more stress. In turn, this could lead to difficulty in communicating brainstem death to the relatives of the patient. Hence, Ronayne (2008) suggested that nurses should receive support and more education to allow them to overcome this kind of dissonance. Ronayne (2008) emphasises that this would empower nurses to give the patient's family honest information. Communicating information on brainstem death is recognized as being a sensitive matter and Ronayne (2008) suggests not only verbally informing relatives about this kind of death but also giving them leaflets. How nurses define their own roles and their expectations for themselves when caring for patients in an ICU who need end-of-life care will determine how well they communicate with a patient's relatives. This was highlighted in the study by Stayt (2006), which suggests that nurses are often confronted with the realities of their everyday work and their own role expectations. Since nurses are mainly responsible for providing care and attending to the families of ICU patients, the demands of fulfilling these roles while also effectively communicating with their patients can only add to the stress of their work. Hence, the suggestion by Ronayne (2008) appears important to ensure that nurses can effectively communicate with patients' families.

The study by Engstrom and Soderberg (2005) also highlighted the need for effective communication. In this study, nurses expressed the frustration they feel when immediate family members are absent and they cannot communicate with the family to create an individua