


Nurse Perceived Barriers to Effective Nurse-Client Communication

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NURSE PERCIVED BARRIERS TO EFFECTIVE NURSE-CLIENT
COMMUNICATION

by

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A thesis submitted in partial fulfillment of the requirements
for the Honors in the Major Program in Nursing
in the College of Nursing
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ABSTRACT

Successful client care depends on effective nurse-client communication. It is essential in meeting clients' needs, providing quality care, and maximizing positive client outcomes. The intent of this thesis was to explore nurse perceived barriers to effective nurse-client communication. A literature review was conducted and nine articles were identified as addressing nurse perceived barriers to communication. Four major barriers were identified: nurse comfort and knowledge, environment, time, and culture and language. Research on interventions to address nurses' perceptions of barriers to effective nurse-client communication may provide a better understanding of communication barriers and address issues created by ineffective communication with clients.

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INTRODUCTION

Communication begins every time a nurse enters a client's room; it is an ongoing and dynamic process that occurs throughout the delivery of care. Communication involves the transfer of information by exchanging verbal and non-verbal messages. Effective communication allows the sender's messages to be received and understood by participants (Bramhall, 2014). The sender is the person sending the message to the receivers. Within communication, the two roles are fluid. A nurse and client will be both sender and receiver. Communicators must have the ability to send messages to receivers in a manner that maximizes understanding.

Communication is central to the nurse-client relationship, and effective communication must occur to result in positive client outcomes. Nurse perceived barriers to effective nurse-client communication have been identified as time constraints, language and cultural differences, and nurse discomfort and lack of knowledge, which can lead to poor client outcomes (Farahani, Sahragard, Carrol, & Mohammadi, 2011; Hemsley, Balandin, & Worrall, 2012). It is incumbent upon nurses to perceive the barriers to effective nurse-client communication. When nurses are able to recognize and correct their perceived barriers to communication, better client outcomes may result.

Effective communication is beneficial for both nurses and clients. Bramhall (2014) reports nurses with poor communication training can experience negative psychological effects and an inability to meet job demands. Nurses with effective communication training and skills, report less frustration and more patience in interactions with clients (Radtke, Tate, & Happ, 2012). Effective nurse-client communication assists clients in coping with difficult diagnoses and situations, positively influencing emotional health, aiding in symptom resolution, can improve

physiological functions, and can decrease pain levels. Client decision making may be improved when there is effective nurse-client communication (Bramhall, 2014).

BACKGROUND

Elements of Communication

Communication is a multifaceted, complex process. Central to the communication process is the message. The message is the communication format that is transmitted between sender and receiver (Arungwa, 2014). The content of the message is sent with the purpose of making all parties involved come to a shared understanding. By reaching this shared understanding, participants are able to work towards a common goal. In healthcare, the common goal is the improvement of the client's health problems. The message can occur verbally and/or non-verbally. These forms can then be subdivided into smaller components.

Verbal communication is comprised of language, vocabulary, sounds, and intonation (Arungwa, 2014). Each of these sub-categories contain communication aspects that differ from person to person. The first part of the verbal message, language, is the root of all communication and is made up of the vocabulary of that language. Even within the same language, there are vocabulary differences based on regions, sociocultural groups, and profession. The medical and nursing professions have their own nomenclature, that non-medical persons may not be able to understand (Arungwa, 2014; Savio & George, 2013). Sound and intonation are important factors that influence the success of communication. The sound level of communication must be loud enough so the message can be heard, but not too loud to where the speaker becomes offensive. Intonation engages the audience and aids the receiver in properly decoding the message (Trujillo, 2014).

Non-verbal communication occurs without the use of words. Research suggests approximately ninety percent of communication occurs without the communicators ever uttering a word (Pease, 2001). Instead, facial expressions, touch, eye contact, gestures, posture, and body

language are used to convey the intended meaning (Kourkouta & Papathanasiou, 2014). Non-verbal communication can be intentional or unintentional, and many times the speaker is unaware of the messages they are sending nonverbally (Tidwell, 2016).

Research has shown that non-verbal communication is influenced by sociocultural and familial background, environment, and innate human processes (Ekman, 1970; Reiman, 2007). In the 1960s Ekman undertook a pan-cultural study of body language in New Guinea, Borneo, the United States, Brazil, and Japan. Ekman (1970) found similarities in facial expressions that spanned the different cultures and concluded that certain aspects of body language and facial expressions are innate.

Cultures with high emotional restraint disprove of public touch; cultures that encourage emotion approve of frequent touching within the same gender (Tidwell, 2016). In Latino and Arabic cultures, it is common to exaggerate facial expressions when the person is feeling grief or sadness. Conversely, Americans use more controlled facial expressions when dealing with grief, while Asian cultures suppress all facial expression. In western cultures eye contact can communicate emotion levels, influence attitudes, indicate interest or attention, and define power within a group. Frequent eye contact conveys the speaker is knowledgeable in his or her subject (Jiang & Pell, 2015). Asian and African cultures avoid eye contact as a sign of respect to the speaker (Tidwell, 2016).

The communication process involves encoding, transmitting, decoding, and providing feedback (Waner & Winter, 1993). The process begins with the sender who initiates communication because they have information they wish to transfer to others (Arungwa, 2014). The sender encodes the message and conveys it either verbally, non-verbally, or both. The sent

message reaches the receiver, and is then decoded. Decoding is the receiver interpreting the information (Waner & Winter, 1993). The method in which information is encoded and decoded is based on individual factors and perceptions past experiences (Waner & Winter, 1993).

Communication is considered effective if verbal and nonverbal messages align, and the message was decoded in the manner the sender intended (Kourkouta & Papathanasiou, 2014). Feedback is essential in ensuring the message was decoded properly as perceptions of the same interaction can differ due to past experiences and cultural background (Waner & Winter, 1993).

Communication in Nursing

Effective communication between nurse and client requires the nurse to have a general understanding of the client's personal background, as well as an understanding of the client's previous health experiences (Kourkouta & Papathanasiou, 2014). Nurses must also possess a sincere desire to understand the client and their needs, both medical and non-medical. Each client has a distinctive personality that affects how they conduct themselves throughout the communication process with the nurse (Kourkouta & Papathanasiou, 2014).

Nurses receive specialized instruction in therapeutic communication, which is “an interaction between a health care professional and a patient that aims to enhance the patient's comfort, safety, trust, or health and well-being” (Hoekstra & Margolis, 2016, p. 401).

Therapeutic communication techniques include active listening, silence, focusing, use of open ended questions, clarification, exploring, paraphrasing, reflecting, restarting, summarizing, and acknowledgment (Registerednursing.org). The standard elements of communication are part of therapeutic communication. Both verbal and nonverbal forms of communication are utilized when a nurse engages in therapeutic communication (Goldin & Russel, 1969). Therapeutic

communication allows nurses to provide education for clients in a delicate and effective manner. Research has shown nurses use therapeutic communication to establish rapport with clients, allowing clients to feel secure and comfortable when describing symptoms and expressing opinions (Hoekstra & Margolis, 2016).

Barriers to communication

Nurse perceived barriers to effective nurse-client communication can be divided into physical, psychological, or social themes (Weaver, 2010). Communication barrier themes can overlap based on nurse and client factors and the relationship between participants. When multiple communication barriers exist in a nurse-client setting, the nurse must dedicate additional time and effort to communicate effectively in order to maximize client care (Coleman & Angosta, 2016; Hemsley, Balandin, & Worrall, 2012).

Physical barriers to effective communication include the environment where communication occurs. Sufficient lighting, room size, ambient noise, and lack of privacy can prevent effective communication between nurse and client (Weaver, 2010). Physical barriers may be created by therapeutic and care requirements such as clients on ventilators or in comas (Karlsson, Forsberg, & Bergbom, 2010). Time constraints affect the quality of communication and can negatively impact client outcomes (Hemsley, Balandin & Worrall, 2011). Time may act as a physical barrier to nurse-client interaction (Hemsley, Balandin & Worrall, 2011; Moore, Higgins, & Sharek, 2013). Nurses' numerous responsibilities reduce the amount of time available to care for clients and communicate with physicians concerning client care (Steele et al., 2011; Wittenberg-Lyles, Goldsmith, & Ferrell, 2013).

Psychological barriers to effective communication include anxiety, personality traits, level of self-esteem, and psychological disorders. Nurse anxiety concerning client care or low self-esteem have been shown to decrease communication between nurse and client (Arungwa, 2014; Steele et al., 2011). When a nurse is anxious about a client's medical needs due to unfamiliarity with the situation, negative past experiences, or fear of rejection, the communication process is disrupted. Clients with intellectual disabilities that cannot reliably relay information also pose additional communication challenges (Hemsley, Balandin, & Worrall, 2012)

Social barriers to effective communication are constructed around culture. Culture forms the basis of a person's customs, roles, rules, rituals, religion, and laws (Savio & George, 2013). Culture is reliant on communication for the continuation of traditions, while at the same time, communication practices and styles are largely shaped by culture. The sociocultural background of the nurse and client affects the extent the nurse perceived barriers can impact the nurse-client relationship and communication success (Arungwa, 2014). Proper education and experience can allow nurses to overcome communication barriers and engage in effective communication (Coleman & Angosta, 2016).

Interpersonal Relations Theory

Nurses can use communication theories to guide interactions with clients, gain a better understanding of the elements and importance of general and therapeutic of communication. In 1952, Peplau published the Interpersonal Relations Theory. Interpersonal Relations Theory assumes both the nurse and the client can interact and benefit from communication, and communication is affected by the environment, participants' attitudes, practices, beliefs, and

culture (Neese, 2015). There are four phases to the nurse-client relationship experiences: orientation, identification, exploitation, and resolution (Peplau, 1952).

The nurse initiates the orientation phase by engaging the client in their plan of care. Verbal communication is used as clients ask questions and nurses respond with explanations and information. Nurses also interview clients by inquiring about symptoms the clients have been experiencing. The exchange of information allows clients to develop a trusting relationship with the nurse (Peplau, 1952; Wayne, 2014). Barriers to effective communication can have the most damage to the nurse-client relationship within the orientation phase. The participants' values, culture and race, beliefs, language barriers, and past experiences can negatively effect relationship development and cause clients to experience mistrust towards the nurse (Neese, 2015; Peplau, 1952). Non-verbal communication of the nurse must be open and welcoming so the client is not apprehensive (Peplau, 1952). Nurses who allow their preconceived ideas about a client to influence their initial communication can damage the possibility of a therapeutic relationship before it is formed (Kourkouta & Papathanasiou, 2014).

During the identification phase, verbal and non-verbal communication continues as the nurse identifies the client's problems and develops a nursing care plan based on the client's condition and goals (Peptiprin, 2016). The client can begin to feel as if they are belong in the healing journey (Peplau, 1952). An essential aspect of the Interpersonal Relations Theory is the ability for nurse and client to work together as the client becomes an active participant in treatment (Neese, 2015; Wayne, 2014).

In the exploitation phase, the client utilizes all available resources provided by the nurse (Peplau, 1952). The exploitation phase often overlaps with the identification and terminal phases.

The client realizes the benefits of working with the nurse and assumes full participation in the plan of care. The nurse should utilize interview techniques, derived from therapeutic communication, in order to obtain a complete picture of the client's underlying issues (Peptiprin, 2016). Client independence is likely to fluctuate during care, at times needing more direction and education from the nurse (Wayne, 2014).

The resolution phase is the end of the nurse-client relationship. Client needs were met and health care goals achieved as a result of therapeutic communication and the client is able to move on to independent care. This phase can be difficult on nurses and clients who developed a strong bond during the caring process; however, it is a necessary part of the client becoming fully independent (Neese, 2015; Wayne, 2014).

PROBLEM

Significance

Successful client care depends on effective nurse-client communication. Research has shown that effective communication is essential in meeting clients' needs and providing quality care that will lead to positive client outcomes (Bramhall, 2014; King, Desmarais, Lindsay, Pierart, & Tetreault, 2015; O'Hagan et al., 2014). Breakdowns in communication produce more sentinel events and medical errors than any other factor (Smith & Pressman, 2010).

Purpose

The purpose of this research paper was to conduct a systematic review of the current literature and to synthesize the findings related to barriers of nurse-client communication as perceived by nurses.

Method

A systemic review of the literature was conducted to identify original research articles that addressed nurses' perceived barriers to effective nurse-client communication. Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medical Literature On-Line (MEDLINE), and PsychINFO databases were utilized to identify articles and governmental reports published in nursing, medicine, psychology, and other human science disciplines. Search terms included combinations of nurs*, patient*, communicat*, "nurse-patient relations," time*, language*, gender*, barrier*, obstacle*, verbal communication, and non-verbal communication.

Inclusion criteria included peer reviewed, original quantitative and qualitative research published from 2010-2017. The search included research articles from all countries published in English. Specific exclusion criteria included articles not published in English, physician or provider perceptions, patient perceptions, student perceptions.

A total of 362 articles were identified at the conclusion of the initial literature search. The articles included 277 CINAHL articles, 30 Medline articles, and 55 PsychINFO articles. Exclusion criteria reduced the number, which resulted in 41 CINAHL articles, 12 Medline articles, and 16 PsychINFO articles. These articles were reviewed by article title and abstracts., resulting in a final nine articles used in the literature review and analysis.

FINDINGS

Nine studies were identified and evaluated for nurse perceived barriers to nurse-client communication in the literature review. Included studies were evaluated for nurses' understanding and perception of barriers to communication with clients (Table 1). All reviewed studies were published within the last seven years. Seven studies were published within the last 5 years (Arungwa, 2014; Coleman & Angosta, 2016; Hemsley, Balandin, & Worrall, 2012; Moore, Higgins, & Sharek, 2013; Savio & George, 2013; Tay, Ang, & Hegney, 2012; Wittenberg-Lyles, Goldsmith, & Ferrell, 2013).

Two articles which initially met exclusion criteria were included (Arungwa, 2014; Wittenberg-Lyles, Goldsmith, & Ferrell, 2013). Arungwa (2014) provided a unique quantitative perspective on nurse-client communication barriers in an area with high cultural and ethnic diversity. Wittenberg-Lyles, Goldsmith, and Ferrell (2013) was included because of the nurse managers large scale view of how communication among hospital staff can create communication barriers between nurse and client.

The majority (6) of the articles were qualitative. Researchers reported the qualitative approach allowed for better understanding of the nurses' perceptions. Interviews and focus groups allowed nurses to voice their perceptions in their own words.

Studies were included from the US, Australia, Nigeria, Iran, Singapore, and Ireland. As America becomes increasingly diverse, the various cultural groups presented in the articles will be cared for by nurses across the country (US Census Bureau). It is important for all nurses to recognize and then act to overcome the various barriers that may be present.

Nurse Comfort and Knowledge Levels as Communication Barriers

Arungwa (2014) surveyed 80 nurses and 80 clients in the National Orthopaedic Hospital Igbobi, Lagos to assess the effects of nurse-client communication. Within this literature review, only the nurses' perception was analyzed. A quantitative cross-sectional survey was administered using stratified random sampling. The hospital was a World Health Organization Collaboration Center that specialized in training and research and served the inhabitants of twenty local governments and thirty-seven Local Council Development Areas of Lagos State and other states of the country. Nurses perceived four barriers to effective communication between nurses and clients. Culture was the biggest barrier in communication with 36.25% of nurses describing it as the predominant barrier experienced. Language (31.25%), religion (23.75%), and gender (8.75%) were reported as negatively effecting nurses' communication with clients. Time constraints and culture were significant influences on nurses' interactions with clients, and at times acted as barriers to effective nurse-client care and relationship development.

Steele et al. (2011) examined school nurses' perceived barriers to discussing obesity with children and their families using qualitative focus group research. Twenty-two school nurses from three Midwestern school districts participated in four different focus sessions. The focus groups were conducted around open-ended questions that evaluated two content areas. The first area assessed nurses' attitudes and knowledge about pediatric obesity, and the nurses' perceptions of barriers to addressing weight issues in the school setting. The next set of focus groups focused on nurses' preferred interventions to combat pediatric obesity. Focus group sessions were conducted by three master's-level graduate students. The groups were videotaped and/or digitally audiotaped for later transcription by a professional transcriptionist. The

transcripts were then coded by a bachelor's level research assistant to identify themes and barriers.

The majority (71%) of participants worked in elementary schools, with the others working in middle (8%) and high schools (12%), preschools (4%), and all grades (5%). Nurses reported serving an average of 617 students within their schools. A wide range of barriers were described and comments were categorized into several subsections: individual nurse factors, family factors, interactions between nurses and families, institutional factors, and societal factors. Individual nurse factors that acted as barriers to communication included the nurses' lack of knowledge or resources, self-perceived competency, and personal challenges with weight. Difficulty in establishing rapport with clients and families acted as a barrier and made it difficult for nurses to initiate discussions on sensitive topics. About half of the nurses cited societal barriers as affecting their ability to address sensitive topics. Societal barriers included the normalization of obesity, increased sedentary behavior, and proliferation of non-nutritious foods as barriers to success in communication with students about weight management (Steele et al. 2011).

Tay, Ang, and Hegney (2012) investigated barriers to effective communication between nurses and inpatient oncology adults clients using qualitative face-to-face interviews. Interviews were transcribed and then thematically analyzed. The study used the interpretivism paradigm, which is based on the beliefs and feelings the researcher has about the environment (Denzin & Lincoln, 2005). The researchers acknowledged the method would prevent the study from forming any absolute conclusions. Four interdependent themes were identified by nurses as barriers to effective nurse-client communication: characteristics of the client, nurse-client

interaction, characteristics of the nurse, and the environment (Tay, Ang, & Hegney, 2012). Clients newly diagnosed and in end-stage disease processes experienced altered communication abilities from baseline. Nurses perceived the grief, fear, and denial of clients to hinder communication efforts. Lack of respect for nurses caused clients to ignore education provided and undervalue nurses as part of the care team. Many nurses felt clients saw them as low class workers who were uneducated. Clients who were described as demanding and unreasonable presented communication challenges for nurses. These clients and their families expected demands to be met immediately. Nurses reported that some clients acted as if they were the only client a nurse was responsible for. Nurses recognized how their own emotions act as barriers to communication. Questions about death, dying, and spirituality were difficult for nurses to answer. It was also difficult for female nurses to speak to male clients about sexuality issues relating to treatment. Some nurses reported limiting communication with clients from different ethnic or religious backgrounds, because they did not want to offend them. Language barriers affected many nurses due to the high diversity of clients in the hospital. The nurses were able to provide basic care, but the psychosocial and emotional issues were not addressed (Tay, Ang, & Hegney, 2012).

Wittenberg-Lyles, Goldsmith, and Ferrell (2013) interviewed seven nurse managers using guided qualitative focus groups about their perceptions of communication barriers. Three managers worked in inpatient oncology units, three worked in outpatient clinics, and one worked as an operations manager. The nurses identified two evident barriers to effective nurse-client communication. The first was a lack of communication among the health care staff which created difficulties when nurses attempted to communicate with clients and their families. Nurses

had to take additional time to collect information about clients through their charts and by contacting the client's physicians as well as from the clients and their families. During the process, the nurse was unable to dedicate the usual time to the client's psychosocial and spiritual needs, which were both identified as essential to client-centered care. The second barrier to effective nurse-client communication was based on physician expectations of nurses' abilities, and exclusions of information when communicating with nurses. Lack of complete information negatively impacted the communication flow between the nurse and client in relation to the plan of care.

Moore, Higgins, and Sharek (2013) studied oncology nurses' perceived knowledge and comfort discussing sexuality concerns with men diagnosed with testicular cancer to ascertain communication barriers for nurses. A quantitative questionnaire was distributed by an selected gatekeeper in five randomly selected oncology centers in Ireland. Two hundred oncology nurses were administered the questionnaires and one hundred and five questionnaires were returned. Sixteen of the questionnaires were returned incomplete. Eighty nine surveys were accepted into the final study. All nurses were female and the majority (91%) were Roman Catholic. More than fifty one percent of respondents had worked in oncology longer than six years, with the majority (53.9%) working in inpatient units. Only ten percent of respondents frequently informed clients of their availability to discuss sexual concerns related to testicular cancer, and only one respondent reported discussing sexual concerns with more than ten clients. The low levels of communication between nurse and client stems from nurses' discomfort and lack of knowledge on the topic of sexual concerns relating to clients' testicular cancer. Nearly twenty percent of nurses reported receiving no sexual education, and only about thirty three percent reported

receiving between one and five hours of sexual education in their pre-registration nursing programs. When nurses were asked to report their knowledge on eleven different areas related to sexuality and testicular cancer, no more than fifty nine percent felt they had the necessary knowledge to discuss the topics.

Nurses' comfort levels also acted as barriers to communication with clients (Moore, Higgins, & Sharek, 2013). Comfort level was affected by the lack of private environments (63.6%), lack of services for client reference (58%), and lack of time related to a heavy client workload (48.9%). Language, religion, and culture of the clients affected nurses' comfort levels and posed as barriers. Nurse respondents (73.1%) believed that clients would be either embarrassed or offended if the nurse initiated conversation about changes to sexuality as a result of cancer if a family member was present.

Time as a Communication Barrier

Only one out of nine articles focused exclusively on time as a barrier to nurse-client communication. Hemsley, Balandin, and Worrall (2012) examined nurses' perception of time as a barrier to communicating with clients with developmental disabilities (DD) and complex communication needs (CCN). One-on-one qualitative narrative inquiry interviews were conducted in a conversational style with 15 hospital nurses in two metropolitan hospitals in Brisbane, Australia. While the researchers did not begin the study focused solely on time, after 13 of 15 participants identified time as the main barrier, it became the theme presented in the article. Due to nurses' heavy workload, clients with DD and CCN were subject to the same time constraints as other clients. The nurses regretted having time constraints with DD and CCN clients, and knew that it interfered with establishing rapport and effective client care. Time as a

barrier prevented nurses from being able to treat the clients with difficult communication need properly and efficiently.

Culture and Language as Communication Barriers

Three of the nine articles focused on culture and language as barriers to nurse-client communication (Coleman & Angosta, 2016; Farahani, Sahragard, Carroll, & Mohammadi, 2011; Savio & George, 2013). Farahani, Sahragard, Carroll, and Mohammadi (2011) used open-ended questions to conduct qualitative interviews with nurses in Iran about the communication barriers they faced with clients. The following questions were used: “What are your experiences of patient education?” “How do you educate your patients?” and “What are the communication barriers between nurses and patients?” (Farahani, Sahragard, Carroll, Mohammadi, 2011, p. 324). Nurses interviewed were primarily women (78%) and had a mean age of 35 years with 8.4 years of work experience. Culturally proscribed traditions which affected clients’ identities interfered with nurse-client communication on topics such as sexuality, differing customs and languages, and gender identity issues. Clients felt shame and embarrassment, which nurses believed influenced communication and education success. An example explained how a Kurdish man refused to remove facial hair for a medical procedure because it would ruin his body image. The nurse communicated the issue of sterility with facial hair during surgery, however the client refused.

Savio and George (2013) conducted a descriptive survey study in Australia to assess communication barriers and nurses’ attitudes and perceptions about the barriers. Reliability and feasibility were tested by conducting a pilot study and administering the survey sample to twenty random nurses at Kasturba Hospital. In the actual study, one hundred nurses were surveyed. The

majority (71%) were in the 30-40 age range, and female (88%), worked in general wards (49%), intensive units (40%), and other units around the hospital (11%). Verbal and non-verbal communication barriers were assessed. Nineteen percent of nurses experience mild barriers, seventy nine percent experienced moderate barriers, and two percent experienced severe barriers in communicating with clients who have culturally and linguistically diverse. Savio and George (2013) also found that male nurses experienced more difficulties in communicating with culturally diverse clients.

Coleman and Angosta (2016) studied the experiences of nurses who cared for clients with limited English proficiency. Forty registered nurses were interviewed using the phenomenological research approach. Nurses in the study expressed desire to communicate and connect, provide care and cultural respect for clients with limited English proficiency. Nurses identified language as a barrier to developing rapport, providing education, and caring for clients with limited English proficiency. However, nurses with a deep inclination for client centered care were able to overcome the challenges and develop a satisfactory nurse-client relationship (Coleman & Angosta, 2016).

DISCUSSION

Through the literature review five main barriers were identified by nurses as affecting the nurse-client communication process and relationship. Nurses perceived barriers to be their lack of comfort, lack of knowledge, environment, time, and cultural differences. Across the studies conducted in different countries, the same barriers were present and reported by nurses in varying degrees.

Three articles focused on nurse-client communication barriers in oncology units (Moore, Higgins, & Sharek, 2013; Tay, Ang, & Hegney, 2013; Wittenberg-Lyles, Goldsmith, & Ferrell, 2013). Effective communication has been recognized as a vital aspect in standard cancer care, and should include clients, family members, and psychosocial care (Wittenberg-Lyles, Goldsmith, & Ferrell, 2013). Nurses working in oncology units are placed in situations involving bad news, spiritual and/or religious concerns, and potential cultural variations. The sensitivity of potential subjects requires nurses to possess effective communication skills to properly care for clients (Tay, Ang, & Hegney, 2013). Nurse-client communication barriers found in oncology units include nurse comfort and knowledge level barriers, environmental barriers, time barriers, and culture and language barriers.

Comfort and Knowledge Barriers

Comfort and knowledge barriers perceived by nurses were based their own difficulty, and not that of the client. Lack of comfort was found to be affected by lack of knowledge and fear of rejection or angering the client. One of the most important aspects of client care is when the nurse provides education (Moore, Higgins, & Sharek, 2013). Nurses who felt they were not knowledgeable about the topic at hand, were less likely to provide the necessary education (Moore, Higgins, & Sharek, 2013; Steele et al., 2011). Moore, Higgins, and Sharek (2013) cite

an example of a female oncology nurse capable of discussing some oncology related matters, but matters specific to male disorders, i.e. erectile dysfunction, impotence, and prosthesis, created discomfort related to a lack of knowledge.

A significant barrier occurs when nurses allow their personal challenges interfere with the clients' educational needs. School nurses were less likely to provide adequate education to parents and obese children if they themselves were overweight (Steele et al., 2011). Nurses were also found to project their assumptions upon clients. If the nurse felt a client would not be concerned about sexual issues, they would not to approach the subject or provide education, even though the importance of sexual function information for clients with testicular cancer has been acknowledged the in the literature (Moore, Higgins, & Sharek, 2013).

Environment Barriers

Environmental factors can act as barriers to effective nurse-client communication (Farahani, Sahragard, Carroll, & Mohammadi, 2011; Tay, Ang, & Hegney, 2013; Wittenberg-Lyles, Goldsmith, & Ferrell, 2013). Tay, Ang, and Hegney (2013) identified healthcare organization and nursing management have a significant role in influencing the importance of nurse-client communication. As hospitals become increasingly business oriented, the public image of the hospital can interfere with necessary communication that must occur between nurses and clients concerning healthcare issues. Nurses believed that viewing the 'patients' as 'clients,' and placing more value on the 'customers' satisfaction than suitable care, acted as a barrier to effective communication and appropriate care for the client's diagnosis (Tay, Ang, & Hegney, 2013).

Physicians and nurses are part of the healthcare team, interacting with the client simultaneously. Lack of information consistency can act as a barrier to communication between nurse and client. Differing reports from the nurse and physician, undermines trust and the nurse's ability to effectively provide care (Farahani, Sahragard, Carroll, & Mohammadi, 2011; Wittenberg-Lyles, Goldsmith, & Ferrell, 2013). Clients from cultures that do not respect nurses may perceive poor physician-nurse communication as the nurses' fault (Farahani, Sahragard, Carroll, & Mohammadi, 2011). The effects of poor healthcare team communication can result in nurses experiencing feelings of inadequacy, which result in the development of discomfort in communicating with clients (Farahani, Sahragard, Carroll, & Mohammadi, 2011; Steele et al., 2011).

Time Barriers

Nurses face heavy workloads, regardless of practice environment (Coleman & Angosta, 2016; Hemsley, Balandin, & Worrall, 2012; Steele, et al., 2011). The intense time schedules restrict the amount of time spent with individual clients, and negatively affect the ability of nurses to build meaningful relationships with clients. Time for therapeutic communication negatively influences this cornerstone for nurse-client relationships.

The impact of time is different based on the area in which a nurse works. School nurses who are tasked with caring for more than 900 students find it difficult to establish meaningful relationships with individual students and their families. In addition to communicating with students, school nurses have numerous other responsibilities. Many nurses reported their frustration over the expectation to stay current with the latest research and expertise in multiple areas. These additional responsibilities act as barriers to communication because nurses are

tasked with more duties than allotted time permits, which results in limited time to adequately communicate with clients they are treating (Steele et al., 2011).

Clients with limited English proficiency, DD or CCN require additional communication time that nurses do not always have available. Time constraints can act as a barrier to the provision of proper care for clients with special communication needs. Obtaining the proper interpreter for non-native language speakers requires time, so some nurses report not using interpreters (Hemsley, Balandin, & Worrall, 2012). Nurses who do not effectively communicate with clients due to time constraints may not be able to establish the working relationship that is necessary in the nurse-client dynamic (Hemsley, Balandin, & Worrall, 2012).

Culture and Language Barriers

Culture shapes peoples' language, religion, and traditions. It also has the ability to affect peoples' attitudes and behaviors when communicating with others (Tay, Ang, & Hegney, 2012). Culture and language can act as barriers to communication independently or dependently, conditional on the sociocultural environment, the nurse, and the client (Elmes, 2013; Jiang, 2000). Different cultures have different standards for communicating about certain topics, which can result in problems during client education (Farahani, Sahragard, Carroll, & Mohammadi, 2011). International research supports nurse perceptions of culture as a barrier to effective nurse-client communication (Arungwa, 2014; Farahani, Sahragard, Carroll, & Mohammadi, 2011; Savio & George 2013; Coleman & Angosta, 2016; Tay, Ang, & Hegney, 2012; Moore, Higgins, & Sharek, 2013).

Shame and embarrassment are connected to many healthcare needs, one of the most common being the sexuality concerns of clients (Tay, Ang, & Hegney, 2012; Farahani,

Sahragard, Carroll, & Mohammadi, 2011). Nurses expressed nervousness when educating clients from different cultures about sexual issues (Coleman & Angosta, 2016). For one client, not knowing that the medications he was prescribed would cause impotence, and it being culturally inappropriate to talk about, lead to the break-up of his marriage (Farahani, Sahragard, Carroll, & Mohammadi, 2011).

Nurses across the studies cited language as a cultural barrier to communication (Arungwa, 2014; Coleman & Angosta, 2016; Farahani, Sahragard, Carroll, & Mohammadi, 2011; Moore, Higgins, & Sharek, 2013; Savio & George, 2013; Tay, Ang, & Hegney, 2012). When referencing language, nurses included the use of medical jargon. Research has shown a significant portion of clients lack understanding of common medical terms used in diagnosis, which can lead to clients experiencing distress and anxiety (Taylor, Cantlay, Patel, & Braithwaite, 2011). When clients do not understand the education they are receiving due to the terms being used, often times they do not ask for clarification. This inaccurate communication as a result of cultural communication barriers can have disastrous consequences, even resulting in death (Farahani, Sahragard, Carroll, & Mohammadi, 2011).

LIMITATIONS

Six of the nine studies in the literature review were qualitative, and three were quantitative. Qualitative research provides in depth knowledge of the participants' perceptions; however, the results may not be generalizable. Qualitative research is applicable to the population; however applying the results to other countries and cultures is inappropriate and poor nursing practice.

Three of the nine studies were conducted in areas that are not western societies, and three studies were conducted in the United States of America (U.S.A.). Schwei et al. (2016) found that outside the U.S.A. the major research focus was of the nurse perceptions of communication barriers; while within the U.S.A. the focus was the study of physicians' perspectives. This author found a higher portion of original research articles studying nurse perceived communication barriers were from the research conducted outside the U.S.A.

IMPLICATIONS FOR NURSING

Research

To properly understand nurse perceptions of barriers to communication within the U.S.A., additional research is required. With the rapidly changing demographics of society, there is a need to develop efficient methods to provide high quality care to clients with cultural and language differences. Additional qualitative and quantitative research would be beneficial. Quantitative studies addressing nurse perceptions of communication barriers and interventional strategies would provide more generalizable data. Interventional studies exploring technology advances, nurse education, and workloads need to be researched further. Such studies would provide nurses and nurse managers with increased knowledge of ways to overcome nurse-client communication barriers.

Education

The need for communication education for nursing students has been recognized in many countries (Savio & George, 2013). Education programs need to ensure students develop communication skills needed to discuss sensitive matters such as sexuality and obesity. Role play has been shown to be successful in increasing students' confidence in their ability to communicate with clients about complex topics (O'Hagan et al., 2014). Nursing students benefit from having simulation exercises and labs integrated within their coursework. Continuing education could be available for registered nurses for activities to improve communication.

Discomfort can easily be signaled via non-verbal communication. When nurses are uncomfortable, the clients' behavior can change (Moore, Higgins, Sharek, 2013). Stickley (2011) recommends the acronym SURETY, as a useful way for student and registered nurses to remember steps for creating a therapeutic space when interacting with clients, even when

uncomfortable. The SURETY model allows for cultural variations and the appropriate use of touch. SURETY stands for:

S- sit at an angle to the client

U- uncross legs and arms

R- relax

E- eye contact

T- touch

Y- your intuition

Sitting at an angle to the client is seen as less confrontational than sitting directly across, and is more personal than sitting next to the client. Arm and leg crossing can communicate to the client the nurse is defensive, not interested, or feeling superior. By relaxing and making eye contact, the nurse is signaling to the client respect and attention to the conversation. Though appropriate physical touch can be comforting, touch etiquette varies by culture. The nurse must be knowledgeable about cultural differences, and when in doubt, use their intuition to read the people and the environment (Stickley, 2011).

Student nurses need to be taught additional assessment skills on how to identify clients with limited English proficiency, DD, or CCD. After identifying clients who need additional assistance, student nurses will need knowledge on programs that will provide the necessary support. Studies have shown the significant difference medically trained translators can make in the delivery of care for a client (Coleman & Angosta, 2016). Hemsley, Balandin, and Worrall (2012) reported even when nurses are aware of programs and translators, time constraints prevent the appropriate usage. Education for student nurses concerning time management will

allow them to develop skills to determine how best to provide appropriate care for each client on their team.

Practice

Communication barriers stemming from the environment should be corrected. Team communication processes should be reorganized to prioritize client communication. Effective communication between physicians and nurses can improve nurse-client communication and potentially result in increased respect for nurses (Tay, Ang, & Hegney, 2012; Wittenberg-Lyles, Goldsmith, & Ferrell, 2013).

Healthcare systems should support continual education on communication skills in order to promote effective communication among healthcare staff, and between nurses and clients (Farahani, Sahragard, Carroll, & Mohammadi, 2011). Registered nurses need additional training on how to recognize language barriers present in clients and resources available. Interpreter phones and on-site interpreters have been identified as helpful to nurses when communicating with clients with limited English proficiency (Coleman & Angosta, 2016).

Research on nurse perceived barriers to effective nurse-client communication enables nurses to develop a better understanding of communication barriers, and effective communication with clients.

APPENDIX: TABLE OF EVIDENCE

Table 1: Table of Evidence

Article	Country	Purpose	Sample	Study Design	Results/Key Findings
Arungwa, O. (2014). Effect of communication on nurse-patient relationship in national orthopaedic hospital, Igbobi, Lagos. <i>West African Journal of Nursing</i> , 25(2) 37-39	Nigeria	To study the effect of communication on the nurse-client relationship, its effect on client recovery, and attitude of nurses towards clients.	(n=160) 80 Nurses 80 Clients from national orthopaedic hospital, Igbobi, Lagos For this literature review, only data from nurse responses was analyzed	Quantitative Cross sectional survey	Barriers of communication: 31.25%-Language 23.75%- Religion 36.25%- Culture 8.75%- Gender Factors influencing nurses' interactions with clients: 25%- Culture 20%- Perception 23.75%- Distance 31.25%- Time
Coleman, J. S. & Angosta, A. (2016). The lived experiences of acute-care bedside registered nurses caring for patients and their families with limited English proficiency: A silent shift. <i>Journal of Clinical Nursing</i> , 26, 678-689.	United States of America (U.S.A.)	To study the experiences of nurses who cared for clients with limited English proficiency.	(n=40) Registered nurses	Qualitative Phenomenological exploratory interviews	Nurses in the study expressed desire to communicate and connect, provide care and cultural respect for clients with limited English proficiency. Language was identified as a barrier to developing rapport, providing education, and caring for patients with limited

Article	Country	Purpose	Sample	Study Design	Results/Key Findings
					English proficiency. However, nurses with a strong enough desire were able to overcome the challenges and develop a nurse-client relationship.
Farahani, M., Sahragard, R., Carroll, J., Mohammadi, E. (2011). Communication barriers to patient education in cardiac inpatient care: A qualitative study of multiple perspectives. <i>International Journal of Nursing Practice</i> , 17, 322-328.	Iran	To explore communication barriers from nurses' perspectives.	(n=18) Nurses in cardiac care units in two educational hospitals in Tehran, Iran	Qualitative interviews	There were three major themes identified as barriers to nurse-client communication: 1. Lack of communication between nurses and physicians 2. Problematic communication among healthcare team 3. Cultural challenges

Article	Country	Purpose	Sample	Study Design	Results/Key Findings
Hemsley, B., Balandin, S., & Worrall, L. (2012). Nursing the patient with complex communication needs: Time as a barrier and a facilitator to successful communication in hospital. <i>Journal of Advanced Nursing</i> , 68(1), 116-126.	Australia	To study nurses' perception of the influence of time on communicating with clients with complex communication needs	(n=15) Registered nurses from two metropolitan hospitals in Brisbane, Australia	Qualitative interviews	Nurses perceived time as both a barrier and a facilitator to communication with patients. Clients who required additional time due to complex communication needs increased the nurses' workload. Nurses would wait for client's caregiver before they initiated communication
Moore, A., Higgins, A., & Sharek, D. (2013). Barriers and facilitators for oncology nurses discussing sexual issues with men diagnosed with testicular cancer. <i>European Journal of Oncology Nursing</i> , 17(4), 416-422	Ireland	To study oncology nurses' perceived knowledge and comfort discussing sexuality concerns with men diagnosed with testicular cancer and to ascertain barriers nurses had to the discussions.	(n=89) Surveys All respondents were female 48.4% with less than five years of experience in oncology 91% Roman Catholic	Quantitative self-administered anonymous survey	Nurses reported being open to discussing concerns, but many did not notify clients they were available for questions. Main barriers perceived by nurses: <ul style="list-style-type: none"> • Lack of knowledge • Discomfort

Article	Country	Purpose	Sample	Study Design	Results/Key Findings
Savio, N. & George, A. (2013). The perceived communication barriers and attitude on communication among staff nurses in caring for patients from culturally and linguistically diverse background. <i>International Journal of Nursing Education</i> , 5(1), 141-146.	Australia	To assess communication barriers and nurses' attitudes towards the importance of communication	(n=100) Registered nurses from Kasturba Hospital in Australia	Quantitative questionnaire	Verbal and non-verbal communication barriers were assessed, 19 % of nurses experienced mild barriers, 79% moderate, and 2% severe. Male nurses experienced more difficulties with clients from culturally diverse backgrounds.
Steele, R., Wu, Y., Jensen, C., Pankey, S., Davis, A., Aylward, B. (2011). School nurses' perceived barriers to discussing weight with children and their families: A qualitative approach. <i>Journal of School Health</i> , 81(3), 128-137.	U.S.A.	To further analyze school nurses' perceived barriers to addressing obesity issues with children and their families.	(n=22) School nurses from three Midwestern school districts	Qualitative Four focus groups sessions	Barriers Identified: <ul style="list-style-type: none"> ● Self-perceived competency ● Lack of knowledge or resources ● Personal weight challenges ● Perceived lack of support from school and other health professionals ● Time constraints ● Family characteristics ● Child lack of motivation ● Fear of reactions ● Difficulty establishing rapport with children and families

Article	Country	Purpose	Sample	Study Design	Results/Key Findings
					<ul style="list-style-type: none"> • Negative past experiences • Food at school • Societal norms
<p>Tay, L., Ang, E., & Hegney, D. (2013). Nurses' perceptions of the barriers in effective communication with inpatient cancer adults in Singapore. <i>Journal of Clinical Nursing, 21</i>, 2647-2658.</p>	<p>Singapore</p>	<p>To investigate barriers affecting effective communication between nurses and inpatient oncology adults</p>	<p>(n=10) Registered nurses from inpatient oncology teaching hospitals in Singapore</p>	<p>Qualitative interviews with interpretivism paradigm</p>	<p>Communication was affected by characteristics of the nurse and client, nurse-client interaction, and the environment. Culture and language were identified to be large barriers to communication within a multicultural environment.</p>

Article	Country	Purpose	Sample	Study Design	Results/Key Findings
Wittenberg-Lyles, E., Goldsmith, J., & Ferrell, B. (2013). Oncology nurse communication barriers to patient-centered care. <i>Clinical Journal of Oncology Nursing</i> , 17 (2), 152-158.	U.S.A.	To examine communication barriers perceived by nurse managers on oncology care units.	(n=7) Nurse managers from Markey Cancer Center	Qualitative focus groups	Two main communication barriers were identified: lack of consistency in communication from healthcare staff AND physician expectations and assumptions about nurses

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