CONTRIBUTIONS OF NURSES' INTERVENTIONS IN COMMUNICATION IN PALLIATIVE CARE: SCOPING REVIEW

Contributos das intervenções dos enfermeiros na comunicação em cuidados paliativos: scoping review

Contribuciones de las intervenciones de los enfermeros en la comunicación en Cuidados Paliativos: scoping review

Sérgio Soares*, Carla Pinho**, Elisabete Bastos***, Luísa Ferreira****

ABSTRACT

Background: communication in palliative care is a continuous challenge for professionals. Nurses are responsible for the development of these interventions and it will be from these that the best results for patients and families will result. **Objective**: to map the interventions on communication of nurses in the context of palliative care. **Methodology**: exploratory review study following the methodology of the Joana Briggs Institute. Faced with the question "What communication interventions are developed by nurses in palliative care teams?", a search was carried out in the databases, with descriptors MESH, "palliative care", "nursing Care", "communication" with eligibility criteria. **Results**: from the 88 studies, we selected 11, presenting the adopted selection criteria. They report the existence of few studies in the area of communication in palliative care; physicians are less represented; the clinical condition at the time of the encounter is restrictive and focuses on a single moment. It is important to communicate even with computer tools associated with the ability to choose and enhancing its unquestionable benefit. Communication is a very relevant link between the nurse and the patient. **Conclusion**: humanization of death and the understanding of nurses in the communication of information sustain "a meaning for life". It is possible to map the interventions identified by nurses and identify limitations/gaps of knowledge in communication in palliative care.

Key Words: palliative care; nursing care; communication;

*PhD., Professor Adjunto convidado da Escola Superior de Saúde do Instituto Politécnico de Leiria, e Enfermeiro Especialista de Enfermagem à Pessoas em Situação Paliativa, Unidade Local de Saúde da Região de Aveiro, Portugal - https://orcid.org/0000-0002-8629-4411

**RN., Professora Adjunta convidada da Escola Superior de Saúde do Norte da Cruz Vermelha Portuguesa, Oliveira de Azeméis e Enfermeira Especialista de Enfermagem à Pessoas em Situação Paliativa, Unidade Local de Saúde da Região de Aveiro, Portugal - https://orcid.org/0000-0002-7802-9845

***RN, Enfermeira Especialista de Enfermagem à Pessoas em Situação Paliativa, Unidade Local de Saúde da Região de Aveiro, Portugal - https://orcid.org/0009-0002-7370-6998

****PhDs., Professora Ajunta Convidada na Escola Superior de Saúde Norte Cruz Vermelha, Oliveira de Azeméis, Portugal e Enfermeira Coordenadora do Hospital da Luz Coimbra, Portugal – https://orcid.org/0000-0002-5641-5585

Autor de correspondência:
Sérgio Soares
sergiosoares@ua.pt

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RESUMO

Enquadramento: a comunicação em cuidados paliativos é um contínuo repto para profissionais. Os enfermeiros são responsáveis pelo desenvolvimento destas intervenções e será destas que advém melhores resultados junto dos doentes e famílias. **Objetivo**: mapear as intervenções sobre a comunicação, dos enfermeiros em contexto de cuidados paliativos. **Metodologia**: estudo exploratório de revisão seguindo a metodologia da Joana Briggs Institute. Perante a questão "Que intervenções de comunicação são desenvolvidas pelos enfermeiros nas equipas de cuidados paliativos?", realizou-se uma pesquisa nas bases de dados, com descritores MESH, "palliative care", "nursing Care", "comunication" com critérios de elegibilidade. **Resultados**: dos 88 estudos, selecionamos 11, apresentando critérios de seleção. Referem a existência de escassos estudos na área da comunicação em cuidados paliativos; os médicos encontram-se menos representados; a condição clínica no momento do encontro, é condicionadora e foca-se num momento único. É importante a comunicação até com ferramentas informáticas associada à tomada de decisão e realçando o seu indiscutível benefício. A comunicação é um instrumento muito pertinente entre o enfermeiro e o doente. **Conclusão**: a humanização da morte e o sentir do enfermeiro na passagem de informação sustentam "um sentido para a vida". É possível mapear as intervenções dos enfermeiros e identificar limitações/lacunas dos saberes na comunicação em cuidados paliativos.

Palavras-chave: cuidados paliativos; cuidados de enfermagem; comunicação

RESUMEN

Marco Contextual: la comunicación en cuidados paliativos es un reto continuo para los profesionales. Las enfermeras son responsables del desarrollo de estas intervenciones y será a partir de ellas que se obtengan los mejores resultados para los pacientes y sus familias. **Objetivo**: mapear las intervenciones sobre la comunicación de las enfermeras en el contexto de los cuidados paliativos. **Metodología**: estudio de revisión exploratoria siguiendo la metodología del Instituto Joana Briggs. Frente a la pregunta "¿Qué intervenciones de comunicación son desarrolladas por los enfermeros en los equipos de cuidados paliativos?", se realizó una búsqueda en las bases de datos, con los descriptores MESH, "cuidados paliativos", "cuidados de enfermería", "comunicación" con criterios de elegibilidad. **Resultados**: con 88 estudios, seleccionaron 11, presentando criterios de selección adoptados. Relatan existencia de pocos estudios en área de comunicación en cuidados paliativos; médicos están menos representados; condición clínica en momento de entrevista, es impactante y se centra en un solo momento. Es importante comunicarse incluso con herramientas informáticas asociadas a capacidad de elegir y potenciando su incuestionable beneficio. Comunicación es un vínculo muy relevante entre la enfermera y paciente. **Conclusión**: la humanización de la muerte y la sensibilidad de enfermeros en la transmisión de informaciones preservan "un sentido para la vida". Es posible mapear intervenciones identificadas por enfermeros y identificar limitaciones y brechas de conocimiento en comunicación en cuidados paliativos.

Palabras clave: cuidados paliativos; cuidados de enfermería; comunicación

INTRODUCTION

The communication processes in palliative care have been the subject of important research in an attempt to scrutinize the problems experienced by the various parties involved. The clinical nature of palliative care supposes improving the quality of life of the patient and family, relieving suffering, elevating human dignity and comforting those who are experiencing problems in the face of a complex and progressive illness through early prevention, detailed assessment of the multiple dimensions that contribute to it and control of physical, emotional, social and spiritual problems. According to Keeley (2017), "*Final conversations between the terminally ill and their family members can help individuals begin the grieving process while their terminally ill loved one is still present and can help in the process; it can help family members move on after the death without regret because nothing was left unsaid; and it can help individuals grow from the experience*." (Keeley, 2017:2). This emphasizes that, when providing care to patients, health team members always consider the planning of that care by focusing on the needs of the patient/family (the main concern of professional intervention). Palliative care requires a multi-professional approach. In addition to this pillar, there is another: teamwork for a multidisciplinary intervention that aims to respond to the multiple suffering of the patients and their family. Given this context, we can say that palliative care is surrounded by these dimensions, which are interrelated in a sustained way, such as symptomatic control, support for the family, emphasis on the team and the relationship and communication's component. Communication with patients in palliative care is part of a culture of wide-ranging interventions within multidisciplinary teams. This is determined by the concept of care, which is based on its cognitive, relational and attitudinal dimensions. This is why palliative services require structured training so that the involved nurses can develop their own ways of communicating as well as the associated skills. The communicative dimension is an alliance between the patient, family and health professionals. It requires professionals to have the highest level of relational competence in order to interact assertively. Talking, looking, touching or simply listening, are different and inherent ways of communicating and relating. For our research we opted for a *scoping review* because it differs from other methods by representing key concepts, definitions, factors and limits alluding to concepts, which can justify carrying out a systematic review and also identify gaps in knowledge. The aim of this review is to map nurses' communication interventions in the context of palliative care. We believe in the proposal to improve knowledge in the communication process of health teams. The *scoping review* has grown a lot in the last decade, due to its importance in the area of synthesizing evidence in health and palliative care in particular.

METHODOLOGY

For the research question, we were guided by the proposal of the *Joanna Briggs Institute (JBI) (Peters et al.,*2020*)*, that with the established inclusion criteria contemplated the acronym PCC which were then defined as: Population - nurses working with palliative care patients. Concept - interventions developed in communication; Context - units with palliative care patients. Based on this strategy, we considered the following review question: **What interventions do**

nurses develop in communication in palliative care? This research will consider studies on communication that include nurses working in palliative care units. We have included all qualitative, quantitative and mixed methods studies in this research. We consider primary studies as well as systematic reviews, integrative reviews, dissertations, opinion pieces, *Gray literature*, according to the three stages defined for *scoping reviews* by the *JBI* (*Peters et al.,* 2020). Qualitative studies that emphasize qualitative data are also considered, including, but not limited to projects such as phenomenology, substantiated theory, qualitative description and action research. We carried out a *Scoping review* because, according to Peters *et al.* (2020), we wanted to identify existent evidences in specific areas of knowledge, offering a broad view of what has already been studied, identify and analyze existing research gaps and justify other more specific scientific work in the area of study, such as systematic literature reviews. The research was carried out by two researchers, simultaneously, between October and November 2022. The review is in accordance with the three stages presented by the *JBI* methodology, according to Peter *et al*., (2020). We considered the time period from 2013 onwards. The languages considered were Portuguese, Spanish and English. In the first stage, we began a limited search in the databases *Medical Literature Analysis and Retrieval System Online* (MEDLINE) via *Pubmed Central and Cumulative Index to Nursing and Allied Health Literature* (CINAHL) via EBSCO, using the descriptors MESH, *"palliative care", "nursing Care", "communication",* combined with the Boolean operator *AND*. This research was carried out to identify the titles, abstracts of the articles under study and the indexing terms of the chosen results, identifying specific and alternative terms and keywords. In the second stage, the indexing terms identified, as well as the keywords, will be used for new searches in the identified databases, Google Scholar, PubMed Central, Scientific Electronic Library Online (SciELO) and *Repositório Científico de Acesso Aberto de Portugal* [*Open Access Scientific Repository of Portugal*](RCAAP). Through EBSCOhost we searched the *Cumulative Index to Nursing and Allied Health* Literature (CINAHL). We searched for *"Gray literature"* using Google Scholar. In the third stage, we analyzed the bibliographical references of all the studies included to identify additional sources of information. The process of including studies is systematized in the PRISMA diagram (Figure 1).

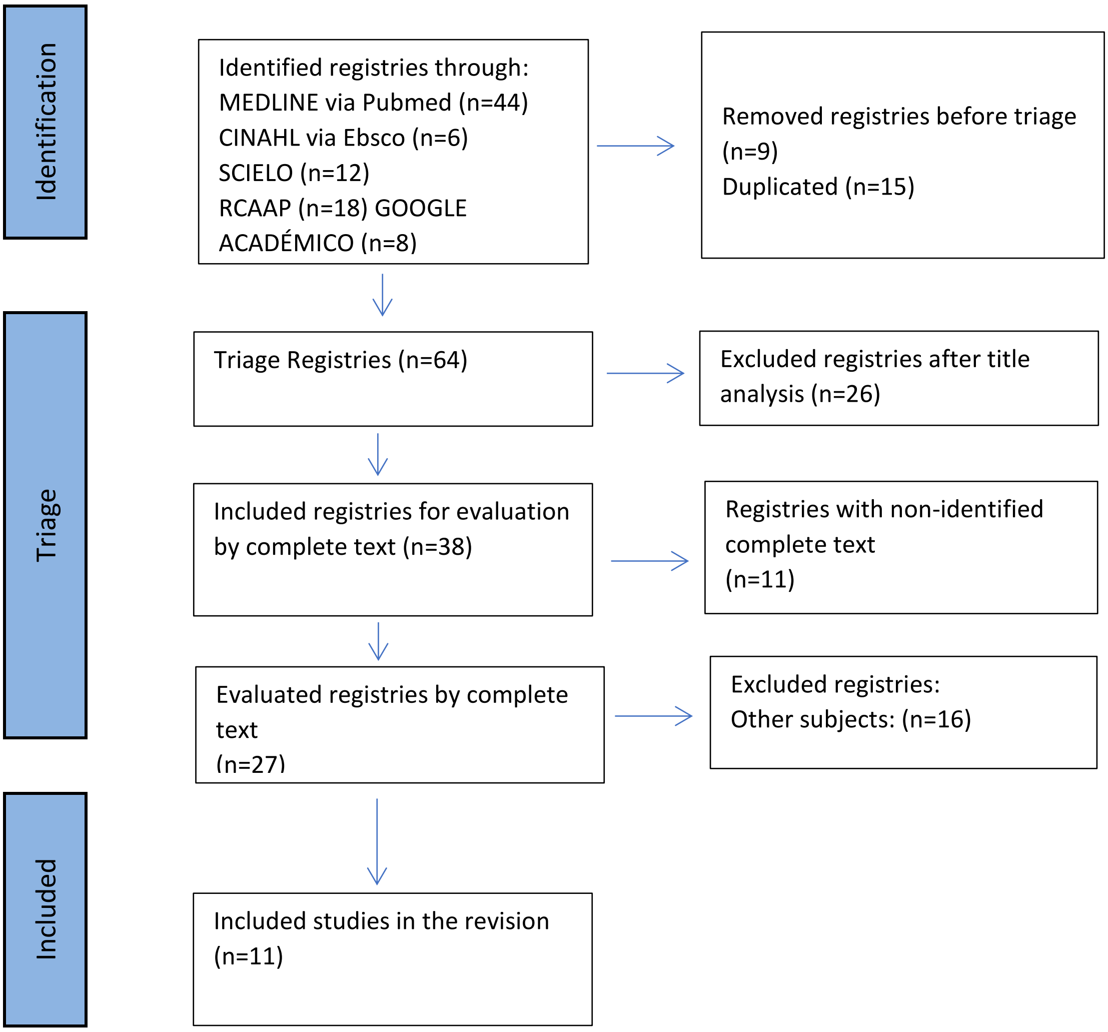

Figure 1

Study identification and selection process (Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram flow)

RESULTS

From the 88 studies carried out, we selected 11, presenting the selection criteria adopted. Table 1 shows the characteristics of the studies in terms of the year of publication, from 2013 to 2021, their authors, the type of qualitative study, review, exploratory and experimental study, the titles that would be promising in terms of content and the research method used.

Table 1

Extraction of evidence from the selected studies

Study	Year	Authors	Tyoe of Study	Title	Method
1	2016	Gustavo Baade de Andrade; Vanessa Sores Mendes Pedroso; Juliana Marques Weykamp ; Luana da Silva Soares ; Hedi	Descriptive exploratory study with a quantitative approach	Palliative Care and the Importance of Communication Between Nurse and Patient, Family and Caregiver	Integrative review

		Crecencia Heckler de Siqueira ; Janaína Cassana Mello Yasin			
2	2020	Cecilia Widberg, Birgitta Wiklund e Anna Klarare	Experimental and non-experimental	Patients' experiences of eHealth in palliative care: an integrative review	Systematic Integrative Review
3	2018	Raul de Paiva Santos, Bárbara Caroliny Pereira, Silvana Maria Coelho Leite Fava, D.Sc., Zélia Marilda Rodrigues Resck, Eliza Maria Rezende Dázio	Proposed Method by Whittemore; Knafl	Contextual factors in communicating a cancer diagnosis in the process of finitude and death	Integrative review
4	2018	Pamela N. Bowman, BSN, RN, OCN, Kim Slusser, MSN, RN, CHPN, NEA-BC, and Deborah "Hutch" Allen, PhD, RN, CNS, FNP-BC, AOCNP		Collaborative Practice Model Improving the delivery of bad news	Integrative review
5	2019	Teixeira Prado, Roberta;Leite, Josete Luzia;Silva, Ítalo Rodolfo;Johanson da Silva, Laura	Exploratory, qualitative research.	Communication in the management of the nursing care before the death and dying process.	Grounded Theory
6	2015	Kelviani Ludmila dos Santos Almeida , Dayse Maioli Garcia Nurse..	Integrative review	Use of communication strategies in palliative care in brazil: integrative review*	Integrative review
7	2015	Lucélia Terra Jonas, Natália Michelato Silva, Juliana Maria de Paula, Sueli Marques, Luciana Kusumota	Qualitative	Communicating a cancer diagnosis to an elderly patient	Integrative review
8	2018	Annelie Rylander, Stina Fredriksson, Ewa Stenwall e LenaKarin Gustafsson	Exploratory, descriptive, qualitative	Significant aspects of nursing within the process of end-of-life communication in an oncological context	Qualitative
9	2020	Paola Melis, Maura Galletta, Cesar Ivan Aviles Gonzalez, Paolo Contu, Maria Francisca Jimenez Herrera	Qualitative study with interpretative phenomenological analysis	Ethical perspectives in communication in cancer care: An interpretative phenomenological study	Phenomelogic
10	2013	Cristiani Garrido de Andrade, Solange Fátima Geraldo da Costa, Maria Emília Limeira Lopes	Exploratory study of qualitative nature	Palliative care: communication as a strategy of care for the terminal patient	Qualitative
11	2021	Lilia da Silva Pinheiro Pacheco, Gleidiane Silva dos Santos, Renata Machado, Daniel da Silva Granadeiro, Noemi Garcia Silva de Melo, Joanir Pereira Passos	Integrative review of qualitative literature	The nurse's effective communication process with the patient in palliative care	Exploratory

Table 2 presents the main limitations and suggestions of the selected studies. From the 11 studies analyzed, 3 have no limitations and 8 express the scarcity of studies in the area of communication in palliative care and with end-of-life patients; doctors are less revealing than nurses; the clinical condition at the time of the interviews is striking and they focus on a single circumstance and scenario. Studies 1, 3 and 4 present the importance of communication in caring for patients at the end of life. Study 2 emphasizes the importance of IT tools as the future of information in palliative care. Studies 6, 7 and 8 mention the effectiveness of communication with the patient, taking into account the ability to choose for decision-making and self-control, valuing its unquestionable purpose. Responsibility for providing information on diagnosis and prognosis differs between doctors and nurses, according to study 9. In studies 10 and 11, communication is mentioned as a highly relevant link between nurses, patients and their families.

Table 2

Presentation of the main limitations and suggestions of the selected studies

Estudo	País	Limitações	Implicações/Sugestões
1	Brazil	It has no limitations	The authors consider that this study needs to be categorized into the following dimensions: Palliative Care and the Interpersonal Relationship between the Nurse and the Patient; Communication as a Strategy to Strengthen the Bond between the Nurse and the Palliative Care User; The Importance of Communication between the Nurse and the Family/Caregiver. Considering that for nursing to offer palliative care is to live and share moments of love and compassion with a therapeutic purpose and to understand that it is possible to make death eminently dignified and to assure the patient support and humanized care at that moment; Refers that communication goes beyond words, attentive listening, gaze and posture, it is an efficient mediator and a way of recognizing the needs of the patient and family, allowing them to participate in specific care decisions by providing dignified treatment; also valued is the support for the family strategy, promoting effective communication and including the family in care, understanding special needs, providing existential support, preparing the family for death, promoting greater support for bereavement.
2	Brazil	Use of many different terms in the area of e-Health, running the risk of some being lost; Patients in various settings and palliative care, but no interventions, diagnoses or context of care were classified; language restrictions can cause information bias; research could be broader and not from 2014; the integrative review comprises a qualitative approach, but it is important to synthesize various types of research results; in a global view, resources are presented unevenly and in certain countries the implementation of e-Health may be unrealistic and impossible, having to explore local resources, being a guideline to follow in health research and interventions in certain areas.	e-Health applications promote patient and family communication through: usability and feasibility of e-Health applications; symptom control and individualized care promoted through e-Health applications; the use of e-Health applications increasing the feeling of safety and of involved parties. In all the selected studies, the experiences of patients and family members were positive towards e-health applications and communication. They also mentioned the desire for technical help, both to receive and provide information digitally and thus facilitate communication with health professionals;
3	Brazil	It has no limitations	The authors discussed the communication of cancer diagnosis and communication in finitude and death in two dimensions: The communication of cancer diagnosis and treatment; The communication of bad news and communication in finitude and death. Communication affects both the psychosocial factor of the patient and their family. When we think of palliative care, we think of bringing the whole family together as a fundamental support in the care unit and providing assistance to them. Communication is essential, promoting a dialogue of bonding and co-responsibility, allowing a process of building autonomy, where the patient and the professional need to have space and a voice in decision-making processes. Addressing terminality in communication is always a challenge for healthcare professionals. The process of finitude doesn't mean that health professionals don't have to worry about the patient's comfort, appearance and general situation. On the contrary, this study states that they are responsible for adopting interventions based on respect, humanization and welcoming the patient. Thus, humanized, quality and ethical care must be provided to patients throughout their entire life process, from birth to the process of finitude and death.
4	United States	The Collaborative Practice Model has only been implemented in one medical oncology	Nurses say they don't feel prepared to properly support peers going through the crises that bad news can present, and they find it difficult to communicate bad news. The six-step SPIKES

	of America	unit. Its implementation in other clinical units is necessary for a successful practice.	protocol emphasizes the process of delivering bad news: scenario, perception, invitation, knowledge, emotion and summary. This protocol highlights the fact that bad news is communicated as a planned event, which allows essential family and team members to be present and comfort, privacy, cultural aspects and support to be provided in the case of children. The effective style requires openness, responsiveness, acceptance, empathy and honesty. Availability and not being in a hurry are important. This communication requires knowledge of body language, showing openness, inclusion and promoting a therapeutic, responsible relationship, simulating bad news, allowing the team to practice therapeutic communication in the transmission and consequences of bad news. The study provides a unique contribution to the literature by describing the development and implementation of a model to improve the delivery of bad news using evidence-based practice.
5	Brazil	Being carried out only in one place, at a historically dated moment and scenario, in a very particular cultural context; it focused specifically on caring for the process of death and dying in adults. More research is therefore needed in this area, in different settings and focusing on the death of patients in other age groups	Care takes place between people in various health scenarios and contexts. In this study, the management of care in the process of death and dying is based on three categories: In the process of communication between professionals, in which assertiveness is very important for the management of care, they ask the multidisciplinary team for opinions, holding meetings with the opportunity to discuss cases, enabling understanding between organizational aspects that influence communication and quality in health. It addresses the aspects of communication between the family, through the dying process, as well as the interactions for the act of communication between professionals in the interdisciplinary health team and the links between this team and the patient's family. The interactions and feedback in this communication process are not limited to the scenarios in which these processes take place, because the identities of those being cared for are also important. Family members raised doubts, uncertainties and concerns about the patient's clinical condition. They also found it difficult to talk openly about death and the dying process. They identified failures in communication, particularly by some professional groups. They identified a lack of sensitivity on the part of nurses when it came to communicating about the dying process. Doctors were not clear, leading to a negative experience on the part of the professionals. Communication of death, when it occurred, by telephone, made the act mechanical and insensitive. After the death, the nurses' interaction with the family was aimed at providing support and consolation, as well as other information. They also believe that, at the time of death, all members of the multi-professional team should be present in the process of communicating the death to the family. Families did not always realize that they were facing a process of terminal illness. They considered it necessary to address the dimensions related to the communication process with the patient themselves. They reported that many professionals don't seek out terminally ill patients to talk about the process of death and dying, and when they do, they omit their real situation, alleviating the clinical state, especially when the patient is elderly. They also pointed out that patients don't seek them out to talk about this process. Doctors also sometimes questioned whether patients were fit enough to receive this news, and preferred to talk to the family rather than the patient about the end of life, justifying this attitude by overprotecting the patient about their prognosis, believing that they would not cope well with the situation, leading them to not comply with the "treatment". It is the relatives themselves who request not to talk to the patient about the truth of their prognosis, in order to spare them suffering. The authors believe there is a need for more research in this area, in other scenarios and focusing on the death of patients from other age groups, not just adults.

6	Brazil	Studies are scarce, due to the fact that these issues are not addressed in medical courses, therefore contributing to a lack of interest in this subject.	From reading this article, the authors suggest that the most commonly used communication strategies in palliative care are active listening, therapeutic silence and affective touch and empathy. Professionals have insufficient training in this area. The inability to carry out actions through communication is a barrier to quality, humanized care, and it is essential to know communication strategies.
7	Brazil	The low number of productions involving the dissemination of cancer diagnosis to elderly patients; publications considered evident and classified as moderate and weak.	Health professionals must be trained to provide safe and enlightening communication, as a way of facilitating the flow of information and adapting it to the specific needs of patients within their realities and experiences. It is also necessary to involve family members in this process of disclosure and decision-making. The presence of the nurse is essential in the process of transmitting the diagnosis to the elderly cancer patient, helping them to face the new reality and avoid their preferences not being met, taking into account their bio-psycho-social-spiritual condition. They suggest that there should be more research, especially studies with strong evidence in the field of communication with elderly cancer patients.
8	Sweden	It has no limitations	End-of-life stage communication should be considered as a step in the transition of the palliative process and not as a single event that occurs too late in the patient's life. Nurse intervention is very important before, during and after end-of-life communication, reducing anxiety and suffering for the patient and their family. End-of-life communication that is more orientated towards the doctor and medicine needs to be complemented by aspects related to nursing care, increasing the experience of safety for patients and their families.
9	Italy	The clinical conditions of the patients and the time of normal attendance had an impact on the average duration of the interviews; a lack of time on the part of the nurses and doctors led to many missed appointments for interviews, thus prolonging the data collection phase; the opinion of the doctors was less represented compared to that of the nurses, because one doctor changed his mind and refused to be interviewed; the caregivers were only represented by the female gender.	The difficulty of recruiting groups of four interrelated participants (patient, caregiver, nurse and doctor) meant that the selected sample of patients was homogeneous in terms of life expectancy. The team available in the services is not as numerous and not all oncologists and nurses showed interest in taking part in the research, and we were also unable to reach data saturation for all perspectives. This study adds important experiential considerations to existing research, which generally only considers bidirectional aspects of the clinic. It investigates the shared and distinct perspectives of the four types of participants (doctors, nurses, patients and caregivers), which is an additional value for qualitative research.
10	Brazil 2013	They mention the scarcity of studies on palliative care and communication in relation to caring for terminally ill patients.	This study highlights the importance of care centered on the patient as a whole, and not just on their clinical condition. This study should be replicated with terminally ill patients and their families to confirm the importance of communication as a basic strategy for the practice of palliative care for end-of-life patients.
11	Brazil 2021	The low production of previous evidence on the subject was described as a limitation for completing the instrument, since there is a shortage of new studies that address the basic instrument of improving communication to patients in palliative care.	From the critical-reflexive analysis of the research carried out, two categories emerge: effective communication as an essential tool for nursing care; and the feelings and emotions shown by nurses when communicating with patients in palliative care. Communication emerges as a recursive dimension in the process of smoothing anxiety, anger, fear and depression, among other emotions, when informed of the state of health, serving to clarify this moment of doubt and multiple uncertainties.

DISCUSSION

Through analysis of the selected studies, we aim to answer the objective and research question of this *Scoping Review*, mapping the data and presenting them in narrative form. Among the studies mapped, the first, according to Andrade *et al*, (2019), highlighted the extreme importance of communication in the therapeutic approach of palliative care, showing the benefits for the health and well-being of patients and their families/caregivers. With good communication, nurses are able to control symptoms and patients are able to communicate their emotional needs, resulting in a better quality of life.

In study 2, Widberg *et al*, (2020) report that e-health applications are promising in promoting equal and individualized care. These applications can be a tool to advocate for accessibility and patient participation in palliative care. E-Health communication allows patients and families to receive more information, contributing to patient experiences and feelings of security. At an organizational and social level, e-health can promote sustainable development and more efficient use of resources. By taking a holistic view of patients' needs and well-being, e-Health can determine increased value at macro, medium and micro levels for patients, palliative care services and health systems.

According to Santos *et al*, (2018), in study 3, in order to provide quality care, health professionals must be prepared in relation to the health-disease process, communication as a light technology, therapeutic communication, aiming for integrated, individualized and, above all, humanized care in the process of finitude and death. During the therapeutic approach to the cancer patient, experiencing a process of finitude, the importance of the multi-professional health team is taken into consideration. Health care must be based on the triad of patient, multi-professional team and family, with clear communication, according to the biopsychosocial and spiritual context of the individuals. It is essential that this team takes care of their mental health in order to provide quality care.

According to Bowman *et al*, (2018), in the fourth study, the authors seek to optimize the transmission of bad news by exploring staff perceptions, daily routines and best practices. Before the communication processes, they suggest using training scenarios and simulating bad news. They present a Collaborative Model of Practice that aims to improve the transmission of bad news. Before implementing this model, all team members underwent training on communication, the main strategies, dialogue for monitoring patients in the palliative care unit and the expectations of the unit's team in using this model. The use of this model was supported by the medical and nursing managers. This model was used 85 per cent by the team to communicate bad news successfully. Two themes were included in the structured interviews with the team, namely inclusion and support. Nurses began to be sought out more for the communication of bad news. The medical team realized that nurses should and wanted to be included in this model. This collaborative model of practice improved communication and teamwork, increasing the team's ability to provide fundamental support to patients and families and also promoted feelings, preparing them for emotional responses to bad news. As stated by Apolónia, Moreira, Silva, Castro, Oliveira, & Mota (2018), through communication nurses are able to guide patients to deal with the concerns and emotional difficulties that occur due to the transmission of bad news.

The fifth study (Prado et al., 2019) states that care management in the communication of the death and dying process should cover three categories, initially addressing the sphere of care between professionals, then extending to the patient's family and finally addressing the sphere of the patient. Care takes place with people in different health conditions, different scenarios and contexts, with different experiences. With regard to the communication processes between professionals, it was found that they avoided talking about death, as well as the limitations of life, because it leads to talking about death itself. Reflections on the finiteness of life can lead nurses to understand these situations and have an impact both on their personal lives and on the exercise of their profession. With regard to doctors faced with a serious diagnosis, the study states that the question was not how to approach the patient about their terminality, but rather how they shared and explained this issue with the patient. We emphasize that the information should be shared with the patient, not relating it directly to near death. Approaching death with patients, as long as they agree, is crucial. This act can serve as a way of reflecting on life until death, allowing it to grow. An important step before telling a patient about their end-stage illness is to understand their needs, desires, weaknesses and to detect their reactions. The fact that nurses ask the multi-professional team for their opinion and take part in meetings fosters closeness, promoting better reflections on care in the face of the death and dying process. Addressing terminality is not an easy process because it involves affections and health professionals share their suffering on these issues, most of whom have not been prepared for it either. Professionals say that patients don't ask questions because they don't understand their condition or don't want to know, but they also recognize that patients are often waiting for them to come and talk to them about the process of death and dying. There are cases in which families realize the end of their relative's life, but there are others who are unaware of it, which leads them to constantly ask the nursing team or even request their relative's transfer to intensive care units. Whereas some professionals argue that the patient is not prepared to receive the news about their end of life, others defend the patient's right to know their diagnosis and prognosis, but that they need to be prepared to communicate the bad news and support their patients and families.

According to the sixth study analyzed (Almeida & Garcia, 2015), it focuses on communication as a fundamental factor in intermediary relationships, due to its enormous value in the palliative context. When it comes to patients in palliative care, professionals reduce communication strictly to negative news, making it difficult for the team and patients to manage. The verbal and non-verbal communication strategies revealed as essential by the authors were, firstly, active listening, secondly, the therapeutic use of silence and thirdly, questioning what patients know about their condition and how they feel, encouraging them to talk about their feelings, establishing light conversations, affective touch, eye contact and the use of empathy. Patients also considered it significant to convey a willingness to help, talk, answer questions, closeness and physical presence. The studies show that a smiling expression, a positive attitude and gestures, and encouragement led 75% of patients to verbalize, respecting space, removing obstacles and clearly and sincerely expressing their questions and expectations about their condition. They mentioned the effectiveness of sharing communication with their patient, associated with the ability to choose, self-control and reason, underlining the unquestionable benefit. Music is also a very effective communication strategy, it is therapeutic and provides relief from anxiety and pain. During the night, nursing care for patients is compromised because the number of nurses is reduced, there are no more team members and the night for many patients is associated with death, aggravating feelings of fear, suffering and loneliness. Studies report the importance of health professionals' training needs and training in the use of communication strategies. Traditionally, they have learnt to save lives and act in a curative way, making it difficult to be therapeutically rational in controlling symptoms and accepting the patient's decisions. Also to be considered are the feelings of impotence and failure when they can't act in a curative way, leading them to distance themselves from patients. It is important for professionals to reflect on their practice, their points of view, their technical skills and their feelings about a patient in a palliative situation.

Study 7 (Jonas *et al.,* 2015) showed that although many cancer patients want information about the disease, many of them do not understand the real meaning of what is said and misinterpret the diagnosis of their illness and the purpose of treatment. It is therefore clear that disclosure of the diagnosis deserves special attention when directed at this age group, bearing in mind that many elderly people have compromised cognitive abilities. Furthermore, the information given varies according to characteristics such as age, ethnicity, education, income, location and cultural level. Female patients are less concerned about obtaining information on communicating their cancer diagnosis and those with more education are more concerned about receiving more detailed information from their doctors. Disclosure of the diagnosis is an aspect of care and has been attributed to lower levels of anxiety, mood disorder, distress and better acceptance of the treatment plan. Another important aspect is the way in which the health professional communicates the news, which can interfere with the way the patient accepts the illness. The difficulties experienced by health professionals include a lack of training in how and when to communicate bad news. Nurses need to develop effective communication strategies in order to deal with everyone, caring for them and making themselves understood in an honest, clear, comprehensive and respectful way. In caring for cancer patients, the nursing team plays an important role in the multi-professional team, and is often the professional chosen by patients to adjust and share their thoughts and feelings, playing a fundamental role in encouraging the process of adapting to the patient's new reality and establishing a therapeutic relationship.

According to Rylander *et al,* (2019) in the eighth study, they state that nurses need to be prepared before end-of-life communication in order to face the uncertainty of the patients and their families. They build up their experience when talking to patients at the end of life, because they feel "trapped in the context" between doctors, patients and their families, without being aware of what has already been said to them. They emphasize the importance of cooperation, a good relationship between doctors and nurses and knowledge of what the team has already covered. Otherwise, nurses feel powerless and unable to respond to patients' questions, doubts or emotional reactions. If care is not structured to meet the patient's needs or acceptance of their illness, there can be a barrier to communication. Inaccuracy or omission in patient records can also be a barrier to team meetings and communication with patients. Whether nurses felt safe and comfortable is related to how the doctor acts during end-of-life communication. The way doctors give information to patients and their families in end-of-life communication affects the way they receive and experience a poor prognosis. It seems to be confirmed that effective communication at the end of life is an essential skill for nurses, and training in this area is important. End-of-life communication is a communication between doctors and patients, included in the doctor's professional duty, as pointed out by political law in Sweden. Nurses do not have a distinct role in end-of-life communication. However, the results show that the participation of nurses in the conversation with patients gave them better opportunities to provide adequate and quality care, and that they should be updated when the disease is changing. There are not many studies that adopt a multiperspective design, and this type of design makes it possible to consider the context of relationships in which illness and care are experienced.

Observing how meanings are attributed and interwoven allows us to see and compare the different moral perspectives on diagnosis and prognosis-related communication espoused by the four participant figures, as Melis *et al* (2020) state in study 9. All participants are involved in and affected by communication regarding diagnosis and prognosis. The context of communication seems to be characterized by contradictory perceptions and fragmented experiences in which people struggle to reorganize their ideas and values. The idea of what is going to happen appears to the participants as both empowering and disempowering for the patient. Not all patients were willing to have prognostic information, some did not express their willingness and others expressed an ambivalent desire. The different attitudes and priorities of patients in relation to wanting to know their diagnosis and prognosis highlight the ethical importance of providing personalized communication according to the needs of each patient. Responsibilities in communication related to diagnosis and prognosis differ between doctors and nurses. Nurses experience this type of communication as a form of holistic care for the person, and also as a personal attitude, at the limit of their own professional role. For caregivers and patients, it is essential to provide support for the person and not just for health problems. With regard to doctors, not only informational aspects are important, but also aspects of medical care. The existential dimension, addressed by all participants, describes the ethical framework in which communication is perceived: respect for the individual dimension is at the heart of any caring relationship (Melis *et al.*, 2020).

According to Andrade *et al*, (2013), in study 10, three areas were assessed, whose dimensions reveal how nurses use communication to humanize nursing care for end-of-life patients and their families, with emphasis on valuing verbal and non-verbal communication in palliative care. The first category refers to the value of the human relationship, noting that communication with the patients experiencing their moment of finitude is the basis for a good interpersonal relationship. They want to be perceived as a human being who is suffering, because in addition to pain, as a physical phenomenon, they experience emotional and existential conflicts that generates a lack that therapy or high-tech tools can't fulfil. In the second category, the communication in palliative care as a strategy for strengthening the bond between nurses and patients at the end of life. The study states that nurses, through effective communication, show concern for end-of-life patients and their families, developing listening skills, seeking to clarify uncertainties regarding their state of health and offering them reassurance. It is essential for nurses to transform the way they assist, transforming what they do in order to listen, realize, understand, identify needs and not just plan actions. Terminally ill patients and their families value the use of verbal and non-verbal communication, as well as qualified listening, as effective therapeutic tools. In the third category, relating to the importance of communication between nurses and the families of terminally ill patients under palliative care, the family is the fundamental link in the process of caring for the patient, and a good relationship between professionals, patients and their families is essential. The importance of the type of language used depends on the patient's level of commitment. They communicate by transmitting information that strengthens, explains and dignifies the end of life. For humanized nursing care, it is important that the interpersonal relationship between the nurse and the patient/family in the care process is based on communication skills.

Communication, according to Galvão *et al,* (2017), in study 11, is a relevant link between the nurse and their palliative care patient, as a formula for caring that occurs in an interpersonal way, with a safe nursing focus and strong interaction. Dialogue is a crucial part of effective communication, with multiple emotions, for the relationship between nurse and patient/family. Addressing communication is also talking about reception and humanization, which are part of one of the pillars of nursing care for patients in need of palliative care, working throughout the care process, related to and focused on the terminally ill patient (Galvão *et al*., 2017).

Communication is a privileged therapeutic action for end-of-life patients. Reassuring the patients and associating with their pain and feelings is the nurse's role in providing quality, qualified and humanized care. Nurses in palliative care use communicative dialogue as a fundamental strategy for their care. It is a form of support that is both demonstrated and experienced by nurses in order to alleviate the negative feelings of families, to minimize suffering, to comfort and serenade patients by making them understand their ability to experience each moment, expressing their feelings and being able to practice something personal that they can keep in their memories for a legacy, and to experience the natural emotions that they cannot help but feel.

CONCLUSION

All communication in palliative care promotes intrinsic aspects of care. It exerts a strong commitment to the health professional's therapeutic activity in order to gain a better understanding of the person being cared for, anticipating that during the relationship there is a wide range of *feedbacks* that reorganizes the care plan. Therefore, communication as a pillar, is fundamental to managing the therapeutic regime. As a synthesis of the evidence from this research, we consider some of the areas in which nurses intervene. The management of nursing care in the face of life and death is a process that continually involves the order of the approach, the disorder of individual responses and organization in a dynamic that is sometimes incompatible, but also complementary. Even lapses, unpredictability and doubts encourage reorganization, generating a system of care that self-organizes based on interactions. It simultaneously integrates order-disorder-organization in everyday work, enhancing the similarities and natural differences of professionals and organizations, providing better inclusion with society and improving practice, highlighting the performance of nursing as a profession of human relationships in care. As most of the articles on communication in palliative care are instrumental research, they limit other approaches, and there is a lack of studies looking at other dimensions of communication/relational care. Another limitation of the research is the language of publication. It is believed that there will be other studies in English that were not included in this *Scoping Review*. Palliative care is focused on valuing life, helping the sick person to control their symptoms and relieve suffering. Communication, as a pillar, gains the patient's trust, which is fundamental to the structure of palliative care.

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