

Challenges and Learning Needs of Nurse-Patients' Family Communication: Focus Group Interviews With Intensive Care Unit Nurses in South Korea

Evaluation & the Health Professions
2022, Vol. 45(4) 411–419
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DOI: 10.1177/01632787221076911
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Abstract

Intensive care unit (ICU) nurses are expected to facilitate effective day-to-day communication with patients and family members at the bedside. To date, communication training for ICU health care professionals has targeted mainly intensivists-in-training, but there is limited data on communication experience and needs to be evaluated among ICU nurses. This qualitative study used focus group interviews to explore daily communication experiences with patients' families and communication training needs and preferences among ICU nurses in South Korea. Five focus group interviews were conducted with 27 ICU nurses (4–6 nurses per group). The results of inductive qualitative content analysis highlighted four main categories: "Perceived difficulties during communication," "burden from working conditions," "endeavors to promote communication skills," and "strategies for cultivating effective communication." Regarding suggestions for future communication training, nurses preferred interactive learning with peer-support over traditional methods (e.g., lectures). Nurses also suggested that communication training for ICU nurses should include learning skills appropriate for difficult situations (e.g., angry family members). Findings from this study can serve as a framework for stakeholders in ICU care and healthcare education (e.g., hospital and nursing administrators, nurse educators) when designing communication training to support ICU nurses with their practical knowledge and communication skills.

Keywords

communication, nurses, families, intensive care unit, qualitative study

Introduction

Effective family-clinician communication in the intensive care unit (ICU) is crucial to provide support, build trust, and promote outcomes and satisfaction for patients and families (Hamilton et al., 2020; Seaman et al., 2017). Unfortunately, many ICU patients cannot communicate due to the critical nature of illnesses and/or the effects of ICU treatments, such as mechanical ventilation and sedation (Karlsen et al., 2019). With these limitations, family members are expected to process complex updates about the patient's illness and make decisions (Davidson et al., 2017). While physicians are usually responsible for delivering significant updates on medical care, ICU nurses are expected to help families understand patients' daily conditions and to provide emotional support (Anderson et al., 2015; Newcomb et al., 2020; Pecanac & Schwarze, 2018).

Studies indicate that ICU nurses need better support to improve communication skills (Adams et al., 2017; O'Donnell et al., 2020). Schubart et al. (2015) reported that the major obstacles to efficient nurse-family communication were emotional arousal of families under stress, disjointed

interactions between ICU teams and families, and limited resources and time. Studies also reported that role constraints in nurses made them less empowered to fill in the information gaps asked by families (Bloomer et al., 2017; Pecanac & King, 2019; Schubart et al., 2015). In an ethnographic study of ICU nurse-patient-family communication (Slatore et al., 2012), communication mainly was on updating patients' biophysical information (e.g., vital signs), but rarely included the implications of the information. Nurses recognized the importance

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of their role as a communication partner and an intermediary between physicians and patients/families, yet nurses were also reluctant to be active in such roles (Slatore et al., 2012). Also, according to a multi-center survey with 199 ICU nurses in Korea, nurses rated their communication competence at a moderate level (Park & Oh, 2018).

To date, communication training for ICU clinicians has mainly targeted training physicians about leading formal family meetings (Scheunemann et al., 2011). Since most nurse-family communication occurs at patients' bedsides (Au et al., 2019), training for ICU nurses may need a different focus. But, few studies to date have explored day-to-day challenges and needs from the viewpoints of bedside ICU nurses. To inform communication training for ICU nurses in Korean hospitals, conducting a qualitative study was crucial. Thus, this study aimed to (1) explore ICU nurses' communication experiences with patients' families and (2) identify nurses' needs and preferences regarding communication training methods and content in South Korea.

This study is guided by the Facilitated Sense-making Model (FSM), a middle-range theory that presents a basis for family-centered critical care (Davidson, 2010). According to the FSM, ICU admission is a disruptive event for families who need to make sense of what has happened to the patient and the new roles expected of families (Davidson, 2010). Since nurses are the key facilitators of the sense-making process, the model suggests four intervention foci: caring relationships (e.g., building rapport between families and ICU clinicians), communication (e.g., effective delivery of updates), presence (e.g., inviting families to bedside activities), and decision-making (e.g., facilitating shared decision making) (Davidson, 2010). The FSM is relevant to our study because high-quality nurse-family communication is a key contributor to the success of each focus in the model.

Methods

Study Design and Setting

This qualitative study was conducted in a tertiary academic medical center in Seoul, South Korea. We conducted focus group interviews to generate rich discussion from participants with similar backgrounds but varying perceptions and reactions (Kreuger & Casey, 2014).

Study Sample and Recruitment

We enrolled 27 nurses who provided direct patient care from six adult ICUs. We excluded nurses working in ICU management. For recruitment, we posted flyers in the nurses' lounge and visited each ICU to present the study and answer nurses' questions.

Focus Group Interview and Data collection

We conducted five interviews (4–6 nurses/group) between November 2019 and January 2020. Each interview took place in a conference room for 50–60 minutes. We used a semi-

structured interview guide with questions about ICU nurses' communication with families and preferences regarding future training (e.g., "Tell us about your communication experience with patients' family." "Tell us what you wish to learn to improve communication with families."). A facilitator (JJ or JC) opened each interview by presenting the purpose and asking participants to share their experiences and thoughts. At the end of the interview, the facilitator summarized the discussion and asked the participants to clarify the content. Interviews were audio-recorded, transcribed verbatim, reviewed for accuracy, and uploaded into the NVivo 11 (QSR International Pty Ltd., Victoria, Australia).

Ethics Statement

The institutional review board approved the protocol at Yonsei university (IRB number: Y-2019-0078). Written informed consent was obtained before the interview from each participant.

Data Analysis

Two investigators (JJ, JC) with extensive experience in qualitative methods analyzed data using inductive content analysis (Elo & Kyngäs, 2008). The episode of nurse-family communication was the unit of analysis. Each investigator repeatedly read the interviews and independently conducted open coding. In the weekly meetings, investigators reviewed and compared the codes and discussed discrepancies until a consensus was reached. Then, codes were grouped into categories. These categories were re-evaluated and grouped into higher-order categories. We paid attention to (1) the frequency of critical words, (2) the depth of the shared thoughts, (3) the extent to which individual experience was reflected upon, and (4) the observed group dynamics.

To assure trustworthiness, we used a guide from Elo and colleagues (2014). To secure credibility and dependability, a debriefing was conducted immediately after each interview. When new data was added, we compared/contrasted the categories found in each interview. For coherence (Morse et al., 2002), weekly meetings continued to verify categorization and abstraction consistency. For transferability, we used purposive sampling to ensure diversity in ICU experience (3 years or ≥ 3 years) and ICU types (medical or surgical). Two researchers scrutinized the reporting process to compare/contrast the nurses' voices and categories presented.

Results

Sample Characteristics

Table 1 describes sample characteristics. Most nurses were female ($n = 25, 92.59\%$), with a median age of 26 years (range: 23–49 years). The median of ICU experience was 3 years (ranged: 0.7–20 years). Ten (37%) nurses reported having previous communication training. Self-rated communication capacity on a 10 cm horizontal visual analogue scale (0 = not

Table 1. Participants' Characteristics by Focus Group.

Characteristics of Focus Group	All (N = 27)	A (n = 4)	B (n = 6)	C (n = 5)	D (n = 6)	E (n = 6)
Age, years						
Median (range)	26.0 (23–49)	28.0 (24–38)	29.0 (25–42)	29.0 (26–49)	24.5 (24–29)	25.0 (23–27)
Gender						
Female, n	25	4	6	4	6	5
Male, n	2	0	0	1	0	1
Years of nursing experience, median (range)	3.0 (0.7–28)	2.9 (0.7–12)	6.0 (3–18)	6.0 (3–28)	1.0 (0.7–2)	1.5 (0.8–3)
Years of ICU [†] experience, median (range)	3.0 (0.7–20)	2.9 (0.7–8)	6.0 (3–15)	6.0 (3–20)	1.0 (0.7–2)	1.5 (0.8–3)
Type of ICU						
Medical ^a , n	14	2	6	0	6	0
Surgical ^b , n	13	2	0	5	0	6
Communication training experience						
Yes, n	10	2	0	3	3	2
No, n	17	2	6	2	3	4
Self-rated communication capacity ^c median (range)	6.1 (1.7–7.7)	5.0 (1.7–7.7)	6.5 (5.8–7.5)	5.8 (5.5–6.7)	5.6 (4.8–7.0)	4.9 (3.0–7.2)

Note. ICU: intensive care units.

^aMedical: medical, oncology and cardiac ICUs.

^bSurgical: surgical, neurosurgical, and cardiothoracic surgical ICUs.

^cHorizontal visual analogue scale (0–10 cm; 0 = not capable at all; 10 = highly capable).

capable at all; 10 = highly capable) showed a median score of 6.1 (range: 1.7–7.7).

Main Categories

Four main categories were identified: (1) Perceived difficulties during communication, (2) burden from working conditions, (3) endeavors to promote communication skills, and (4) strategies to cultivate effective communication. Table 2 shows the main categories and sample quotes. In Figure 1, we illustrated how the main categories support empirical context of developing a communication training intervention within the FSM. These categories depict ICU nurses' experience while interacting with families and support rationale for future intervention.

Perceived Difficulties During Communication. This category illustrates nurses' overall concern and emotions during nurse-family communication. These reactions led to self-doubt and avoidance behaviors.

Struggling With Uncertainty. Nurses were often uncertain about the level of detail to communicate to families. With uncertainty, nurses often had to keep their communication vague with little detail while making efforts to give hope to families (Table 2, Quotes #1 & #2).

Becoming Aware of One's Inexperience. Nurses, especially new graduate nurses, stated a lack of confidence and experience to master communication with families. Ascribing such difficulties to a lack of clinical experience, some new graduate nurses said they either tried to avoid face-to-face

contact with visiting families or relied on senior nurses (Table 2, Quotes #3 & #4).

Feeling Devalued and Mistrusted. Nurses stated, regardless of their efforts, families' reactions were often harsh and filled with complaints on minor details that seemed irrelevant to patients' overall safety and well-being. Nurses reported perceiving devaluation and mistrust often negatively affected the dynamics of the nurse-family interactions (Table 2, Quote#6). Nurses also shared disappointment when they noticed disrespect towards their work based upon unreasonable standards set by the families (Table 2, Quote #7).

Feeling Indifferent and Losing Empathy. Nurses said that experiencing disheartening situations repeatedly made them indifferent to family interactions. Nurses said it made them avoid direct nurse-family interactions unless necessary (Table 2, Quote #8 & #9).

Burden From Working Conditions. This category refers to structural factors unique to ICU settings and culture. These factors further complicated daily nurse-family communication.

Time Constraints. Nurses described that time constraints were often challenging during visiting hours. Since they were rushed to manage routine tasks, nurses often wanted to strictly enforce the visitation policy upon families; however, families resisted leaving patients' bedsides. Despite the ICU policy limiting the number of visitors and visiting hours, nurses often felt pressured and reluctantly

Table 2. Main Categories, Subcategories, and Sample Quotes About Challenges and Needs of Nurse-Family Communication as Perceived by Intensive Care Unit Nurses.

 Main Category 1. Perceived Difficulties During Communication

Subcategory 1.1. Struggling with uncertainty

"It's hard to say that they [the patients] are okay at the moment because that's a situation where the patient could be intubated at any time.

However, if the family thinks the patient's condition has improved according to their own criteria, they keep asking questions until they receive confirmation from the nurse that the patient is better. Well... I tell them it's a bit difficult to give them a definite answer." (Quote #1. Group A-P3; ICU experience for five years)

"If the patient's condition is okay, the conversation with the family can end. If it's not good, even if I explain what is happening and what I am doing, families ask me one by one about the plan." (Quote #2. Group E-P26; ICU experience for two years)

Subcategory 1.2. Becoming aware of one's inexperience

"I, as a new graduate nurse, didn't know how to explain to the families... because it would take time to reach a certain level of expertise in my career to learn that..." (Quote #3, Group E-P23; ICU experience for nine months)

"There are things to be learned by watching the way experienced nurses respond to the families. What I learned when I was a new nurse was, 'let's not talk since I might tell the families something wrong.'" (Quote #4. Group C-I1; ICU experience for eight years)

Subcategory 1.3. Feeling devalued and mistrusted

"I wish I could tell [a family member], 'You are not taking care of the patient 24 hours a day, are you? Once the patient transfers from the ICU to the ward, you will need to do suction every 30 minutes and clean the stool with your own hands. Then [if you had to do all of this like I do], you wouldn't say this to me.' I can't help but feel angry sometimes." (Quote #5. Group B-P8; ICU experience for 15 years)

"There was an eyedrop prescribed to a patient. His daughter asked, 'have you given this medication to my father? Are you sure? At what time did you give it?' Well... I felt as if I was being checked by a teacher who was checking my homework (...). I thought she would never believe I did [give the patient the eyedrop]. [...] Since then, I answer her questions mechanically and turn around because I have a strong feeling that she won't believe me anyway." (Quote #6. Group B-P10; ICU experience for three years)

"She [a family member] was good at secretly recording through her smartphone, and she often asked me why what I said was different from what other nurses said. For this reason, I avoided talking to her." (Quote #7. Group C-P11; ICU experience for eight years)

Subcategory 1.4. Feeling indifferent and losing empathy

"I felt it was all in vain. In the past, I really dwelled on all the words of a patient's family; however, at one point, I suddenly felt that it was futile to think like that. I'm the only one who gets hurt in the end." (Quote #8. Group B-P9; ICU experience for five years)

"Since I've been suffering in my heart, I want to avoid constructing rapport with any patient's family." (Quote #9. Group C-P15; ICU experience for 20 years)

Main category 2. Burden from working conditions

Subcategory 2.1. Time constraints and spatial separation

"If the patient's death is impending, honestly speaking, only the closest family members are allowed to come in; but, in reality, everyone who can visit eventually enters... such as distant relatives, church members." (Quote #10. Group B-P7; ICU experience for 15 years)

"I told her [a family member] I would get back to her if she waited, but she kept on waiting at the door and asking when she would be able to see her family, pressing the interphone [bell] every 5 minutes." (Quote #11. Group A-P4; ICU experience for eight months)

Subcategory 2.2. Disjointed communication

"Since doctors don't explain things enough, the family asks me this and that during the visit. But, there is a limit to what I can say; so I try and encourage the family to at least talk with the doctors about the treatment process first. However, families are reluctant to ask the doctor." (Quote #12. Group D-P19; ICU experience for two years)

"Doctors and family members often go outside the ICU to talk, and in such cases, I often don't know what they talk about. [One time,] After hearing what the next treatment plans could be from the family member, not from the doctor, I found myself bitterly saying, 'Oh, really?'" (Quote #13. Group B-P8; ICU experience for 15 years)

Main category 3. Endeavors to promote communication skills

Subcategory 3.1. Trying what is already known

"I don't think that family members expect us to do something magical. Whenever they come to visit, I always greet them and ask, 'Are there any questions you have for me?' This approach has always been welcomed. Let me share my personal experience that I think worked out well. (...) Since I knew what this family member cared about, I got somewhat worried about it potentially making the family member upset. But, when I provided an explanation, the family member was understanding and said 'You found this and will take care of it...it is okay.' I felt that the way by which I interacted with and responded to family members' questions helped to build the family's trust [toward me]." (Quote #14. Group B-P7; ICU experience for 15 years)

"To reassure the families and acknowledge the patient, I say '[the patient name] is doing all the hard work.' I also say 'We are working as hard as [the patient] does.'" (Quote #15. Group E-P27; ICU experience for three years)

(continued)

Table 2. (continued)

Main Category 1. Perceived Difficulties During Communication

Subcategory 3.2. Finding their own ways

“During visiting hours, I try saying something to family members to express that I am concerned about them as well as the patients, like asking, ‘Did you have your lunch? I hope you are taking care of yourself, too.’ Many family members appreciated when I said things like that.” (Quote #16. Group C- P14; ICU experience for six years)

“I try not to deliver any hands-on care to the patient during the visiting hour because I see it as a private time for the patient and the family member. (...). I try to make myself more available to respond to their questions. In most cases, after I started approaching the families and providing them with brief updates on the patient’s condition, such as temperature or trends in vital signs, families were highly appreciative. So, I try to explain patients’ conditions with as much detail as I can.” (Quote #17. Group B-P9; ICU experience for five years)

Main category 4. Strategies for cultivating effective communication

Subcategory 4.1. Suggested topics

“Some family members have a hard time in grasping the situation. For example, when a patient is still on the ventilator, even when the patient presents minor physical movements, some families keep on asking us ‘Is (s)he waking up?’ Even though the nurse keeps on explaining [the situation].” (Quote #18. Group D- P17; ICU experience for one years)

“Sometimes, the family member keeps on complaining about frustration, and repeatedly asks me the same questions, and I see their emotions escalate... I need to learn how to deal with such situations.” (Quote #19. Group E-P25; ICU experience for nine months)

Subcategory 4.2. Preferred training methods

“I think we can learn from each other. We can learn by exchanging our stories. Aside from instructors, there may be something like peer coaching, and then the instructor can provide some directions [regarding the peer coaching] and help us to move on. This kind of training would help us to find some practical ways to learn from our peers.” (Quote #20. Group E– P25; ICU experience for nine months)

“Something like a lecture sounds difficult... It sounds like a method by which information goes in one ear and out the other. A role play, in which participants alternate their roles, could work better; something that I can do or participate in more.” (Quote #21. Group C-P14; ICU experience for six years)

Note. P: Participant; ICU: intensive care units.

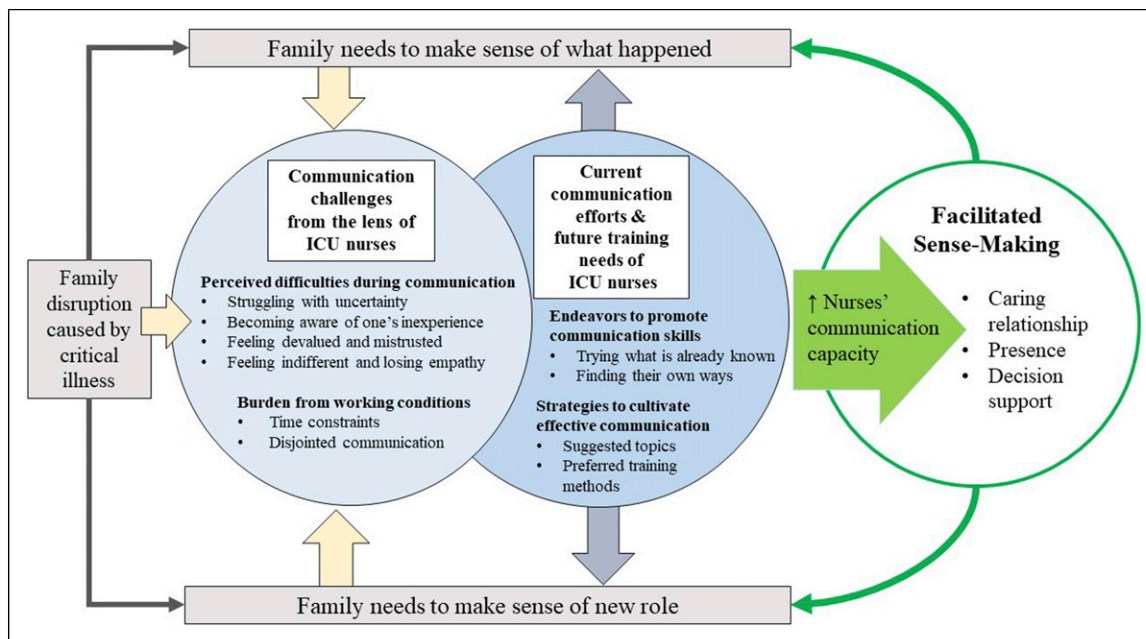


Figure 1. Intensive Care Unit Nurses’ Communication Experiences and Training Needs that Correspond to the Family Needs and the Focus of Facilitated Sense-Making Model.

allowed additional visitors or extended visits (Table 2, Quote #11).

families’ dissatisfaction with the information from physicians (Table 2, Quote #12 & #13).

Disjointed Communication. Nurses said that physician-family communication was often not shared with nurses, causing communication breakdown. Sometimes nurses had to handle

Endeavors to Promote Communication Skills. This category refers to how participants tried to apply communication skills at the bedside. Nurses used communication

strategies that had worked in the past or some individualized support.

Trying What is Already Known. Nurses shared experiences that led to positive responses; for example, being silent around family members; verbalizing empowering words to family members; giving a light physical touch (e.g., lightly placing a hand on the family members' shoulder while escorting them to the door). (Table 2, Quote #14 & #15).

Finding Their Own Ways. Nurses said that providing simple instrumental support helped calm families (e.g., physical space for grieving). When communicating about patients' conditions, helpful strategies included giving daily updates (e.g., test results), inviting families to ask questions, or helping families learn basic hands-on care skills (Table 2, Quote #16 & #17).

Strategies for Cultivating Effective Communication. This category refers to suggestions for future communication training. Nurses acknowledged the need to learn more of the "how-to" to improve their communication.

Suggested Topics. Nurses highlighted skill gaps that were most problematic. For example, they wanted to learn simple phrases to support bereaved families. In addition, they suggested that communication skills to assist angry families would be valuable. (Table 2, Quote #18 & #19).

Preferred Training Methods. Nurses preferred using interactive formats (e.g., role play) and including peer support (e.g., sharing experiences and reflections) as training methods. Nurses agreed that lengthy readings or one-way lectures—regardless of mode of delivery—were less helpful except as Supplemental materials (Table 2, Quote #20 & #21).

Discussion

In this qualitative study, we explored nurses' daily communication experiences with patients' families among 27 ICU nurses in an urban tertiary academic medical center in South Korea. To the best of our knowledge, this study is one of the first that highlights gaps in communication skills expressed by Korean ICU nurses and preferences of communication training specific to bedside ICU nurses. Furthermore, we illustrated how our results support developing communication training for ICU nurses within the FSM (Figure 1). The categories that emerged in our data depict communication challenges from the lens of ICU nurses when they respond to the needs of family members who experience disruptions caused by patients' critical illness. While dealing with these challenges, nurses were making efforts to help family members make sense of the situations and their new roles and were eager to learn more to cultivate effective communication. This finding justifies the importance of improving ICU nurses'

communication capacity to achieve the cores of the FSM and ultimately promote family-centered critical care.

Previous studies on ICU communication training primarily focused on training physicians to support structured family meetings and/or end-of-life decision-making (Mendez et al., 2020; Miller et al., 2016; Scheunemann et al., 2011). Because of the nature of nursing care, not every ICU nurse attends or facilitates family meetings; thus, these types of training may not be appropriate for nurses. Instead, ICU nurses are present at patients' bedsides, and families are often influenced by daily communication with nurses (Au et al., 2019; Hamilton et al., 2020). Our findings provide viewpoints from bedside ICU nurses to guide interventions for nurses.

Cultural contexts unique in Korean ICUs contributed to our findings. Compared to Western countries, the length and flexibility of visiting hours are more restrictive, and families have limited control over the environment and access to information (Choi et al., 2021). Also, power differentials between professions and genders that are more prevalent in East Asia (Lee et al., 2021) may have contributed to the nurses' uncertainty about sharing information with families. Assessment of cultural contexts may be necessary when interpreting communication self-efficacy rated by nurses in future studies.

In our results, the perceived difficulties during communication indicated that ICU nurses need better support to build communication self-efficacy. While individual differences existed, participants felt that their preparation and authority to communicate with family members was insufficient, which hindered their ability to fulfill families' expectations. These results are consistent with a review by Adams et al. (2017) which called such a sequence "a vicious cycle." Nurses first experienced emotional exhaustion due to constant feelings of devaluation and mistrust from families; subsequently, nurses noticed that these emotions negatively influenced their interactions with families; finally, these resulted in negative behaviors (e.g., avoidance). In our results, vicious cycles seem to negatively affect nurses' overall emotional well-being as well.

Based on our findings, we recommend strategies to develop future communication training for ICU nurses that are practical and sustainable. First, given the family members' experience of uncertainty and emotional distress, empathic communication skills must be the core of the training to help nurses effectively explore and respond to each situation. Learning to recognize emotion from verbal and non-verbal cues and expressing compassion will help build rapport and set a safe stage to communicate more complex topics (Moudatsou et al., 2020; Pehrson et al., 2016).

Secondly, our participants suggested using interactive learning (e.g., role play) rather than traditional approaches (e.g., lecture). Our participants liked the focus group format; they saw the group discussion as an opportunity to self-reflect, voice their experiences and concerns, and learn from each other. Thus, for future interventions, we recommend including

small group activities and peer support, strategies used by oncologists (Bickell et al., 2020; Niglio de Figueiredo et al., 2018). Training a nurse champion may be a practical resource for nurses to enable unit-based communication training. The nurse champion can facilitate small group sessions that promote reflection of day-to-day communication experience and peer-learning. While evidence of the use of nurse champions in improving communication is limited (Miech et al., 2018), if successful, they have been effective in other unit-based implementation studies.

Thirdly, organization-level support and cultural changes are essential to sustain the benefits of communication training. Consistent with the report from a previous study (Schubart et al., 2015), time restriction was a structural factor that caused role constraints in nurses. Altering family visiting restrictions may be a way to resolve this concern. However, despite the prominence of open visitation internationally (Chapman et al., 2016), restricting in-person visits is often inevitable (e.g., global COVID-19 pandemic). Therefore, employing alternate strategies is imperative (Hart et al., 2020). For example, interventions using technology (e.g., short message services for updates) may help reassure families (Rodríguez-Huerta et al., 2019).

Lastly, institutions should treat the quality of nurse-family communication as a major element of family engagement in ICUs (Seaman et al., 2017). Developing unit-based information-sharing processes among ICU healthcare teams can help mitigate nurses' reluctance to discuss patient information with families. Strategies to optimize the sharing of daily updates and goals between ICU healthcare teams and families may be a way to improve family-centered care (Justice et al., 2016; Seaman et al., 2017). Considering that most existing ICU communication training is "physician-centric," future training needs a more interdisciplinary focus and increased nurse-family communication content (Slatore et al., 2012).

Limitations

Our study contains several limitations. First, we only interviewed bedside ICU nurses; thus, future studies should examine diverse viewpoints from other stakeholders (e.g., family members, ICU physicians). Second, although our participants had varied clinical experiences and came from multiple ICUs, they all worked at a single institution; therefore, interpretation should be made with caution due to limited representability. Last, our groups were homogenous (i.e., women in mid-20s to late 40s), thus hindering access to more nuanced insights.

Conclusions

Although communication is the foundation of patient- and family-centered critical care, the nurses in our sample admitted that time constraints and inefficient information sharing within the ICU healthcare team restricted their communication capacity. This study highlights the need for intervention

development to assist ICU nurses in improving communication with families.

Author Contributions

Study design: JC. Data collection: JC, JJ. Data analysis: JC, JJ. Study supervision: JC. Manuscript writing: JC, JJ, YJS, JAT. Critical revisions for important intellectual content: JC, JJ, YJS, JAT.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This research was supported by Basic Science Research Program through the National Research Foundation of Korea (grant number 2019R1F1A1057941) and Mo-Im Kim Nursing Research Institute, Yonsei University College of Nursing.

Ethical Approval

This study protocol was approved by Yonsei University Health System Institutional Review Board (No. Y-2019-0078).

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