Table 29: Aslakson 2012

Study (RefID)	Aslakson 2012[31]
Aim	To identify nurse perceived barriers to effective communication regarding prognosis and optimal end-of-life care for surgical ICU patients
Population	n=32 SICU nurses
Setting	Surgical intensive care unit, tertiary referral centre in USA
Study design	Focus groups.
Methods and analysis	Four focus group sessions were convened. Open-ended questions focused on the nurses' perceptions of communication regarding prognosis, "Prognosis" was defined as incorporating whether or not the person was likely to die during the hospitalisation and and what would be the quality of life during the hospitalisation and after discharge. Qualitative analysis of content. Written notes taken during discussion were compared and pooled and content analysis technique used to identify major themes emerging in the discussions. After initial validation of the domains by the study investigators these domains were disseminated to a subset of 10 nurses who participated in the focus groups for verification.
Themes with findings	**Logistics** • Surgical team rounds before family is present • Cannot assemble entire team (intensivists, surgeons, nurses) • Not all parties present when meetings do occur

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	• Other support resources not always available (social work, pastoral care, palliative care) • Insufficient time during meeting • Poor availability of doctors or family for a meeting • Multiple decision makers in a family • Surrogate decision maker not at the meeting • Meetings interrupted by healthcare provider pagers and/or telephone calls • Lack of unbiased person • Patient cannot participate in conversations • Unclear what prior specialists and consultants have said regarding prognosis.
	Discomfort with discussion
	• Physician discussions with nurses and families are inconclusive • Family members do not want to "hear bad news" and avoid meeting • Prognoses are unrealistic and often portray "small victories" instead of overall prognosis • Unclear whose role it is to discuss prognosis and no one ends up doing so • Poorly defined goals of care, even prior to surgery.
	Perceived lack of skill or training
	• Physician discussions are rushed • Families are not given adequate time to ask questions • Communication is done "last minute" often before a procedure • Families are unaware of a patient's diagnosis • There is no accepted protocol about when and what to communicate • If families do not ask for meetings they will not receive them • Physicians both use language that the family do not understand and do not recognise it • Families do not remember to ask all their questions • Families do not know what resources are available to them • Fear of legal ramifications of bad outcomes
	Fear of conflict
	• Different opinions about prognosis between care providers

Study (RefID)	Aslakson 2012[31]
	• Inconsistencies between team members in communicating prognosis to families • Surgery and ICE teams rarely discuss prognosis but get angry when nurses discuss it • Difficult personalities of some healthcare providers.
Limitations	Serious limitations
Applicability of evidence	Population of intensive care unit not representative of review population, but many aspects explored in the analysis may be applicable to the wider population.