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Achury Saldaña, Diana Marcela; Pinilla Alarcón, Maribel; Alvarado Romero, Herly
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Universidad de Antioquia
Medellín, Colombia

Aspects that facilitate or interfere in the communication process between nursing professionals and patients in critical state

Diana Marcela Achury Saldaña[1]
Maribel Pinilla Alarcón[2]
Herly Alvarado Romero[3]

Aspects that facilitate or interfere in the communication process between nursing professionals and patients in critical state

Objective. To describe aspects facilitating or interfering in the communication process between nursing professionals and patients in critical state. **Methodology**. Descriptive study conducted during the second semester of 2013, with the participation of 112 nurses who work in Intensive Care Units of Bogotá (Colombia). To gather the information, the researchers designed a survey. **Results**. A total of 91.6% of the nursing professionals considers communication important with patients and their families; 75.9% seeks to provide, during the care interventions, physical care and communicate per shift from two to four times with the patient and from one to two times with the family; 50% states feeling afraid to communicate; only 53.7% integrate their emotions in the patient's physical care. Regarding the elements of communication developed during their graduate formation, 42.8% received tools of therapeutic communication during their undergraduate studies and only 33.0% during graduate studies. It is worth to indicate that 80.36% of the Intensive Care Units, where the nursing professionals work, privilege interventions aimed at satisfying physiological needs. **Conclusion.** The communication process between nurses and patients in critical state is limited by restrictive institutional policies and by the nurses' scarce academic formation. The need exists to start a process of change in relation to models of professional practice deeply rooted in physical care of critical patients to establish models that, during physical care, are centered on communication and the patient-family-professional relationship.

Keywords: communication; nurse clinicians; patient care; intensive care.

Aspectos que facilitan o interfieren el proceso comunicativo entre el profesional de enfermería y el paciente en estado crítico

Objetivo. Describir los aspectos que facilitan o interfieren en el proceso comunicativo entre el profesional de enfermería y

1 RN, M.Sc. Pontificia Universidad Javeriana. Red Internacional de Enfermería en Cuidado Crítico, National Coordinator, Colombia.
email: dachury@javeriana.edu.co
2 RN, M.Sc. Pontificia Universidad Javeriana. Clínica Montserrat, Colombia.
email: mpinilla@javeriana.edu.co
3 RN, M.Sc. Pontificia Universidad Javeriana, Colombia.
email:herlynga@gmail.com

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el paciente en estado crítico. **Metodología**. Estudio descriptivo realizado durante el segundo semestre del 2013, en el cual participaron 112 enfermeras que laboraran en unidades de cuidado intensivo de Bogotá (Colombia). Para la recolección de la información las investigadoras diseñaron una encuesta. **Resultados**. El 91.6% de los profesionales de enfermería considera importante la comunicación con el paciente y su familia; el 75.9% intenta proporcionar, durante la intervenciones de cuidado, cuidado físico y comunicarse por turno de 2 a 4 veces con el paciente y de 1 a 2 veces con la familia; el 50% refiere sentir temor para comunicarse; tan solo el 53.7% integra las emociones en el cuidado físico del paciente. Con respecto a los elementos de comunicación desarrollados en su formación posgraduada, el 42.8% recibió herramientas sobre comunicación terapéutica en su pregrado y solo un 33.0% en el posgrado. Cabe señalar que el 80.36% de las unidades de cuidado intensivo, en donde laboran los profesionales de enfermería, privilegia las intervenciones orientadas a satisfacer necesidades fisiológicas. **Conclusión.** El proceso comunicativo entre la enfermera y el paciente en estado crítico está limitado por las políticas restrictivas institucionales y por la escasa formación académica de las enfermeras. Hay necesidad de iniciar un proceso de cambio en relación con los modelos de práctica profesional profundamente arraigados en el cuidado físico del paciente crítico con el fin de establecer modelos que, durante el cuidado físico, estén centrados en la comunicación y relación paciente-familia-profesional.

Palabras clave: comunicación; enfermeras clínicas; atención al paciente; cuidado intensivo.

Aspectos que facilitam ou interferem o processo comunicativo entre o profissional de enfermagem e o paciente em estado crítico

Objetivo. Descrever os aspectos que facilitam ou interferem no processo comunicativo entre o profissional de enfermagem e o paciente em estado crítico. **Metodologi**a. Estudo descritivo realizado durante o segundo semestre do 2013, no qual participaram 112 enfermeiras que trabalharam em unidades de cuidado intensivo de Bogotá (Colômbia). Para a recolha da informação as pesquisadoras desenharam uma enquete. **Resultados**. 91.6% dos profissionais de enfermagem considera importante a comunicação com o paciente e sua família; 75.9% tenta proporcionar, durante a intervenções de cuidado, cuidado físico e comunicar-se por turno de 2 a 4 vezes com o paciente e de 1 a 2 vezes com a família; 50% refere sentir temor para comunicar-se; tão só 53.7% integra as emoções no cuidado físico do paciente. Com respeito aos elementos de comunicação desenvolvidos em sua formação pós-graduada, 42.8% recebeu ferramentas sobre comunicação terapêutica em sua graduação e só um 33.0% na pós-graduação. Cabe assinalar que 80.36% das unidades de cuidado intensivo, em onde trabalham os profissionais de enfermagem, privilegia as intervenções orientadas a satisfazer necessidades fisiológicas. **Conclusão**. O processo comunicativo entre a enfermeira e o paciente em estado crítico está limitado pelas políticas restritivas institucionais e pela escassa formação acadêmica das enfermeiras. Há necessidade de iniciar um processo de mudança em relação com os modelos de prática profissional profundamente arraigados no cuidado físico do paciente crítico com o fim de estabelecer modelos que, durante o cuidado físico, estejam centrados na comunicação e relação paciente-família-profissional.

Palavras chave: comunicação; enfermeiras clínicas; assistência ao paciente; terapia intensiva.

Introduction

For Louis[1], communication is the act of giving and receiving information and it comprises three elements: the sender, the message, and the receptor. It is a learned process that depends on the individual's attitude, the sociocultural background, the context, past experiences, knowledge on the theme, and the capacity to relate with others. The nurse-patient-family interaction is a priority in the exercise of the professional practice and becomes the articulating hub in care. Consequently, nursing

professionals require managing communication systems like: intrapersonal (inner dialogue), interpersonal (expression of feelings, problem resolution), and transpersonal (meditation-spiritual).[2] Thus, communication is taken within a clear manifestation of values and attitudes like comprehension, empathy, acceptance, authenticity, and respect. It is a process that permits establishing and consolidating a therapeutic relationship that, centered on an interaction process, seeks to identify, understand, and satisfy the psychological and psychosocial needs confronted by patients and their families. The fundamental basis of this is team work or "concordance" between patient and nurse, and identification of objectives agreed upon by both. If the relationship between the professional and the patient is not effective, the results are minor. To achieve greater effectiveness in communication, subjective negotiation is needed; additionally, it is fitting to consider an anticipated work with respect to communication, given that it is a technique that requires personal and social skills to accomplish providing well-being to patients.[3]

Notwithstanding the previous considerations, in Intensive Care Units (ICU) it is not easy to note the communication process. This situation is determined by the dynamics of the patient in intensive care, which is more aimed at management of technology, routine activities, and prioritizing physiological needs.[4] It has been found that poor communication affects patient recovery and increases days of hospitalization. Likewise, it is considered that care is incomplete if it is not accompanied by communication interventions that address emotional and physical situations, which will help to diminish the sense o fear, anxiety, lack of trust, and vulnerability experienced by patients in critical state.[5,6] It should be pointed out that the satisfaction of relatives of patients in Intensive Care Units depends more on how nursing professionals communicate with them than on the care received.[6] However, follow up of these individuals indicates lack of satisfaction with the communication delivered by nursing personnel.[7] Based on the aforementioned, the International Network on Critical Care Nursing (REINECC, for the term in Spanish) found that the professional-patient-family communication process becomes one of the most difficult aspects in the daily practice and it has still not been considered as an effective process in ICU blocking detection of the needs of patients and their families.[8] Because of this, it was decided to conduct an initial diagnosis of the situation of this process to set up effective communication strategies in the mid-term. The REINECC, as work and cooperation strategy aimed at enhancing the quality of care, calls on different nursing professionals who work in this area both in academic and hospital environments in countries like Colombia, Mexico, and Argentina.

Methodology

A situational diagnostic descriptive study was conducted regarding the communication process between the nursing professional and the patient in critical state. The population was constituted by 300 nurses from the REINECC who were called on to participate in the diagnosis during the second semester of 2013. The sample selected, through non-probability convenience sampling, was of 112 nursing professionals. The selection criteria were: members of the network, volunteer participation, working in Intensive Care Units in the city of Bogotá (Colombia). To gather the information, the researchers designed a survey, which included 12 closed questions with multiple choice answers whose objective was to know in general manner the aspects that facilitated and/or interfered in the communication process during their formation process and professional performance. The guiding theoretical framework was that by Johnson,[9] as pioneer in assertive communication. For the purpose of revising clarity, coherence, and comprehension of the survey a pilot test was run with a group of 20 ICU nurses in the network, who did not participate in the sample selected. The results of the pilot test indicated that the writing of the three questions needed improvement. But it was, nevertheless, proven that the instrument responded to the objective proposed. This last aspect was evaluated

through an open question from which the participants provided their appreciation regarding the 12 questions posed and if these fulfilled the general objective of the research. The information collected was processed via Excel. To present the results, descriptive statistics was used through absolute and relative frequency distribution. Additionally, mean and standard deviation was determined for the age variable.

Results

With respect to the sociodemographic characteristics of the participating professionals, it was found that mean age was 37 years (Standard deviation: 8.9); 71.42% were women; 59.8% had undergraduate formation; and 50% had between 2 and 6 years of experience (Table 1).

Table 1. Sociodemographic characteristics of the 112 participating professionals

Variable	Number	Percentage
Age group		
20-30 years	50	44.64
31- 40 years	30	26.78
>40 years	32	28.57
Gender		
Men	30	26.78
Women	80	71.42
Without data	2	1.78
Formation		
Undergraduate	45	40.17
Graduate	67	59.82
Experience in years		
< than 2	25	22.32
2-6	56	50.0
7 and more	31	27.67

Table 2 shows the findings obtained in the variables measured in the survey. In summary, nurses consider communication with patients and their families very important (91.6%), which is why their shift is aimed at developing activities to provide physical care and develop communication processes with patients and their families (75.8%); in turn, they state that the number of times they speak to patients is between 2 and 4 (86.6%), while the number of times they communicate with families is between 1 and 2 times (70.5%). Regarding some feelings experienced by nurses during their work, they expressed that, frequently, they consider themselves sensitive when trying to satisfy and respond to the needs of critical patients and their families (44.6%); sometimes they integrate their emotions to the patient's physical care (53.7%); feel no fear during their work (50.0%); and feel satisfied at the end of their shift (82.1%).

Regarding their undergraduate formation, they report having received training in therapeutic communication (42.8%), but did not receive such during their graduate studies; nor did they receive crisis intervention, self awareness, or meaning of others (33.04%). In terms of their place of work, they agree with the fact that one of the aspects in the ICU policies is aimed at maintaining the nurse-patient relationship (53.5%) because, currently, activities aimed at satisfying physiological needs (80.3%) continue being privileged.

Table 2. Response percentage of each of the communication survey questions

Questions	Number	Percentage
During the shift, your care interventions are aimed at:		
Providing physical care	23	20.54
Developing communication processes with patients	4	3.57
Developing communication processes with families	0	0.00
All of the above	85	75.89
The approximate number of times you speak with patients during the shift is:		
1 to 2 times	15	13.39
2 to 3 times	33	29.46
3 to 4 times	31	27.68
More than 4 times	33	29.46
The approximate number of times you communicate with patients' families during the shift is:		
1 to 2 times	79	70.53
2 to 3 times	23	20.53
3 to 4 times	8	7.14
More than 4 times	2	1.78
During the shift, you fear:		
Speaking with families	11	9.82
Accompanying critical patients and their families at the end of life	43	38.39
I have no fear	56	50.00
Do you consider yourself sensitive to satisfy and respond to the emotional needs of critical patients and their families:		
Somewhat	31	27.68
No	1	0.89
Frequently	50	44.64
Always	30	26.79
Frequently, do you integrate your emotions with physical care of critical patients:		
Sometimes	60	53.57
Never	12	10.71
Most of the times	28	25.00
Always	12	10.71
At the end of your shift, you feel:		
Satisfied	92	82.14
Stressed	3	8.93
Dissatisfied	10	2.68
Overwhelmed	7	6.25
In your undergraduate formation, you received training mainly in:		
Self awareness	6	5.36
Meaning of others	21	18.75
Crisis intervention	15	13.39

Table 2. Response percentage of each of the communication survey questions

Questions	Number	Percentage
Therapeutic communication	48	42.86
None of the above	22	19.64
In your graduate formation, you received training mainly in:		
Self awareness	4	3.57
Meaning of others	17	15.18
Crisis intervention	23	27.68
Therapeutic communication	31	20.54
None of the above	37	33.04
In your Intensive Care Unit, you privilege interventions aimed at what type of necessities		
Physiological	90	80.36
Communicative	11	9.82
Educational	9	8.04
From your Intensive Care Unit, you agree with policies aimed at:		
Restricted visits	5	4.46
Exclusive communication between physicians and families	13	11.61
Nurse-patient relationship	60	53.57
Family comfort	34	30.36
In your work, do you consider that communication between patients and families is:		
Very important	103	91.96
Frequently important	9	8.04
Of little importance	0	0.00
Not important	0	0.00

Discussion

Results of the survey applied permit identifying that most of the nursing professionals were women aged between 20 and 30 years, with graduate formation and two to six years of experience. It was also observed that they provide comprehensive care to patients in critical state. Also, they consider communication with patients and their families an essential aspect; however, 20.54% indicate that their interventions are aimed exclusively at physical care; only 3.57% highlight the need to develop communication processes with patients. In turn, they state that nurses are the main initiators and regulators of communication opportunities in ICU.[10] Nevertheless, although communication is integrated onto care, they do not manage to establish a sufficient and effective process to achieve a final result that translates into an adequate therapeutic relationship.

Upon inquiring on the number of times they communicate with patients, similar percentages were found ranging between two and four times during the shift. When observing this result, it could be stated that it is adequate if that is the number of times they interact with patients to provide respective care, but in reality what is important is not the frequency but the quality of the communication, which is why the authors deem it necessary to delve into this aspect in future investigations. Some observational

studies,[11,12] showed that time of nurse-patient interaction lasts between one and five minutes. In addition, nurses use technical oral language and establish brief and unplanned physical contact based on physical and technological care without considering patients' emotions and reactions. Due to the aforementioned, some experts recommend that communication should be both verbal and non-verbal to accomplish true interaction. Regarding the number of times they communicate with the family, most do it one to two times during the shift. This finding may be determined by policies of restricted visits that impede greater time of contact with the families. This is more evident given that the professionals have not recognized the family as the complement of a single nucleus of care with respect to critical patients. On the contrary, it is fundamental to include it within the communication process.[13]

With respect to the communication process, half of the participating professionals are afraid to have oral expression with patients and their families at the end of life. This finding is alarming because death of patients in ICU is a frequent fact. Because of this, numerous publications[14-18] state that treatment of critical patients at the end of life and care for the needs of their relatives are far from being adequate. One of the most important studies conducted to improve treatment of the ill at the end of their lives has been SUPPORT,[19] whose most relevant conclusion holds that deficient nursing personnel–patient-family communication exists, due in part to the lack of formation of professionals in communication skills and palliative care.

It is worth mentioning that a high percentage of nurses consider themselves sensitive to satisfy and respond to the emotional needs of patients and their families, nonetheless, only sometimes do they integrate emotions onto patients' physical care. All this is related, given that nursing professionals are closest to the patient's pain and suffering, which generates in them a sense of fear, impotence, and loneliness. Some authors[20,21] consider that the difficulty in integrating emotions is reflected on the scarce use of non-verbal language and depersonalized care, which avoids establishing any type of affective link because it is an emotional defense mechanism.

Considering that the success of an adequate communication process depends on communication techniques, it is – thus – essential that during the formation of professionals to offer a course focused on this sense. Among other matters, the survey identified that very few of the participants received therapeutic communication tools during their undergraduate studies; a fallacy that was heightened during the graduate training, given that they received no communication formation. Only a small percentage received formation in crisis intervention. Hemsley *et al.,*[22] state that nurses tend not to receive specialized formation on communication and try to establish interaction with intubated patients through trial and error and by observing others.

Also, it is remarkable that in both levels of academic formation many nursing professionals were not provided elements on self awareness. This corresponds to what is known as intrapersonal communication, which is considered the most elemental act of communication. It contemplates internalized speech individuals have with themselves.[23] Nurses need time to analyze their own feelings on death before they can help others effectively, given that if they feel uncomfortable with these situations they tend to keep patients and their relatives from speaking about the agony, death, and suffering, which is why they become avoidant and not very therapeutic. If adequate intrapersonal communication exists, as well as coherence with respect to their feelings on death, true therapeutic communication can be successfully established.[24] It is also important for the institutional policies on this aspect to help dissipate tensions that could arise.

It is highlighted that most of the nursing professionals surveyed consider communication with patients and their families important; however, some ICU policies in different healthcare institutions still privilege care interventions regarding satisfaction of physiological needs, limiting adequate nurse-patient relationships. Additionally, undergraduate, graduate, and continuous education formation

processes have not standardized training with respect to communication processes. Scheunemann *et al.,*[25] emphasize that the structural and organizational conditions of the health system will not always benefit personal treatment and achievement of a satisfactory interaction; factors that may eventually escape from the direct control of healthcare professionals. Nevertheless, these professionals must be aware that improving care quality unavoidably involves improving the interactive process established with the patient.[26] The whole therapeutic relationship necessarily implies a process of interpersonal relationships.

The prior findings require establishing some philosophical reflections and changes in the care staff in relation to the professional practice models, which are deeply rooted, against the need to establish models centered on communication and patient-family-professional relationships. To accomplish this, we must discover the resistance and barriers interfering said communication and relationships. Nurses must, given their professional skills, retake the most active role in accompanying patients during their stay in ICU; in addition to recognizing the family in its caregiving role and implying it in continuous communication processes, in basic care toward their relative, and interventions during the process of death. Furthermore, there is the possibility of providing assertive information to the families, improving emotional security and satisfaction with patients and their families. However, this requires training in intra- and interpersonal communication and necessary techniques for their recognition and achievement of authentic therapeutic relationships. In this sense, academic entities are invited to retake in their undergraduate and graduate curricula of professionals in the area of health, mental health assignments necessary to enhance self-awareness, human development theories from the psychosocial perspective, development of communication skills, crisis intervention, coping with stress, death and managing grief, among others.

In turn, the members of healthcare institutions are recommended to establish communication protocols for families during death, which include fostering a support environment and biopsychosocial and interpersonal protection as requisite for care. They should also offer the necessary information to access community resources, links with networks, spiritual care, funeral services, and support groups. Likewise, these members should reflect and participate in the formulation, implementation, and evaluation of institutional management policies, adjusted to current regulations in effect, but also based on solid arguments that protect the rights and mental health of all the clients who have access to them. The personnel must know them and consider if their values are adjusted to these policies.

Finally, it is necessary to propose research that delves on existing barriers in the work staff that block assertive communication, its coherence, and the clarity of the communication, as well as information and support to relatives in and out of intensive care services.

Conclusion

The aspects found facilitate the communication process with nurses and patients in critical state and their families. Likewise, the conception of the professional providing holistic care includes physical care activities and communication interventions with patients and their families. The communication process is interfered by scarce contact with patients and the limitation of time when these contacts take place, as well as by nurse resistance to engage in the communication process due to lack of awareness, fear, and use of not very assertive technical language. Also, leaving out the families as subjects of care in the care process, added to restrictive institutional policies and scarce academic formation to support it emotionally, limit the communication process.

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