**An-Najah National University**

**Faculty of Graduate Studies**

# KNOWLEDGE AND AWARENESS OF PALESTINIAN CRITICAL CARE NURSES ABOUT COMMUNICATING BAD NEWS

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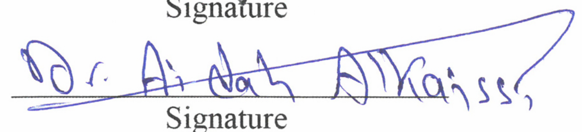
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# Dedication

This study is wholeheartedly dedicated to the Almighty God, for his guidance, power of mind, and protection and forgiving us a healthy life to be able to carry out this research.

My study is dedicated to my loving parents, who have always been a source of motivation and inspiration for me, and who have given me the strength and commitment to work with enthusiasm and determination on every task. I dedicate my study to my family members as a mark of their support.

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Also, we would like to thank all the people who contributed directly or indirectly to the development of this work.

**Moath Rayyan**

# Declaration

I, the undersigned, declare that I submitted the thesis entitled:

**KNOWLEDGE AND AWARENESS OF PALESTINIAN CRITICAL CARE NURSES ABOUT COMMUNICATING BAD NEWS**

I declare that the work provided in this thesis, unless otherwise referenced, is the researcher's own work, and has not been submitted elsewhere for any other degree or qualification.

**Student's Name:** معاذ عزيز سمير ريان

**Signature:** معاذ

**Date:** 5/10/2022

# Table of Contents

Dedication ........ III
Acknowledgements ........ IV
Declaration ........ V
Table of Contents ........ VI
List of Tables ........ VIII
List of Figures ........ IX
List of Appendices ........ X
Abstract ........ XI
Chapter One: The Introduction ........ 1
1.1 Background ........ 1
1.2 Problem statements ........ 7
1.3 Significant of the study ........ 7
1.4 Aims ........ 8
1.5 Research questions ........ 8
1.6 Hypothesis ........ 9
Chapter Two: Literature Review ........ 10
2.1Introduction ........ 10
2.2 Summary ........ 24
Chapter Three: Methodology ........ 26
3.1 Study design ........ 26
3.2 Study population and sample ........ 26
3.3 Site and Setting ........ 26
3.4 Inclusion criteria ........ 27
3.5 Instruments ........ 27
3.6 Reliability and validity of the instruments ........ 27
3.7 Pilot study ........ 28
3.8 Data collection ........ 29
3.9 Ethical considerations ........ 29
Chapter Four: Results ........ 30
4.1 Introduction ........ 30
4.2 Demographic characteristics of participants ........ 30

4.3 Knowledge about communication bad news ....................................................................32
4.4 Awareness about communicating bad news: ....................................................................37
Chapter Five: Discussion ....................................................................43
5.1 Discussion ....................................................................43
5.1.1 knowledge ....................................................................43
5.1.2 Awareness ....................................................................48
5.1.3 Conclusion ....................................................................52
5.2 Limitations ....................................................................53
5.3 Recommendations ....................................................................53
References ....................................................................54
Appendices ....................................................................60
الملخص ....................................................................ب

# List of Tables

Table 1: Demographic characteristics, Work-related variables, Training Toward Communication Bad News for the study participants' nurses ........ 31
Table 2: The mean rank of level of nurses' knowledge about communicating bad news ........ 33
Table 3: Association of the average of knowledge in communicating bad news among nurses in relation of participant's demographics, Work related variables, training towards Communication Bad News ........ 36
Table 4 :linear regression for demographic characteristics of nurses in predicting the nurse's level of knowledge on communicating bad news ........ 37
Table 5: Nurses' responses frequency and mean rank of items related to awareness about communication bad news ........ 38
Table 6: Demographic and characteristics, Work-related variables, Training Towards Communication Bad news of participants and awareness level on the issues of communicating bad news ........ 41
Table 7: linear regression for demographic and characteristics of nurses in predicting the nurses level of awareness on communicating bad news ........ 42
Table 8: bivariate correlation between the nurses' knowledge and awareness of communicating bad news ........ 42
Table 9: Reliability Statistics ........ 42

# List of Figures

Figure 1: Histogram of the average knowledge level of the nurses participating in the study 34
Figure 2: histogram of the average awareness level of the nurses participating in the study..39

# List of Appendices

Appendix A: Questionnaire ........................................................................................................ 60

# KNOWLEDGE AND AWARENESS OF PALESTINIAN CRITICAL CARE NURSES ABOUT COMMUNICATING BAD NEWS

**By**
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## Abstract

"Bad news" refers to any information provided to patients and their families that suggests, directly or indirectly, any undesirable or severe disorder that could affect their views and attitude on life in the future. Communicating bad news is now widely recognized as a phase and it refers to any unpleasant, upsetting, or challenging information that affects patients' perceptions of their present and future.

**Aim:** This study aims to evaluate the level of critical nurses' knowledge and awareness about breaking bad news.

**Methods:** To explore how critical care nurses communicate bad news, a quantitative, cross-sectional design was used. A validated questionnaire containing questions was used to evaluate the critical care nurses awareness and knowledge of communicating bad news to patients and their families in hospitals in the North West Bank (Nablus, Ramallah, Salfeet, and Qalqilia). All the nurses who work in intensive care units of the hospitals in Nablus and Ramallah were recruited from different ICU and CCU units.

**Results:** One hundred seventy-seven nurses participated in this research. The findings have shown that the average knowledge level of the critical care nurses participating in the study was poor (62.3%). There is no difference in the average knowledge level on communicating bad news among nurses that can be attributed to the demographic characteristics of the nurses participating in the study, that the average awareness level of the nurses participating in the study on the issue of communicating bad news was poor (58.2%), and that there is no difference in the average awareness level on communicating bad news among nurses that can be attributed to the demographic characteristics of the nurses participating in the study.

**Conclusion:** The study found that the nurses' knowledge and awareness of how to communicate bad news were poor. The most important predictors of practice were the nurse's knowledge and awareness of bad news communication in the ICU and protocol or policy. Additionally, the biggest obstacle to communicating bad news among nurses was their lack of knowledge.

**Keywords:** Awareness; Bad news; Knowledge; Nursing; Cardiac Care Unit; Intensive Care Unit.

# Chapter One
# The Introduction

## 1.1 Background

"Bad news" refers to any information provided to patients and their families that suggests, directly or indirectly, any unfavorable or severe disorder that could change their perceptions and outlook on life in the future (Ferreira et al., 2017).

In 1992, Buckman was the initial researcher to define "bad news." He suggested that anything that negatively and significantly influences the attitude of a person toward their future is called "bad news." It can be asserted and then proven that "bad" and, as a result, "bad news" is considered evil by humans. In many cultures and nations, people who receive bad news have comparable reactions, so it's possible to uncover psychological and global factors to understand such bad news (Abbaszadeh et al., 2014).

One of the most important aspects of healthcare is communication with the patient and their family. Nursing frequently has to deal with the difficult task of communicting bad news (CBN). These situations arise during the treatment course and as the disease advances, and they can put a great deal of constant stress on the patient, their family, and healthcare workers. Nurses, on the other hand, who are confronted with the hard and frequent task of Communicating bad news in their daily work, do not have these specialized instruments to aid, orient, and evaluate the CBN process (González-Cabrera et al., 2020). Various studies have identified existing gaps in CBN knowledge, attitude, and skills, suggesting the need for an instrument that assesses how bad news is communicated and the need for further education in this area. This is even more justified when you realize that a lack of these abilities has serious effects on patients and their families, as well as healthcare workers (González-Cabrera et al., 2020).

Evidence suggests that a patient-centered health consultation leads to higher patient satisfaction, emphasizing the importance of communication as a key professional skill and component of clinical competence. The bad news has a common denominator: a message that has the capacity to destroy hopes and dreams, resulting in drastically altered lifestyles and futures. Examples include: a) The man who learns his partner has

Alzheimer's illness; b) The patient who learns the bump on his arm is cancer; and c) The couple who learn they are unable to have children (Al-Mohaimeed et al., 2013).

Many patients experience distress after learning they have a disease, and giving a diagnosis to a patient is frequently an emotionally challenging experience for the nurses as well. As a result, interactions with patients may be hampered or prevented. Although communication is one of the most important aspects of patient care and is thought to be a prerequisite for effective nursing care, there is frequently an imbalance in the communication skills displayed by nurses when caring for cancer patients. Overwhelming the patient with medical information, failing to determine the patient's level of understanding regarding their diagnosis and treatments, being concerned about the physical care, being unable to elicit a patient's feelings, failing to accurately assess the patient's concerns, and overusing closed questions are just a few of the blocking behaviors that have been identified as having an adverse effect on the nurse-patient communication process. There is evidence that there is a constant need for nurses and doctors to enhance their communication abilities, underscoring the need for encouraging strong communication skills in caring for the cancer patient (Tobin, 2006).

Nurses have difficult interactions with patients and their families on a daily basis, which can lead to unhappiness or bad feelings for nurses. Nurses frequently deliver unfavorable news to patients and/or their loved ones regarding a patient's condition, diagnosis, or prognosis. This may have a significant negative effect on the patients' and/or their families' lives, resulting in anxiety, sadness, and despair (Imanipour et al., 2016). Giving bad news calls needs a high level of expertise and skill, as well as the ability to prevent negative effects on patients and their families. Nursing professionals find it challenging and demanding to deliver bad news because of their fears of being held responsible, lack of information, inability to express the appropriate emotions, insufficient preparation, and inadequate training of the news breaker (Imanipour et al., 2016).

With the rise of chronic illnesses and quality-of-life concerns, it's more important than ever to understand how bad news affects patients and their families. Studies have repeatedly shown that the way a health care worker communicates bad news to a patient leaves an irreparable scar on the nurse-patient relationship. Cultural conventions could take precedence over professionalism. Families in patriarchal societies, like the culture of the Palestinians, frequently defer to the elders for guidance. Preferences and attitudes

in Palestine have not yet been researched. Patients are asking for more information regarding their diagnosis, survival chances, adverse effects from treatment, and an accurate life expectancy projection. Health care professionals can decide how to communicate bad news best by considering patients' preferences and attitudes toward it. The presence of relatives can prevent patients from disclosing unpleasant concerns they may want to discuss (Alrukban et al., 2014).

The nurse's responsibility is to help the clients throughout the consultation.to act as a witness to what is stated, and to provide support to the recipient of the news once the session is completed. More recently, it has been claimed that this picture of bad news breaking is too basic and may not adequately reflect the experience of people receiving or conveying the information have been made (Warnock, 2014). Questions have been raised in particular about how this depiction focuses on the moment that unfavorable news is officially confirmed during a planned consultation, as well as the limited scope of issues that it labels as bad news (Warnock, 2014).

Companions and relatives of patients are occasionally exposed to news, events, and conditions that they may find unacceptable based on their perceptions of customs, common values, social habits, and other factors. The therapeutic team must consider the patients' social, psychological, and clinical concerns when breaking bad news to patients and families. A patient's therapy and interactions with the therapeutic team may suffer if they are told they are not emotionally ready for therapy. However, providing patients with information does not always lead to feelings of anxiety, helplessness, fear, depression, or insomnia. In some cases, it may even help the patient's condition and how they interact with their loved ones and the therapy team (Abbaszadeh et al., 2014). By preventing patients from making informed therapy decisions based on their unique goals, information hiding results in higher costs, unnecessary distress, tension in the body and mind, as well as feelings of helplessness and anxiety. According to studies, nurses can provide important information to patients and their families, as well as share facts about the disease, as part of the therapeutic team. Nurses are among the most valuable members of the therapeutic team and can play a significant role in delivering terrible news (Abbaszadeh et al., 2014).

Many of the difficulties nurses faced when breaking bad news to patients are explained by their fears of doing harm and suffering to them as well as their fears of being held responsible for or required to deal with their patients' emotions. All of these feelings could be unexpected and unpredictable. It's difficult, unpleasant, and uncomfortable to communicate bad news; it is an absolute necessity that needs the expertise of healthcare professionals. According to studies, nurses who take a course on delivering bad news don't just rely on their own experiences or observations, and they feel more at comfort and secure when delivering such information (Ferreira da Silveira et al., 2017). As a result, arranging workshops to educate professionals on ways of breaking bad news will result in professionals who are better prepared and more confident (Ferreira da Silveira et al., 2017).

In the critical care unit, which is a high-stress setting, nurses frequently assist patients and their families in dealing with life-or-death situations. In these high-stakes scenarios, nurses must build skills and techniques to be excellent communicators for having this essential conversation, which might include discussions about the targets of care or limiting aggressive care, along with unpleasant news. Patient care and communication will be improved when nurses learn to put effective communication skills into practice (Hollyday et al.,2015).

Definition of Breaking Bad News: Any revelation that has a negative impact on a patient's perspective on the future is called "bad news." Breaking bad news usually refers to sharing a diagnosis with a patient. However, it can also refer to sharing a new chronic diagnosis or information that a chronic disease has worsened (Bumb et al., 2017).

One of the most frequent and important duties of a practicing clinician is to deliver bad news to patients. Buckman (1992) defined bad news as "any news that dramatically and negatively impacts the patient's perception of her or his future”. The definition of bad news can also include other situations in which there is "a sense of no hope" or "a message is transferred that transmits to an individual fewer choice." (Dafallah et al., 2020). As a result, even experienced nurses may realize that particular situations involving breaking bad news necessitate extensive planning. This might be as a result of some nurses being worried about being held accountable, the reactions that come with breaking bad news, and not knowing what will happen next. Importantly, poorly conveyed unpleasant news can have an impact on the practitioner, patients, and

relatives. Delivering bad news in hospitals, particularly to patients with chronic conditions like Parkinson's disease, myocardial infarction, dementia, multiple sclerosis, and stroke, is common (Dafallah et al., 2020).

It's difficult to predict the individual impact and implications of unpleasant information on the patient and his or her family because bad news can be a personal view. For both patients and healthcare providers, the subject of breaking bad news can be confusing. (Burton et al., 1997).

Additionally, conveying bad news requires a complex and skilled approach in order to protect patients, their families, and any potential professional relationships from negative consequences. (Warnock et al., 2010).

Healthcare's basic and transcendental element is common for healthcare professionals to communicate with patients and their families, and as a result, nurses frequently have to deliver difficult news to patients and their families (CBN). These conditions can result in severe emotional distress, including anxiety, anger, etc. in both the patient and their family, and they often develop during the course of treatment and illness evolution (González-Cabrera, 2020). "That which will seriously or adversely change a patient's perspectives on the future". Since CBN can lead to challenging, violent, or emotionally unstable situations for both the nurse's and the patients, it is crucial that healthcare professionals develop and/or hone the awareness, attitudes, and skills necessary for this challenging role. The nurse’s knowledge and ability of CBN will be measured by using a special scale. When patients and families receive bad news, it is impossible for them to forget how, where, and when it was delivered. This highlights the importance of CBN and the need for professionals to have excellent knowledge in this area (González-Cabrera, 2020).

About 117 million people in the United States are diagnosed with chronic health conditions, such as heart disease, cancer, arthritis, and diabetes. Serious chronic or life-threatening illnesses often require that the patient or the patient’s family are made aware of the diagnosis. The approach used to deliver the bad news of a diagnosis is important and requires preparation and knowledge of techniques helpful for delivering potentially distressing information (bumb, 2017).

Cancer is a relatively common disease and most physicians will be faced with the task of breaking bad news to cancer patients. Unfortunately, most medical school do not include structured education and training in communication skills in their curriculum. For this reason, physicians develop their own approach which may not cater to the needs of patients receiving serious health related news. In some cultures, the issue is compounded by possible misperception that patients may not want to receive worrisome health information. Our findings indicate that in our region, the vast majority of cancer patients prefer to be informed of cancer related bad information. Furthermore, more than half of patients want to be involved even in end-of-life discussion. A change of approach in the clinic towards asking each individual patient how much information he/she wants to be informed will guarantee the delivery of the right amount of information to the right patient (karim et al., 2015).

Poor communication of end-of-life matters by interns is all too common and has been shown to be associated with poor patient-care outcomes, including inadequate pain and symptom relief delivery of unwanted care, and conflicts between physicians including vandalizing hospitals and nursing homes. Although there is some training in the students regarding breaking bad news, assessment of skills in breaking bad news is not commonly done. there is no formal training in communication for end-of-life issues, including breaking bad news (supe, 2011).

Breaking bad news to patients or being present when bad news is given is part of the daily activity of many healthcare professionals. receiving and giving bad news relates to the giving and the receiving of a diagnosis of cancer. The most recent figures issued suggests that Cancer diagnosis has seen a steady increase for both genders. it presents the healthcare professional with ongoing challenges, not only in relation to prevention and treatment but also in relation to how the diagnosis is given and how the recipient of the diagnosis is supported throughout their journey. The care and intervention required for these people demands that we provide the highest standards of knowledge and skill. However, there is little empirical evidence as to the needs of the patient when the diagnosis is given, and even less empirical evidence as to the needs of the healthcare professional involved in giving the diagnosis (Tobin et al., 2006).

Breaking bad news is one of the most complex and difficult tasks for healthcare providers. Among all health care providers, nurses have important role in the process of breaking bad news, such as clarifying information for patients, providing emotional support, delivering bad news individually, and clarifying ambiguous words.The critical care units (CCUs) have stressful and complex environment that can contribute to high levels of emotional exhaustion, stress, and anxiety for patients and their families. Bad news may include news about death, illness, or lifestyle changes associated with chronic illnesses such as coma, respiratory distress, diabetes, heart disease, and hypertension. Nurses need to be confident in their skills at delivering bad news, and to achieve such confidence, adequate preparation and collaboration is required between nurses and members of the multi-disciplinary team, including social workers and physicians(rayan et al., 2022).

The purpose of this study was to investigate the awareness and knowledge of Palestinian critical care nurses in giving patients bad news.

### 1.2 Problem statements

Bad news communication involves complex actions that call for knowledge and expertise to ensure proper delivery and avoid negative effects on patients and their loved ones. Delivering bad news in the right way can make patients and their families anxious, confused, hateful, and angry. Contrarily, properly delivering bad news to patients and their families can lower their level of irrational hope, denial, despair, confusion, and anxiety. Giving bad news to patients is frequently difficult and challenging for nurses. Fear of being blamed, worry about having insufficient information and being unable to express the proper emotions when delivering bad news, lack of readiness and inadequate training of the news breaker are some factors that make it seem difficult and challenging. It is necessary to assess the critical care nurses' awareness in breaking bad news. On the other hand, no research on the understanding and expertise of Palestinian critical care nurses regarding breaking bad news has been published.

### 1.3 Significant of the study

This study will provide more information about the level of awareness and knowledge of Palestinian critical care nurses about communicating bad news. This study is critical

for hospitals, nurses, especially intensive care unit nurses because the findings might aid in the development of successful interventions to increase and improve the quality of nursing care and services while communicating bad news.

This study will assess the influence and result of intensive care unit nurses' knowledge and awareness of communicating bad news, which can act an important role in enhancing the quality of care in the future.

This study can reduce risks by intensive care nurses and increase their confidence by understanding their knowledge and the influence of nursing care level on patients.

This study will provide health-care managers with summary of the obstacles to communicating bad news provided by nurses in clinical practice.

The study will assist policymakers in developing informed and evidence-based communicating bad news protocols and policies. The findings of the study will also be useful to other researchers who desire to do similar studies in the future.

Also, the study will shed light on the future nursing process of communicating bad news.

### 1.4 Aims

- To assess the level of awareness of the Palestinian critical care nurses in the process of communicating bad news in the inpatient clinical setting.
- To assess the level of knowledge among Palestinian critical care nurses when communicating bad news.

### 1.5 Research questions

1. What is the level of knowledge of the critical care nurses in communicating bad news?
2. What is the level of awareness of the critical care nurses in communicating bad news?
3. What is the level of association between knowledge and awareness of the critical care nurses in communicating bad news?

## 1.6 Hypothesis

1. The Palestinian critical care nurses have high level of awareness about communicating bad news.
2. The Palestinian critical care nurses have high level of Knowledge about communicating bad news.
3. The Palestinian critical care nurses have positive association between knowledge and awareness in communicating bad news.

# Chapter Two
# Literature Review

## 2.1 Introduction

Breaking bad news involves giving the patient and family information that negatively affects someone's perceptions of or expectations for the future (Warnock,2014).

With regard to nurses' participation in the process of receiving bad news, Warnock identified specific challenges. There wasn't enough time to prepare, the nurse had to stay in close proximity to the patient without having a chance to debrief or retreat, and there were time restrictions due to competing workload demands during the nursing shift. Their involvement in breaking bad news frequently happened ad hoc and at convenient times, which presented an overarching challenge. (Warnock et al., 2010).

Giving patients and their families important information about a diagnosis, prognosis, or course of treatment has been described as breaking bad news.In this context, the nurse's role in supporting all parties is to be present during the consultation, serving as a witness to what has been said and offering help to the new recipient until the consultation is over. More recently, this depiction of breaking bad news has been questioned by concerns that it is too simplistic and does not accurately reflect the experience of those who obtain or supply the details (Warnock,2014).

The majority of critical care nurses were involved in delivering bad news, playing a variety of roles such as offering patients and their families emotional support, translating doctors' words into plain English, assisting patients and their families in gradually accepting bad news, and preparing patients and their families for receiving bad news. (Imanipour et al., 2016).

A study conducted by Abbaszadeh et al. (2014) to investigate Iranian nurses' attitudes toward delivering unpleasant news to patients and their familiesIn clinical settings, nurses frequently lack the communication skills required to effectively communicate bad news to patients and their families. In many cultures and countries, people who get bad news respond in similar ways. 19 nurses with at least a year of ward experience participated in in-depth, semi-structured interviews, and the data were then analyzed using content analysis. Five major categories emerged from the data analysis, including

effective communication with patients and their families, preparing the ground for delivering bad news, minimizing the negativity associated with the disease, passing the duty to physicians, and helping patients and their families make logical treatment decisions. The results of this study show that according to the participants, it is the nurses' duty to give bad news, but nurses play an important role in communicating bad news to patients and their companions and should therefore be trained in clinical and communicative skills to be able to give bad news in an appropriate and effective manner.

A study conducted by Imanipour et al. (2016) to evaluate the position, viewpoint, and expertise of nurses in delivering bad news in four hospitals connected to Tehran Medical Sciences University of A sample of 160 nurses working in critical care units were used in this study. The study revealed that the majority of participants (91.2%) had a favorable attitude toward nurses' involvement in delivering bad news, only a small percentage (16.2%) of nurses had a strong level of knowledge, and most participants (78.8%) had a moderate level of knowledge: The findings showed that while critical care nurses had a positive attitude toward taking part in this process and played a variety of roles in breaking bad news, their understanding of it was lacking.

A study evaluated by Rassin et al. (2013) to view the role of three caregiver groups: doctors, nurses, and social workersin breaking death news included 115 healthcare professionals.In one large hospital in Israel's central business district, the study included 51 nurses, 38 medical professionals, and 26 social workers. For being responsible for breaking bad news (p=0.005) and for the quality of the information they provided, doctors received a higher rating than the other groups. Social workers rated the family's mental support significantly higher than did physicians and nurses (p 0.000). Compared to doctors and social workers, nurses scored the instrumental support provided (tissues, water to drink) significantly higher (p 0.000). Social workers experienced more psychological distress as a result of breaking bad news than either doctors or nurses. The emotional exhaustion, sadness, and identification this task caused in all three groups received high marks.The idea of communicating a death increased nurses' fear and increased their efforts to avoid the task. The study's conclusions will be used to create performance standards for notifying a death and to inform simulations and other trainings.

Additionally, Warnock et al. (2010) investigated the role of the nurse in the process of breaking bad news in the inpatient clinical setting and the provision of education and support for nurses carrying out this role.The term ‘breaking bad news’ is mostly associated with the moment when negative medical information is shared with a patient or relative. However, it can also be seen as a process of interactions that take place before, during and after bad news is broken. Little research has been conducted exploring the role of the nurse in the process of breaking bad news in the inpatient clinical setting. A questionnaire was developed using Likert scales and open text questions. Fifty-nine inpatient areas took part in the study; 335 questionnaires were distributed in total and 236 were completed (response rate 70%). Nurses engaged in diverse breaking bad news activities at many points in care pathways. Relationships with patients and relatives and uncontrolled and unplanned events shaped the context in which they provided this care. Little formal education or support for this work had been received. Guidance for breaking bad news should encompass the whole process of doing this and acknowledge the challenges nurses face in the inpatient clinical area. Developments in education and support are required that reflect the challenges that nurses encounter in the inpatient care setting.

On the other hand, a study conducted by Mohamed (2018) assessed the attitude of nurses towards breaking bad news and identified associations between demographic data and attitudes toward breaking bad news. 49 nurses are listed in the Sudan Hospital-Radiation Therapy. The respondents' demographic details and attitudes toward sharing bad news were obtained through a questionnaire. Nurses strongly agreed that giving bad news should take place in a private room rather than in the emergency room or hospital corridor (69.4%) and preferred to tell patients about their diagnosis when they were in the presence of a relative, a doctor, and nurses (69.4%). Although they need some training, nurses are skilled at breaking bad news to patients, who should be fully informed of their medical condition.

Singh (2018) conducted a study to assess the clinicians', administrators', and nurses' knowledge, attitude, and practice (KAP) regarding sharing bad news with patients. There were 70 respondents from 5 multispecialty hospitals in Delhi NCR, including 54 clinicians, 52 nurses, and 54 administrators. It was a cross-sectional study with a questionnaire as its foundation.Between the three groups, there is a significant

difference in knowledge and attitude, but not in practice. They are more positive, but they poor the knowledge and experience required to communicate bad news to patients. The study's findings indicate that there is a significant need to increase clinicians' and administrators' and nurses' understanding of how to break bad news to patients. These groups will be the foundation of future health care delivery.A specialized method of teaching communication skills in physician-patient relationships is the SPIKES protocol for delivering bad news. This method is also used to teach communication skills in other medical settings. Continuous educational programs like CME are necessary for this, and it should also be incorporated into their curricula as a component of their studies or on-the-job training. The hospital was advised to adhere to a protocol.

A study made by Dafallah et al. (2020) to assess adherence of Sudanese doctors to the SPIKES protocol in communicating bad news. Breaking bad news is an important task for doctors in different specialties. A descriptive cross-sectional study recruited 192 doctors, at Wad Medani teaching hospital, Sudan. A questionnaire-based on SPIKES protocol was distributed among 10 departments in our hospital. Data were analyzed using SPSS and Microsoft excel. Results: There were (n = 101, 52.6%) females and (n = 91, 47.4%) males among the participants. 95.3% have been involved in communicating bad news, but only 56.3 received education and training about this issue. 43% admitted bad experience in breaking bad news, while 65.6% mentioned that bad news should be delivered directly to patients. The majority (>90%) agreed training is needed in the area of breaking bad news. Usual adherence to the SPIKES protocol was reported in a range of 35–79%, sometimes adherence was reported in a range of 20–44% while never adherence was reported in a range of zero–13.5%. Consultants, registrars, obstetrician and gynecologists and surgeons achieved high scores in communicating bad news. Training is an important factor in achieving high score in SPIKES protocol. The unadjusted effect of background factors on SPIKES score, showed that only training has significant impact on protocol adherence (P = 0.034, unadjusted; and P = 0.038 adjusted). Large number of Sudanese doctors will try to adhere to SPIKES protocol. Training is an important factor in the success of communicating bad news.

Arbabi et al. (2010) carried out a study that assessed the medical staff's attitude toward delivering bad news and offering clinical advice in Iran. 50 physicians and 50 nurses from the Imam Khomeini Cancer Hospital made up the sample of 100 medical

professionals. The majority of the physicians (86%, n = 43) and nurses (74%, n = 37) tended to disclose the diagnosis to patients. Just a few doctors (8%, n = 4) were qualified to report bad news, which led to more diagnoses than untrained ones. Patients were typically informed of the diagnosis by doctors or nurses when they were alone or with their spouses, respectively. Few medical professionals (14%) and nurses (24%) agreed to provide patients' life expectancy information. Patients are more likely to hear about a cancer diagnosis from doctors and nurses. Caregiver communication skills are lacking, and they are reluctant to break bad news to patients because they are worried about how they will react emotionally. Therefore, it would make sense to teach medical professionals how to break bad news to patients.

A study conducted by Ferreira da Silveira et al. (2017) to evaluate doctors' capacity to break bad news, ascertain which specialties are best prepared for doing this and assess the importance of including this topic within undergraduate courses. Breaking bad news is one of doctors' duties and it requires them to have some skills, given that this situation is difficult and distressful for patients and their families. Moreover, it is also an uncomfortable condition for doctors. Observational cross-sectional quantitative study conducted at a university hospitalin Belo Horizonte (MG), Brazil. This study used a questionnaire based on the SPIKES protocol, which was answered by 121doctors at this university hospital. This questionnaire investigated their attitudes, posture, behavior and fears relating to breaking bad news. The majority of the doctors did not have problems regarding the concept of bad news. Nevertheless, their abilities diverged depending on the stage of the protocol and on their specialty and length of time since graduation. Generally, doctors who had graduated more than ten years before this survey felt more comfortable and confident, and thus transmitted the bad news in a better conducted manner. Much needs to be improved regarding this technique. Therefore, inclusion of this topic in undergraduate courses is necessary and proposals should be put forward and verified.

Warnock et al. (2017) carried out a study to investigate the challenges faced by nurses and other healthcare workers when engaging in the process of breaking bad news. The study employed a descriptive survey method that included written self-reports from participants and a summary of the situation.Data were gathered using a standardized questionnaire that included a free-text section where participants were asked to describe

a challenging situation they had to report. Multiple interrelated variables posed obstacles for workers involved in reporting bad news-dependent activities. Traditional subjects such as information on diagnosis and treatment were described, but additional topics such as the effects of end-of-life disease and care were also identified. A comprehensive structure has been created that describes the factors that contribute when delivering bad news to creating unpleasant experiences for the workers.

Gorniewicz et al., (2017) conducted a study to evaluate the efficacy of a brief, learner-centered Breaking Bad News (BBN) communication skills training module using objective evaluation measures. Using Common Ground Evaluation and Breaking Bad News, randomized control research (66) compared the communication skills success of residents (38) in the Objective Structured Clinical Examination (OSCE) intervention and control groups (28) of students. Using this simple and direct BBN training module, medical students and residents can successfully improve their BBN communication abilities. Implementing this quick, individualized training program within health education programs could improve patient care and communication abilities.

A study was held by Mostafavian et al. (2018) to assess health workers' abilities and skills in breaking bad news to cancer patients.This research was done in 2016 on 70 specialized doctors at two hospitals in Mashhad. The 16-question Persian SPIKES questionnaire was used to collect the data, which was then analyzed using SPSS software. The most common response on the questionnaire in this study was not breaking the bad news over the phone (100%) and the least common response was placing a hand on someone's shoulder (24.3%). According to this study, 81.4% of doctors concur that bad news should be delivered in private, 72.9% agree that patients should be given some semblance of hope, and 67.1% concur that patients' understanding of their illness should be taken into consideration. The findings of this study demonstrate that, in some respects, doctors' ability to deliver bad news is insufficient.To increase patient trust and reduce the worries and discomforts experienced by doctors when having to break bad news, educational courses should be held both during medical school and after graduation.

A new study done by Patil et al. (2017) to study awareness regarding breaking bad news among nurses.Bad news is a situation where there is a feeling of no hope or a threat to person’s mental or physical wellbeing. Disclosing bad news needs appropriate

communication skills, resulting in a satisfied doctor- patient relationship. Most of the medical graduates acquire this skill through observation and not through specific training. This cross sectional study was conducted among complete batch of 112 medical interns, attached to a tertiary care hospital between Jan-June 2016. A predesigned, pretested, semi- structured questionnaire was used. Only 58% of the participants were aware about what is a bad news but 80%were not aware about how to break a bad news. Half of them felt no need to conduct training. Over >3/4th agreed that doctors were primary deliverers and it can cause stress, anxiety in the recipient. 95% felt that it can alter patients view if conducted improperly. 3/4th could not disclose comfortably, accepting need of specific training for the same. Discussing end-of-life issue was most difficult (48%). Formal training during internship can result in good communication skills, improved doctor-patient relationship and canachieve enhanced quality of services.

Another study was made by Rasmus et al. (2020) to examine medical personnel's experience of breaking bad news in emergency medical services. A cross-sectional sample of 148 individuals working in emergency medical services was performed. An interview was carried out using a standardized questionnaire. 58.1% of study participants were not involved in any training, and 89.2% were not aware of any formal protocol for breaking bad news.Females were more likely than males to say that dealing with the patient's or family's emotional state was the most difficult aspect of breaking bad news. The SPIKES protocol for breaking bad news was known to only a few participants, and none understood what the acronym meant. No relationship between sex, educational attainment, occupation, work experience, or workplace existed for breaking bad news procedure knowledge.

Muneer et al. (2018) carried out a new study assessed the attitude and practice from the doctors' perspective in a patriarchal society. Breaking bad news is a global challenge for all types of health providers. A descriptive cross-sectional hospital-based study was conducted, involving doctors from both medical and surgical departments. Almost half of the respondents believed that Sudanese patients do not like to know their diagnosis, and a slightly higher proportion had no previous training on how to break bad news. Some 20% indicated that they would conceal the diagnosis from a patient if his or her relatives so requested. Less than one-quarter of respondents followed a standard protocol. Although most of the doctors subscribed to the notion that patients have the

right to know everything about their illnesses, not all of them held this attitude towards their local patient population.

A study conducted by Adebayo et al. (2013) to assesse the training, experience and perceived competence of BBN among medical personnel in southwestern Nigeria. Communication skills are vital in clinical settings because the manner in which bad news is delivered could be a huge determinant of responses to such news; as well as compliance with beneficial treatment option. Information on training, institutional guidelines and protocols for breaking bad news (BBN) is scarce in Nigeria. The study was a cross-sectional descriptive study conducted out among doctors and nurses in two healthcare institutions in southwestern Nigeria using an anonymous questionnaire (adapted from the survey by Horwitz et al.), which focused on the respondents training, awareness of protocols in BBN; and perceived competence (using a Five-Point Likert Scale) in five clinical scenarios. We equally asked the respondents about an instance of BBN they have recently witnessed. A total of 113 of 130 selected (response rate 86.9%) respondents were studied. Eight (7.1%) of the respondents knew of the guidelines on BBN in the hospital in which they work. Twenty-three (20.3%) respondents claimed knowledge of a protocol. The median perceived competence rating was 4 out of 5 in all the clinical scenarios. Twenty-five (22.1%) respondents have had a formal training in BBN and they generally had significant higher perceived competence rating (P = 0.003-0.021). There is poor support from fellow workers during instances of BBN. It appears that the large proportion of the respondents in this study were unconsciously incompetent in BBN in view of the low level of training and little or no knowledge of well known protocols for BBN even though self-rated competence is high. Continuous medical education in communication skills among health personnel in Nigeria is advocated.

A study conducted byAl-Mohaimeed et al. (2013) to explore the physicians' perspectives and practices in relation to breaking bad news (BBN) to patients. A quantitative survey was performed in the Qassim Region from January to July 2011. A cross-sectional study was conducted using a questionnaire administered to all practicing physicians working in both hospitals and Primary Healthcare centers in the Qassim Region. Anonymity was maintained throughout. The target groups received a self-administered questionnaire with a covering letter introducing the study and explaining

their rights. A total of 458 physicians participated in the study. Physicians with higher qualifications had lower total scores ofthe mean in BBN skills. The majority (70%) preferred to discussinformation with close relatives rather than the patients. In case ofserious diseases, only 32% said that they would inform the patient'sfamily without the patient's consent. More than 90% of our studysample did not avoid telling their patients the bad news; however, physicians working in Primary Healthcare centers were less reserved. Although most of the participating physicians were keen to help their patients, they lacked the essential knowledge and skills for breaking bad news. Thus, they are in need of specific training in this regard.

Bomb (2017) conduct a study to provide an overview on breaking bad news and to review the utility of the SPIKES and PEWTER evidence-based communication models for oncology nurses. A diagnosis of cancer is a stressful, difficult, and life-altering event. Breaking bad news is distressing to patients and families and is often uncomfortable for the nurse delivering it. Evidence-based communication models have been developed and adapted for use in clinical practice to assist nurses with breaking bad news. Perceptions of breaking bad news from the nurse and patient perspectives, as well as barriers and consequences to effective communication, will be presented. Clinical examples of possible situations of breaking bad news will demonstrate how to use the SPIKES and PEWTER models of communication when disclosing bad news to patients and their families. By using the evidence-based communication strategies depicted in this article, oncology nurses can support the delivery of bad news and maintain communication with their patients and their patients' families in an effective and productive manner.

This study done by Lee et al. (2013) to investigated trainee's attitude and awareness of Delivering bad news (DBN) based on a self-assessment of their experiences and performance in practice. Delivering bad news to a patient or patient's family is one of the most difficult tasks for physicians. As a complicated task, DBN requires better than average communication skills. Survey subjects were also asked to assess their perception and the need for education in conducting DBN. A survey was carried out on their experiences with DBN, how they currently deal such situations, how they perceive such situations and the need for education and training programs. A SPIKES protocol was used to assess how they currently deal with DBN. One hundred one residents and

fellows being trained in a teaching hospital participated in the survey. Around 30% had bad experiences due to improperly delivered bad news to a patient. In terms of self-assessment of how to do DBN, over 80% of trainees assessed that they were doing DBN properly to patients, using a SPIKE protocol. As for how they perceived DBN, 90% of trainees felt more than the average level of stress when they do DBN. About 80% of trainees believed that education and training is much needed during their residency program for adequate skill development regarding DBN. We suggest that education and training on DBN may be needed for trainees during the residency program, so that they could avoid unnecessary conflict with patients and reduce stress from DBN.

González-Cabrera et al. (2020) conducta study to measure nurses' knowledge and ability of Communicating bad news, as well as the analysis of its psychometric properties. Communicating bad news is a fundamental skill in nursing; nevertheless, few instruments exist for its evaluation. Based on a literature search, the initial dimensions of Communicating bad news were identified to construct the questionnaires' items, which were evaluated by experts for the validity of the items' contents. Construct validity and reliability of the resulting questionnaire was carried out in a sample of 71 nurses of an Andalusian university hospital. A questionnaire with 25 items was constructed with a high internal consistency (Cronbach's alpha 0.816). The content validity was evaluated via a literature review and additionally by the assessment of seven experts. The Kaiser-Meyer-Olkin test (KMO) obtained a score of 0.683, and the Bartlett test of sphericity a value of $p < 0.001$. The principal component analysis supported a construct of four dimensions. This questionnaire was found to be a valid and reliable instrument with a high internal consistency for the evaluation of CBN knowledge and skills of nursing professionals.

Shirazi et al. (2019) carried out a study to evaluate the skill of general physicians in breaking bad and unpleasant news to the patient based on the SPIKES questionnaire in educational hospitals of Qom University of Medical Sciences in 2016. Breaking bad and unpleasant news by physician to patient or his or her family is a key moment in communication between a physician and the patient. It is often necessary for physicians to breaking bad and unpleasant news to the patient or his or her family. This descriptive-analytical study was conducted on 200 general physicians. Convenient sampling method was used in this study. Data were collected using standard Spikes

Questionnaire and data were analyzed by using descriptive and inferential statistical tests through SPSSv21 software. Most of the subjects were male (69.5%), married (85.1%), and had no history of receiving formal education about breaking bad news to the patient. The mean and standard deviation of the subjects were 37.43±4.02 years. The mean and standard deviation of the score of the skill of breaking bad news were 63.56 ± 6.51. While independent t test showed significant difference in mean and standard deviation of score of the skill of breaking bad news between the two groups ($p < 0.05$), no significant difference was reported between two groups in terms of two variables of gender and clinic place ($p > 0.05$). Moreover, using variance analysis, a significant difference was found in mean score of breaking bad news in different age groups with different employment history ($p < 0.05$). The research results revealed that the skill level of the research samples was relatively at desirable level. Given the lack of receiving formal education by general physicians and the impact of breaking bad news from physician to patients and their caregivers on the type of relationship between the physician and the patient, it is recommended to put more emphasis on continuous education programs, designed especially for general physicians.

Jameel et al. (2012) conduct a study to assess the perception, skills and comfort level of postgraduate residents with respect to breaking bad news. Five workshops were conducted on communication skills, including the task of breaking bad news, at three teaching hospitals of Peshawar, Pakistan. Teaching methods included interactive lectures, video presentations, role play and small group discussions. Pre- and post-workshop data was collected from all the 97 participants to assess their previous training, comfort level and perceptions regarding the subject and any improvement after attending the workshop. Of the total participants, 92 (95%) residents had not received any training in communication skills at the undergraduate level. Only 64 (66%) residents had witnessed bad news being broken by a consultant. Before the workshop, 83 (85%) residents felt either not comfortable or somewhat comfortable while breaking bad news compared to 36% post-workshop ($p < 0.0000$). Besides, 64 (66%) residents reported breaking bad news to be extremely stressful or very stressful before the workshop versus 25% post-workshop ($p < 0.0000$). Before the workshop, 18 (19%) residents said they would withhold the information from the patient on family's insistence despite the patient's wish to be informed, compared to 6% post-workshop ($p < 0.007$). Regarding the utility of the workshop, 91 (94%) residents said it had changed

their perceptions to a major extent, while 92 (95%) residents rated the workshop as extremely useful or very useful. Formal structured training in breaking bad news is lacking both at undergraduate and postgraduate levels in Pakistan. Structured training programs for residents can do the task effectively.

von Brackenbury (2020) carried out a study to develop a questionnaire based on the SPIKES-protocol to detect patients' preferences for breaking bad news communication. Quality of breaking bad news can seriously affect the course of disease. A frequently applied guideline is the SPIKES-Protocol that have been designed from the physician's perspective. Little is known about patients' preferences in breaking bad news. The Marburg Breaking Bad News Scale (MABBAN) was developed and administered to 336 cancer patients. We used exploratory factor analysis. To examine potential relationships according to demographic and medical variables, regression analyses were conducted. The novel questionnaire supported the six SPIKES-components of breaking bad news: Setting, Perception, Invitation, Knowledge, Emotions, and Strategy. Perception and Invitation clustered together to one subscale. Depending on clinical and demographic variables different components were rated as important. Communication preferences in breaking bad news can be assessed using a SPIKES-based questionnaire. Physicians should improve the setting, share knowledge in all clarity, involve the patients in further planning, and consider demographical variables. Using SPIKES as a framework can optimize breaking bad news conversations but it seems important to emphasize the individual preferences beyond the six steps and tailor the communication process to the individual.

Karim et al. (2015) conduct a study to determine types of bad news common in intensive care units and emergency departments and to investigate nurses 'participation in the process of breaking bad news. Breaking bad news is one of the challenges in intensive care units and emergency departments. Nurses as a person who has responsibility for continuous caring, has a significant role in the process of breaking bad news, but little has been done to explore this issue. In this descriptive study, a sample of 182 nurses working at intensive care units and emergency departments of the hospitals affiliated to Tehran University of Medical Sciences selected in a quota and stratified sampling method. The data collection tool was a self-reported questionnaire which query common bad news that nurses encounter, and the activities they involved in

breaking bad news. According to the findings, news about death was the most common news in CCU (89/5%), ICU (77/3%), and emergency departments (81/8%). The most important activities that nurses had been involved were emotional support of patients and relatives (2/79±0/95), explaining the physician's speech in a simple manner (2/68±0/96), helping patients or relatives adapt with bad news over time (2/63±0/89), preparing the patient or his/her relative for hearing bad news (2/6±1/04). The results showed 34.1% of nurses break bad news to a patient or his/her relative independently. This study showed the scope of bad news in intensive care units and emergency departments is broad and diverse. Also, nurses are mostly involved in activities related to breaking bad news. Therefore, educating nurses about breaking bad news and providing regulations to support them about this issue seems to be necessary.

A study made by Tobin (2006) To explore I the lived experience of receiving a cancer diagnosis, II the lived experience of having to disclose a cancer diagnosis, III the lived experience of being present when bad news is broken, and IV the lived experience of the nurse in caring for a person who has received bad news.This study was guided by the philosophy of hermeneutic phenomenology. Three groups of participants were involved from four geographical areas in the Republic of Ireland. Data were collected through in-depth interviews with 10 recipients of a cancer diagnosis, 20 nurses, and 8 doctors all of whom were working in general medical or surgical areas. Ethical approval was gained from the Joint Ethical Committee, Federated Dublin Voluntary Hospitals and St James's Hospital. Ethical issues relating to autonomy, informed consent, anonymity and confidentiality were addressed. Trustworthiness, situatedness and authenticity were assured throughout the study by demonstrating goodness as an embedded component of the research process. Breaking bad news was conceptualized through the framework of 'Tripartite Transition: a Process of Inclusive Knowing'. Findings from the study indicate that the recipient experiences bad news as a trajectory. Three themes emerged for the recipients entitled: 'Disturbance of the Everyday World', 'Surfacing within the Lived World' and 'Embodiment within the Lived World'. Two themes emanated from the nurses' interviews, these were entitled 'Connectedness: Journeying as Professional within the Everyday World' and 'Connectedness: Exclusion as Professional within the Everyday World. Nurses journeyed with the recipient of bad news through professional companionship. However, their sense of exclusion from the multidisciplinary team and the disclosure of bad news resulted in the nurse being

disempowered, uninformed and hampered in their ability to be authentically present to the patient. One theme emerged from the doctors, entitled 'Objectified Connectedness within the Everyday World'. There would appear to be a dissonance between the experience of the recipient of bad news and the doctor delivering the diagnosis. For the recipient, bad news is seen as a trajectory whereas for the doctor it is seen as an event which is planned for and delivered.

Li et al., (2023) designed a progressive case involving a common end-of-life communication dilemma related to traditional Chinese culture and trained 50 undergraduate nursing students in end-of-life communication skills. Nurses face many difficulties and challenges related to how patients and their families deal with communication about end-of-life care in China because of the strong influence of traditional Chinese culture. Moreover, education and training opportunities in end-of-life communication skills for nursing students are rare in mainland China. A quasi-experimental design was used to compare the training outcomes of nursing students who were divided into a standardized patient simulation group and a role-playing group. The role-playing group (23 participants) was trained via group case discussion and role-playing among classmates, while the standardized patient simulation group (27 participants) completed end-of-life communication training by interacting with standardized patients and their families in a high-fidelity simulation. Attitudes toward death, self-confidence in end-of-life communication, and communication learning were evaluated in both groups during preintervention and postintervention. The results showed that all 3 variables improved after the intervention. This study shows that end-of-life communication skills training has a positive effect on nursing students to a certain extent.

A study conducted by Rayan et al., (2022) to examines critical care nurses' attitudes, roles, experience, education, and barriers regarding breaking the bad news. A descriptive, cross-sectional design was used in this study. A convenience sample of 210 critical care nurses completed the study. Most of the critical care nurses contributed to breaking bad news and they were involved in different roles in this process and they had a positive attitude regarding breaking bad news. In this study, (75.2%) of the participants reported that they did not receive any specific training regarding breaking bad news. In addition, nurses face various barriers when breaking bad news. Critical

care nurses' involvement in breaking bad news should be encouraged. Most barriers to breaking the bad news were negatively associated with nurses' roles, attitudes, and experiences during breaking the bad news. Administrators should promote the involvement of critical care nurses in breaking bad news and strengthen them through addressing the challenges they face in the process of breaking the bad news.

Elashiry et al., (2022) carried out a study to assess physicians' knowledge, attitude, and practice regarding SPIKES protocol for Breaking bad news. Breaking bad news is challenging for patients and physicians. Physicians are usually poorly trained or untrained at all in Breaking bad news despite the existence of consensus protocols for Breaking bad news. This is a cross-sectional multicenter study carried out on 395 physicians of different specialties and workplaces in Fayoum Governorate, Egypt. Data were collected through a self-administered questionnaire consisting of three sections of questions about physicians: the background characteristics questions, questions assessing their knowledge regarding Breaking bad news, and questions assessing their attitude regarding SPIKES protocol for Breaking bad news. The attitude was assessed using the Breaking bad news attitude scale (BBNAS). Only 24% of physicians ever received training on Breaking bad news and 10% knew about SPIKES protocol. Bad experience after Breaking bad news was reported by 52% of physicians. Most (75%) physicians preferred Breaking bad news to the patient's family rather than the patient. Physicians' agreement level with the SPIKES strategy was very high (91.8%). Agreement to the SPIKES protocol steps was statistically significantly higher among men, younger and older age groups (≤ 30 and > 40 years of age) physicians, psychologists and oncologists, and those who received previous training on Breaking bad news. The majority of physicians highly agreed with the SPIKES strategy for Breaking bad news, but they lacked essential knowledge for Breaking bad news. Specific training and standardized protocols in this regard deem to be necessary during medical school study and continuous professional development.

### 2.2 Summary

The literature review in this chapter focused on elements that must be considered in research that intends to assess nurses' knowledge and awareness of communication bad news for patients in Intensive Care Units in the West Bank. The research design and methods will be detailed in the next chapter methodology.

The literature focused more on the knowledge and awareness of communicating bad news by icu nurses, basing on their prior knowledge and experience. Most of the studies on have been done outside Palestine. According to the conclusions of these studies, some of them found that nurses' knowledge and awareness of communicating bad news in the ICU was adequate, while others found it to be inadequate. More research on the predictors and barriers to patients' communicating bad news practice among ICU nurses is required. Furthermore, no studies on predictors or barriers were been out in Palestine. The studies highlighted the necessity for a research on nurses who work in ICU.

# Chapter Three
# Methodology

This chapter illustrates the methods of our research and explains the following: research design, sample, population, sampling process, data collection plan, data analysis plan; ethical consideration.

### 3.1 Study design

This is a cross-sectional, quantitative, descriptive survey about communicating bad news.

### 3.2 Study population and sample

The study population consisted of 210 nurses who work in adult ICU, and CCU units from government hospitals of Nablus, Ramallah, Salfeet, and Qalqilia. Nablus: (Rafedia (30 nurses), AL-Watani hospital (35 nurses)), Ramallah: (Palestine medical complex (110 nurses), Salfeet: ( Salfeet hospital: (15 nurses), Qalqilia: (Darwish nazal hospital (20 nurses).

These numbers represent everyone who works as a nurse in the intensive care unit and cardiac care units. The sample size is 177, calculated based on open-epi.com for sample size estimation by applying the formula:

$$\text{Size of the sample } n = [DEFF*Np(1-p)] / [(d2/Z21-\alpha/2*(N-1)+p*(1-p)]$$

The sample was chosen by a convenient technique. This method was selected due to the lack of access to the list of the staff namesat a specific time and it is both time, cost-efficient and the limited numbers of nurses who work in ICU.

### 3.3 Site and Setting

All government hospitals that include ICU and CCU units in Northern West Bank hospitals were included:ICU, CCU, Alwatani hospital, Rafeedia hospital, Ramallah hospital, Salfeet hospital (ICU), and Qalqilia hospital.

### 3.4 Inclusion criteria

Palestinian healthcare professionals in the ICU and CCU at Rafedia, Al-Wattani, Ramallah, Salafeet, and Qalqilia hospitals with full-time employment were included. All nurses working in other hospital departments were excluded.

### 3.5 Instruments

A questionnaire with three parts was the research tool used:

- The first section included the participants' personal data. (Demographic data).
- The second part is related to their knowledge of communicating bad news, which is composed of 25 items. For evaluating the objects, the 5-point Likert style scale includes never, rarely, sometimes, often, and always. Where 0 will be the minimum value (minimum agreement) and 4 will be the maximum value (maximum agreement). This questionnaire was designed and constructed by a scientific literature review. A review of the relevant literature and the opinions of seven experts were also used to assess the content validity. These experts had clinical experience in various services where it is customary to communicate breaking news, and they were built with high internal consistency (Cronbach's alpha 0.816). They also had adequate training in their field of work and in breaking news communication.
- The third part is related to awareness regarding communication of bad news, which is composed of 17 items. For evaluation of the object (utilizing the Likert scale (which ranges from 0 for strongly disagree to 4 for strongly agree).

Awareness is perceiving, knowing, feeling, or being conscious of events, objects, thoughts, emotions, or sensory patterns. Knowledge is facts, information, and skills acquired through experience or education. The key difference between awareness and knowledge is that knowledge is associated with deep understanding and familiarity with a subject whereas awareness does not imply a deep understanding.

### 3.6 Reliability and validity of the instruments

The assessing knowledge questionnaire is well-known worldwide, with reliable and valid use in literature. Numerous studies have been carried out to evaluate its validity and reliability and its applicability in different areas of the world and different languages. For example, Gonzalez-Cabrera et al. (2020). content validity and an opinion

survey from specialist professors were used in a new study to assess the validity of the questionnaire. Medical educators verified the questionnaire's face validity and found it to be consistent with multiple choice question principle. A pilot study using the test-retest method was carried out with 71 nurses (45 of whom worked in the emergency room and 26 in critical care) at one-week intervals to ascertain the tool's reliability. The results of the pilot study supported the questionnaire's validity. The internal consistency of the questionnaire was calculated by revealing a High internal consistency is indicated by a Cronbach alpha of 0.816.

A questionnaire for awareness was designed by following preceding studies. Questionnaire for Awareness conducted by Patil, S et al. (2017), Experts confirmed that the questionnaire's Face validity was in line with the principles of multiple choice questions. Using the test-retest methodology, a pilot study was carried out with 25 nurses of critical care to communicate bad news to patients and their families in order to ascertain the reliability of the data collection tool. The results of the pilot study validated the questionnaire's validity. The internal consistency of the questionnaire was calculated using a Cronbach alpha of 0.75, showing a high internal consistency.

### 3.7 Pilot study

To determine the effectiveness of the instructions, the completeness of the response sets, and the clarity of the questions, a pilot study involving 25 nurses from different hospitals' ICU and CCU wards was conducted. time required to complete the questionnaire, the success of data collection technique, and suitability of the scale to be used in our culture and these nurses were included in the study. The Cronbach alpha was measured and found for both knowledge (0,95) and awareness (0,75) of communicating bad news, and these results are acceptable and of high reliability.

These respondents were asked after two weeks to measure if there were any cultural differences between our culture and the original culture of the scale.

They were all answered questions. There was no need to clarify any questions. The scientists found that the questionnaire would require fifteen (15) minutes to complete.

### 3.8 Data collection

The data collected from the ICU and CCU nurses' units from; Nablus, Ramallah, Salfeet, and Qalqilia hospitals (from 5 hospitals) N=177. By using questionnaire questions. The questionnaire was communicated in its original English language. 3 months (December 2021 to February 2022) were needed during 2021-2022 to collect the data Face to face interviews were used, which lasted about 20 minutes.

### 3.9 Ethical considerations

Ethical approval was obtained from Al-najah national University and Palestinian Ministry of Health. Consent form was provided for every participant prior to the study. Voluntary participation was explained to nurses. No names were mentioned or any personal information about the participant.All data was be kept confidential and was used for study purposes only. No any harms of consequences due to participation refusal such as care quality or privileges. Clear explanation was given to each participant bout the study objectives and tool, enough time was given for questions

# Chapter Four

# Results

## 4.1 Introduction

This thesis was established and conducted to provide a baseline regarding the level of Palestinian critical care nurses of knowledge and awareness regarding the communication of bad news. It can shed light on the future nursing process of communicating bad news, which can help nurses and other healthcare providers on how they can conduct the protocol of communicating bad news in the inpatient clinical setting. So, This thesis aims to evaluate the critical care nurses' awareness of the process of communicating bad news to patients in an inpatient clinical setting, as well as their level of knowledge regarding this process.

## 4.2 Demographic characteristics of participants

Obviously, by looking at Table 1, the results of the study found that most of the nurses participating in the study were males (65.5%), and their ages ranged from 20–30 years (63.8 %).

As for their areas of residence and social status, a little more than half were living in the villages (52.0%) and married (59.4%).

As for the monthly salaries, although the majority of their salaries were above one thousand dollars (67.8%), there were some nurses whose monthly salaries did not exceed seven hundred and fifty dollars (4.0%).

As for the variables related to the nature of work for the nurses participating in the study, it was found that half of them are nurses (50.3%), a little less than half are senior nurses (46.9%), and a few of them are heads of departments (2.8%).

About 48% of them are from the critical care units at the medical complex, and the majority of them holds a first university degree (81.9%) and work in the intensive care unit (68.4%), and most of them have practical experience of less than ten years. As the percentage of nurses who have practical experience is more than ten years, it is approximately 20.9%.

According to the findings, the majority of the study's nurses did not participate in any workshops or training courses on the issue of communicating bad news, and only 17% of the participants' nurses received training, 12% of whom had a training period of less than a week.

**Table 1**

*Demographic characteristics, Work-related variables, Training Toward Communication Bad News for the study participants' nurses*

| | | Frequency | Percent |
|---|---|---|---|
| Participant Age (years) | 20-30 | 113 | 63.8 |
| | 31-40 | 58 | 32.8 |
| | 41-50 | 5 | 2.8 |
| | More than 50 | 1 | .6 |
| Gender | Male | 116 | 65.5 |
| | Female | 61 | 34.5 |
| Marital Status | Single | 70 | 39.5 |
| | Married | 105 | 59.3 |
| | Divorced or other | 2 | 1.1 |
| Monthly Salary | Less than 750 $ | 7 | 4.0 |
| | 750-1000 $ | 50 | 28.2 |
| | More than 1000 $ | 120 | 67.8 |
| place of living | Camp | 4 | 2.3 |
| | Village | 92 | 52.0 |
| | City | 81 | 45.8 |
| Position | Nurse | 89 | 50.3 |
| | Senior Nurse | 83 | 46.9 |
| | Head Nurse | 5 | 2.8 |
| Place of Work | Alwatani hospital (CCU) | 16 | 9.0 |
| | Alwatani hospital (ICU) | 16 | 9.0 |
| | Qalqilia hospital (ICU) | 19 | 10.7 |
| | Rafeedia hospital (ICU) | 28 | 15.8 |
| | Ramallah hospital (CCU) | 36 | 20.3 |
| | Ramallah hospital (ICU) | 49 | 27.7 |
| | Salfeet hospital (ICU) | 13 | 7.3 |
| Nursing Qualification | Diploma or less | 16 | 9.0 |
| | Bachelor | 145 | 81.9 |
| | Master or more | 16 | 9.0 |
| Department of Work | Cardiac care unit | 56 | 31.6 |
| | Intensive Care Unit | 121 | 68.4 |
| Working Experience | Less than 5 years | 45 | 25.4 |
| | 5-10 years | 87 | 49.2 |
| | 11-15 years | 37 | 20.9 |
| | above 15 years | 8 | 4.5 |
| Training Towards | No | 147 | 83.1 |
| Communication Bad News | Yes | 30 | 16.9 |
| Period of Training Course | None | 147 | 83.1 |
| | One week or less | 21 | 11.9 |
| | More than one week | 9 | 5.1 |

### 4.3 Knowledge about communication bad news

It is noticeable from the study participants, nurses, answers to the questions about their knowledge of communicating bad news that most of their interest and priority was to deliver the news to the patient with minimal loss and safety, as the highest percentage of their responses to the questions, such as calling him by his name and using the appropriate language that ensures his comprehension of the news and monitoring his feelings emanating from receiving the news.

While the patient's opinion and asking him about his feelings or the presence of questions or inquiries were the least interesting to the nurses participating in the study, Table 2.

**Table 2**

*The mean rank of level of nurses' knowledge about communicating bad news*

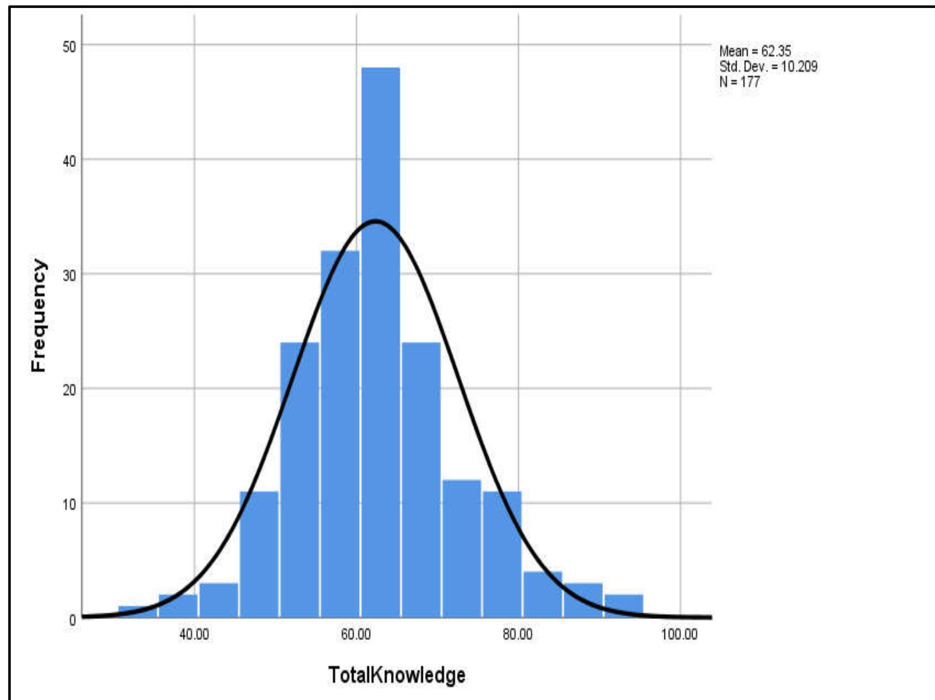
| | Mean | SD | Item-Total Correlation | percentage |
|---|---|---|---|---|
| Call the patients by their name? | 3.26 | .929 | .320 | 81.3 |
| Look at the patients face or in the eyes while you talk or listen? | 3.23 | .863 | .385 | 79.1 |
| Use appropriate language to allow the patient to digest the bad news? | 3.12 | .837 | .384 | 80.8 |
| Observe the emotions that have emerged in the patient following the communication of bad News? | 3.02 | .836 | .262 | 74 |
| Introduce yourself to the patient first? | 2.99 | 1.039 | .145 | 71.2 |
| Communicate the bad news sequentially and in an organized manner, not giving more Information until you are sure that the information already given has been digested? | 2.92 | .832 | .464 | 74.6 |
| Show support and understanding non-verbally? | 2.89 | .882 | .495 | 71.2 |
| Farewell the patient at the end of the conversation? | 2.86 | 1.027 | .478 | 66.1 |
| When you communicate bad news, do you present yourself assertively, expressing your thoughts? | 2.78 | .937 | .477 | 63.8 |
| If a disagreement with the patient exists, do you wait for their input and find a solution to the problem? | 2.67 | .889 | .324 | 64.4 |
| In terms of the feelings, fears and worries of the patient, do you verbally express your awareness? | 2.60 | .931 | .281 | 71.2 |
| When the patient's response is anxiety, fear, sadness or aggression, do you maintain an attitude of active? | 2.54 | 1.148 | .302 | 57.6 |
| Do you tend to facilitate dialog with the patient or let them vent/blow off steam talking? | 2.50 | .912 | .553 | 52.5 |
| In the event that the patient is unsure they wish to be informed, do you give the patient time to consider it? | 2.47 | .942 | .433 | 50.9 |
| Do you establish, if necessary, a care plan together with the patient to address the new situation? | 2.45 | .947 | .342 | 52 |
| Do you ensure that there will be no foreseeable interruption occurring (phone, consult by a colleague, etc.)? | 2.45 | .953 | .357 | 48.6 |
| Before starting the conversation, do you find out what the patient already knows about the news that you are going to communicate? | 2.42 | 1.026 | .399 | 44.6 |
| To find out what the patient knows and how much they want to know, do you use questions such as: Before I talk, do you want to tell me anything or ask me something? | 2.36 | .990 | .318 | 47.4 |
| Do you explore the possible occurrence of challenging situations after the communication of bad news and establish a strategy for future action? | 2.34 | .866 | .317 | 44 |
| Before communicating bad news, do you find out in what way the news may affect the patient's personal, Social or work life? | 2.34 | .910 | .240 | 46.3 |
| Do you choose a quiet and private place before hand to communicate bad news? | 2.29 | 1.125 | .357 | 49.7 |
| Do you plan the duration? | 2.02 | 1.208 | .281 | 38.4 |
| Ensure that at the end of the conversation the patient has no further doubts or questions? | 1.37 | 1.491 | .129 | 28.8 |
| Ask a question to find out how the patient is feeling? | 1.25 | 1.380 | -.012 | 27.1 |
| Keep in the mind the opinion of the patient? | 1.21 | 1.626 | .108 | 25.4 |

SD: standard deviation

Figure 1 reflects that the average knowledge level of the nurses participating in the study was poor (62.3%) and that nearly 70% of the study participants had the average knowledge level on the issues of communicating bad news between 52% and 72%.

**Figure 1**

*Histogram of the average knowledge level of the nurses participating in the study*




By examining, using t-test and ANOVA statistical tests, to measure the differences in the average knowledge of communicating bad news among nurses, which are related to demographic variables, it was found that there are no differences in nurses' average knowledge of breaking bad news that can be attributed to the demographics of the nurses who participated in the study.

Despite the lack of statistical significance, the female nurses participating in the study had a higher average of knowledge than the males, while the study participants from the camps, married and those with higher incomes had the lowest average of knowledge than their peers.

Through using t-test and ANOVA statistical tests to measure the differences in the average knowledge of communicating bad news among nurses, which can be attributed to work-related variables, According to research, there is a statistically significant mean

difference in nurses' average knowledge of communicating bad news that can be attributed to their nursing qualification.Where the analysis showed that masters of nursing were more knowledgeable than the others, and diploma nursing were less knowledgeable than the others. While the other work-related variables had no statistically significant difference in the average knowledge of communicating bad news among nurses.

Despite the lack of statistical significance, the Qalqilia hospital nurses, head nurse, cardiac care unit, and experienced more than 15 years, had a higher average of knowledge about communicating bad news than their peers.

Despite the large number of nurses who claimed that they did not take any training about the process of communicating bad news, the statistical tests (t & ANOVA) did not find any statistically significant differences in terms of taking the training course or even the duration of the training course for nurses. However, the nurses who received training courses for more than a week on communicating bad news had a higher rate of knowledge than others (Table 3).

**Table 3**

*Association of the average of knowledge in communicating bad news among nurses in relation of participant's demographics, Work related variables, training towards Communication Bad News*

| | | N | Knowledge level Mean | SD | *t* / F | P value |
|---|---|---|---|---|---|---|
| Gender | Male | 116 | 61.93 | 9.56 | -.737 | .462 |
| | Female | 61 | 63.13 | 11.37 | | |
| Marital Status | Single | 70 | 63.20 | 10.61 | .499 | .608 |
| | Married | 105 | 61.73 | 9.99 | | |
| | Divorced | 2 | 65.00 | 8.48 | | |
| Monthly salary | < 750 $ | 7 | 70.57 | 17.37 | 2.763 | .066 |
| | 750-1000 $ | 50 | 63.02 | 10.93 | | |
| | >1000 $ | 120 | 61.59 | 9.22 | | |
| District | Camp | 4 | 58.75 | 10.24 | .327 | .722 |
| | Village | 92 | 62.15 | 10.14 | | |
| | City | 81 | 62.75 | 10.38 | | |
| Position | Nurse | 89 | 62.19 | 10.15 | .111 | .895 |
| | Senior Nurse | 83 | 62.40 | 10.33 | | |
| | Head Nurse | 5 | 64.40 | 11.19 | | |
| Hospital (unit) | Alwatani (CCU) | 16 | 63.69 | 17.43 | .504 | .805 |
| | Alwatani (ICU) | 16 | 64.19 | 10.46 | | |
| | Qalqilia (ICU) | 19 | 64.42 | 10.53 | | |
| | Rafeedia (ICU) | 28 | 60.21 | 9.64 | | |
| | Ramallah (CCU) | 36 | 61.78 | 8.90 | | |
| | Ramallah (ICU) | 49 | 62.45 | 9.04 | | |
| | Salfeet (ICU) | 13 | 61.23 | 7.21 | | |
| Nursing qualification | Diploma or less | 16 | 68.56 | 14.82 | 5.811 | .004 |
| | Bachelor | 145 | 61.17 | 9.21 | | |
| | Master or more | 16 | 66.88 | 10.63 | | |
| Department of work | Cardiac care unit | 56 | 63.35 | 11.89 | .892 | .374 |
| | Intensive Care Unit | 121 | 61.88 | | | |
| Working experience | Less than 5 years | 45 | 62.44 | 12.84 | 1.295 | .278 |
| | 5-10years | 87 | 62.48 | 8.44 | | |
| | 11-15years | 37 | 60.62 | 9.66 | | |
| | over 15 years | 8 | 68.38 | 13.11 | | |
| communicate bad news Training | No | 147 | 62.31 | 10.02 | -.088 | .930 |
| | Yes | 30 | 62.50 | 11.25 | | |
| Period of training course | None | 147 | 62.32 | 10.02 | 1.134 | .324 |
| | ≤ 1 week | 21 | 60.67 | 11.35 | | |
| | > 1 week | 9 | 66.78 | 10.39 | | |

The multivariate linear regression statistical examination proved that the monthly salary was predictive of the nurses participating in the study level of knowledge on the subject of communicating bad news, Where the analysis showed that high-income nurses were

more knowledgeable than others, and low-income nurses were less knowledgeable than others.while the other variables had no predictive ability.

**Table 4**

*linear regression for demographic characteristics of nurses in predicting the nurse's level of knowledge on communicating bad news*

| | B | Std. Error | Beta | T | P value | 95.0% C I (B) Lower Bound | 95.0% C I (B) Upper Bound |
|---|---|---|---|---|---|---|---|
| (Constant) | 71.003 | 8.093 | | 8.774 | .000 | 55.026 | 86.979 |
| Participant Age | -.627 | 2.118 | -.035 | -.296 | .768 | -4.808 | 3.555 |
| Gender | .038 | 1.738 | .002 | .022 | .983 | -3.394 | 3.470 |
| Marital status | -1.202 | 1.810 | -.060 | -.664 | .508 | -4.776 | 2.372 |
| Nursing qualification | .861 | 1.956 | .036 | .440 | .660 | -3.000 | 4.723 |
| Monthly salary | -3.675 | 1.725 | -.201 | -2.131 | .035 | -7.079 | -.270 |
| District | .585 | 1.470 | .031 | .398 | .691 | -2.316 | 3.487 |
| Department of work | -1.826 | 1.724 | -.083 | -1.059 | .291 | -5.229 | 1.577 |
| Working experience | 1.828 | 1.578 | .144 | 1.158 | .248 | -1.288 | 4.944 |

A Dependent Variable: Knowledge

### 4.4 Awareness about communicating bad news:

It is clear from the study participants’ nurses' answers to the questions about the awareness of communicating bad news that most of their interest and priority was the training and teaching courses regarding communicating bad news, as the highest percentage of their responses to the questions such as talking to patient important, specific training, need for training.

While the"I avoid talking with dying patient", "Patient should be told is dying", and "comfortable while breaking bad news" were the least interested in the nurses participating in the study.

**Table 5**

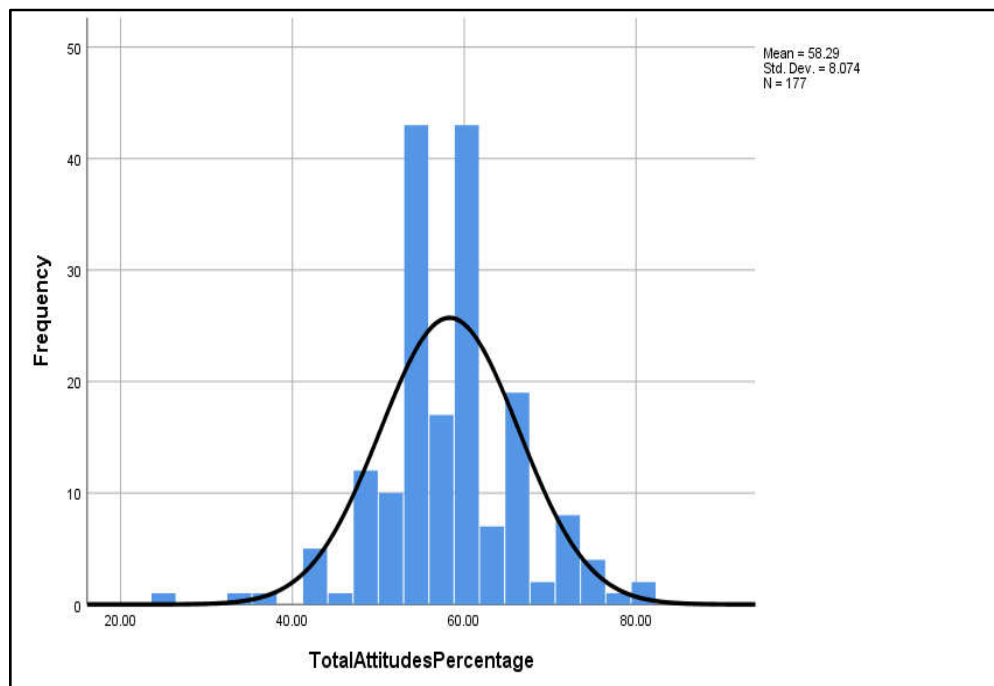
*Nurses' responses frequency and mean rank of items related to awareness about communication bad news*

| | Mean | SD | Item-Total correlation | percentage |
|---|---|---|---|---|
| Talking to patient is important? | 3.15 | .798 | .057 | 85.3 |
| Feel that any specific teaching / training for breaking bad news is necessary? | 3.02 | .856 | .067 | 77.9 |
| Need training in communication bad news? | 2.89 | .970 | .107 | 74.1 |
| Talking to patient's relative is important? | 2.66 | .994 | .173 | 61.6 |
| CBN can produce stress and anxiety in the recipient? | 2.65 | 1.266 | -.144 | 75.7 |
| Nurses need professionals need to consider impact on pt , their family and themselves. | 2.60 | 1.225 | -.020 | 68.4 |
| Alters a person's view of the future: drastically & negatively if not done properly | 2.57 | 1.417 | -.242 | 74 |
| Do you feel that you are able to break bad news? | 2.45 | .941 | .183 | 56.5 |
| Caring for dying patient may be rewarding for a nurses | 2.45 | .916 | .209 | 56 |
| Do you feel you can confidently communicating Bad News? | 2.25 | .964 | .167 | 44 |
| I feel distressed while communicating with dying patients? | 2.25 | .986 | .226 | 47.4 |
| Very little can be done by nurses for patients who are dying? | 2.23 | .980 | .176 | 42.4 |
| Nurses should not worry when patient die? | 2.03 | 1.087 | .225 | 38.4 |
| Nurses have been primary deliverers of bad news to patients? | 1.97 | .965 | .345 | 30.6 |
| I avoid talking with dying patients? | 1.67 | 1.141 | .197 | 23.1 |
| Patients should be told they are dying? | 1.48 | 1.197 | .262 | 23.2 |
| Are you comfortable while breaking bad news? | 1.33 | 1.101 | .300 | 17.5 |

Figure 2 reflects that the average awareness level of the nurses participating in the study on the issues of communicating bad news was poor (58.2%) and that nearly 70% of the study participants had the average awareness level on the issues of communicating bad news between 50% and 66%.

**Figure 2**

*histogram of the average awareness level of the nurses participating in the study*




By examining, using t-test and ANOVA statistical tests, to measure the differences in the average awareness of communicating bad news among nurses, which are related to demographic variables, it was found that there is no difference in the average awareness of communicating bad news among nurses can be attributed to the demographic characteristics of the nurses participating in the study.

Despite the lack of statistical significance, the female nurses participating in the study had a higher average of knowledge than the males, while the study participants from the camps, singles, and those with lower incomes had the lowest average of awareness than their peers.

Through using t-test and ANOVA statistical tests, to measure the differences in the average awareness of communicating bad news among nurses, which can be attributed to work-related variables, it was found that work-related variables did not have a

statistically significant difference in the average awareness of communicating bad news among nurses.

Despite the lack of statistical significance, the Ramallah hospital ICU nurses, head nurses, bachelor, cardiac care unit, and experienced more than 5–10 years had a higher average of awareness about communicating bad news than their peers.

Despite the large number of nurses who claimed that they did not take any training about the process of communicating bad news, the statistical tests (t & ANOVA) did not find any statistically significant differences in terms of taking the training course or even the duration of the training course for nurses. However, the nurses who received training courses for more than a week on communicating bad news had a higher rate of awareness than others.

**Table 6**

*Demographic and characteristics, Work-related variables, Training Towards Communication Bad news of participants and awareness level on the issues of communicating bad news*

| | | | Awareness | | | |
|---|---|---|---|---|---|---|
| | | N | Mean | SD | t | P value |
| Gender | Male | 116 | 58.07 | 8.34 | -.490 | .625 |
| | Female | 61 | 58.70 | 7.58 | | |
| Marital Status | Single | 70 | 57.62 | 9.48 | .402 | .670 |
| | Married | 105 | 58.71 | 7.03 | | |
| | Divorced | 2 | 59.55 | 7.27 | | |
| Monthly salary | < 750 $ | 7 | 54.83 | 9.93 | .695 | .500 |
| | 750-1000 $ | 50 | 58.21 | 9.89 | | |
| | >1000 $ | 120 | 58.53 | 7.10 | | |
| District | Camp | 4 | 57.72 | 4.22 | .053 | .949 |
| | Village | 92 | 58.14 | 8.20 | | |
| | City | 81 | 58.50 | 8.14 | | |
| Position | Nurse | 89 | 57.85 | 8.75 | .305 | .737 |
| | Senior Nurse | 83 | 58.68 | 7.51 | | |
| | Head Nurse | 5 | 59.71 | 3.97 | | |
| Hospital (unit) | Alwatani (CCU) | 16 | 59.47 | 8.79 | 1.724 | .118 |
| | Alwatani (ICU) | 16 | 57.44 | 7.68 | | |
| | Qalqilia (ICU) | 19 | 54.10 | 8.82 | | |
| | Rafeedia (ICU) | 28 | 56.67 | 8.56 | | |
| | Ramallah (CCU) | 36 | 58.42 | 6.31 | | |
| | Ramallah (ICU) | 49 | 60.05 | 8.48 | | |
| | Salfeet (ICU) | 13 | 60.52 | 6.73 | | |
| Nursing qualification | Diploma or less | 16 | 55.33 | 8.84 | 1.199 | .304 |
| | Bachelor | 145 | 58.62 | 7.98 | | |
| | Master or more | 16 | 58.27 | 8.07 | | |
| Department of work | Cardiac care unit | 56 | 58.82 | 7.09 | .595 | .553 |
| | Intensive Care Unit | 121 | 58.04 | | | |
| Work experience | fewer than 5 years | 45 | 55.88 | 9.69 | 2.246 | .085 |
| | 5-10 years | 87 | 59.67 | 7.99 | | |
| | 11-15 years | 37 | 58.11 | 5.81 | | |
| | over 15 years old | 8 | 57.72 | 5.43 | | |
| Communicate bad news Training | No | 147 | 58.07 | 8.04 | -.796 | .427 |
| | Yes | 30 | 59.36 | 8.26 | | |
| Period of training course | None | 147 | 58.07 | 8.05 | .514 | .599 |
| | ≤ 1 week | 21 | 58.75 | 7.68 | | |
| | > 1 week | 9 | 60.78 | 9.84 | | |

The multivariate statistical examination proved that variables had no predictive ability.

**Table 7**

*linear regression for demographic and characteristics of nurses in predicting the nurses level of awareness on communicating bad news*

| | B | Std. Error | Beta | T | P value | 95.0% C I (B) Lower Bound | Upper Bound |
|---|---|---|---|---|---|---|---|
| (Constant) | 34.480 | 4.404 | | 7.829 | .000 | 25.785 | 43.175 |
| Participant Age | .342 | 1.153 | .036 | .296 | .767 | -1.934 | 2.617 |
| Gender | .685 | .946 | .059 | .724 | .470 | -1.183 | 2.553 |
| Marital status | .147 | .985 | .014 | .149 | .881 | -1.798 | 2.092 |
| Nursing qualification | .866 | 1.065 | .067 | .813 | .417 | -1.236 | 2.967 |
| Monthly salary | .369 | .939 | .038 | .393 | .695 | -1.484 | 2.222 |
| District | .356 | .800 | .035 | .445 | .657 | -1.223 | 1.935 |
| Department of work | -.353 | .938 | -.030 | -.377 | .707 | -2.206 | 1.499 |
| Working experience | .266 | .859 | .039 | .309 | .758 | -1.430 | 1.961 |

a Dependent Variable: Awareness

Between knowledge and awareness of breaking bad news, there was a statistically significant correlation (p = 0.014). The correlation was positive but low (r= 0.184) between knowledge and awareness about communicating bad news.

**Table 8**

*bivariate correlation between the nurses' knowledge and awareness of communicating bad news*

| | | Knowledge | Awareness (%) |
|---|---|---|---|
| Knowledge | Pearson Correlation | 1 | .184* |
| | Sig. (2-tailed) | | .014 |
| Awareness (%) | Pearson Correlation | .184* | 1 |
| | Sig. (2-tailed) | .014 | |

**Table 9**

*Reliability Statistics*

| | Cronbach's Alpha | Cronbach's Alpha Based on Standardized Items | N of Items |
|---|---|---|---|
| knowledge part | .771 | .800 | 25 |
| Awareness part | .616 | .616 | 17 |

# Chapter Five

# Discussion

## 5.1 Discussion

### 5.1.1knowledge

In Palestine, this is the first research of its kind. According to a review of the literature, there isn't a detailed study of Palestinian critical care nurses' awareness and knowledge of breaking bad news to nurse practices anywhere in our nation. For patients and their families, nurses are the most essential first point of contact. The current study examines nurses' awareness and knowledge of communicating bad news in intensive care units.

It is essential first to assess nurses' baseline knowledge toward communicating bad news in Intensive Care Units. Nursing knowledge assessment is also important because knowledge influences attitude and behavior consistency. In the current study, the average knowledge level for communicating bad news among intensive care unit nurses was poor (62.3%), and nearly 70% of the study participants had an average knowledge level of between 52% and 72% on the issues of communicating bad news.

This finding was reinforced by Imanipour et al. (2016) study. Only 16.2% of Iranian critical care nurses had a high level of knowledge, and he suggested that the fact that this topic is not covered in the official curriculum of nursing education at either the bachelor's or master's level may be the cause of the lack of knowledge regarding sharing bad news. which might be the same rationale for the poor level of knowledge about communicating bad news in Intensive Care Units among Palestinian ICU nurses. Accordingly, and based on the results, it is clear that there is a need for education in this area, particularly for nurses working in critical care units who are more likely to receive bad news and frequently have to deliver it based on personal experience. This finding is supported by the fact that 62% of the participating nurses felt that they needed education on how to deliver bad news.

Based on our results, the large number of nurses who claimed that they did not take any training about the process of communicating bad news, there are no statistically significant differences in terms of taking the training course or even the duration of the

training course and their knowledge. However, the nurses who received training courses for more than a week on communicating bad news had a higher rate of knowledge than others. Of these stats, confirmed by Muneer et al. (2018), Every healthcare professional must be able to deliver bad news effectively. Although nearly half of the respondents had received training in delivering bad news, there was no discernible difference in knowledge between those who had received this training and those who had not.Only a small percentage of nurses who work in intensive care units have received training in communicating bad news, according to this study. Additionally, we discovered that younger nurses with less work experience were less likely to be involved in breaking bad news.

Training is therefore a crucial element in the success of breaking bad news, but unfortunately, in our study, 83% of nurses had no formal training in delivering bad news, which can be attributed to a lack of knowledge shown previously in statistical analysis. Therefore, Workshops that teach how to deliver bad news will result in professionals who are more prepared and self-assured. Therefore, and based on the results of the Ferreira et al. (2017) study, Healthcare workers who take a course on conveying bad news are less likely to rely exclusively on their own experiences or observations, and they are more at comfort and confident when doing so. Therefore, nurses should be prepared with sufficient training and choice of patient skills to be able to communicate bad news appropriately. Additionally, poorly trained nurses with insufficient knowledge about communicating bad news might experience a greater sense of helplessness in communicating bad news and prefer to pass the duty of delivering bad news to doctors because they cannot deliver bad news resulting from insufficient knowledge and education (Rassin et al., 2006). So, educating and training nurses on communicating bad news not only enhances nurses' ability and confidence but can also have a significant impact on how patients and their families feel about the disease, how they will feel about the multidisciplinary team in the future, and how patients may suffer if there is no organized plan to deliver information. (Gilbey, 2010). Critical care nurses must therefore possess the necessary knowledge and abilities in order to deliver bad news in an organized and coordinated manner. This can decrease the risk of unfavorable outcomes for patients and their families as well as for the nurses themselves.

According to gender of ICU nurses participating and the average knowledge of communicating bad news (p = 0.46), Between the respondents, there was no statistically significant correlation. but the female nurses scored slightly higher than male nurses. Additionally, this outcome is comparable to that of a cross-sectional study done by Al-Mohaimeed et al (2013). The aim of this study was to investigate patient communication of bad news knowledge and practices. There were no significant differences between respondents' gender and average knowledge (p = 0.787), while, in contrast with the present study result, Rasmus et al. (2022) found that the frequency of sharing bad news varied significantly between male and female respondents (P 0.05). Delivering bad news is something that male participants typically say they do several times a year, whereas female participants say this has only happened a few times in their careers (P 0.05).

Communicating bad news can cause stress and anxiety, not only in the recipient but also in the provider. Almost half of the present study participants felt distressed when communicating bad news which is consistent with the result of Jameel et al.'s (2012) study, 85% of participants felt either uncomfortable or66% of respondents said they were only slightly comfortable breaking bad news to a patient in private, and they found it to be very or extremely stressful.Also, Patil et al. (2017) conducted a cross-sectional study and revealed that 75% had no knowledge about communicating bad news; 95% felt that it could change patients' opinions if it was done incorrectly; 75% could not comfortably pass on bad news, and 75% found it difficult to discuss the issue of end of life or the end of a patient's treatment.

The healthcare provider field, according to Martis et al. (2013), is unable to avoid telling the truth. It takes practice and development to develop the concepts and skills necessary to break bad news in a caring way, but this can be done by creating evidence-based theoretical frameworks and training programs.It is suggested that formal training in delivering bad news be given during the internship because it can enhance patient care, communication skills, and the nurse-patient relationship.

All the patients are distressed. When they are sick because they are unaware of their true condition and diagnosis. As a result, nurses have a responsibility to help with the relief of this suffering rather than worsen it through negative actions or emotions. As a

result, nurses must be careful while communicating bad news, using the correct skills to avoid using incorrect nonverbal language (Martin Hernandez, 2009).

Patients are reassured that they can depend on the nurses during their stressful time by behaviors like making eye contact, shaking hands, smiling, and expressing an empathic silence.de Oliveira, (2009). This assertion is consistent with our findings that 79.1% of nurses use looking at the patients' faces or in their eyes while they talk or listen to patients, and 56.5% of nurses feel they can break bad news. Nurses, should be provided with the appropriate training and skill sets to be able to deliver bad news in an appropriate manner. This finding is similar to that of Ferreira et al., (2017), as they discovered that 84.3% of the respondents communicated bad news using both verbal and nonverbal means.

The best place to break bad news is usually searched after by nurses. Setting up a private environment where there won't be any interruptions, such as a particular room or an open office, is one of the phases in communicating bad news. It would be best to select this. Furthermore, it must be established if the patient want to be attended throughout the talk or not. Ideally, the nurse should be seated next to the patient in order to ensure the patient's comfort and safety, as well as to show that they are both on the same level and in the same position.Applying this attitude will therefore provide the patient some room to relax and be at peace as well as some quiet time to listen. (2005) Buckman

These things may be evaluated by using some of the questionnaire's questions regarding how to communicate bad news. (Do you choose a quiet and peaceful setting before breaking unpleasant news? Do you guarantee that no anticipated disruptions (phone, colleague consultation, etc.) will occur? Our research reveals that 48.6% of nurses make sure there won't be any foreseeable disruptions while communicating bad news, and 49.7% of nurses pick a secluded, peaceful setting before doing so. The outcome is consistent with Scheumann et al (2005).'s claim that only 33.7% of healthcare professionals communicate bad news in a suitable and private setting.While in contrast, Ferreira et al., (2017) found about 78% of healthcare practitioners chose a quiet, private location to communicate bad news and 56.20% listened carefully without interruptions.

Another step in communicating bad news is the time to evaluate how much the patient sense of awareness and determine whether there are any questions that need to be answered, so Many Healthcare professionals' fears of hurting and upsetting their patients, as well as their anxiety about being taken to task for or forced to handle their patients' emotions, can be used to explain why they have so many difficulties breaking bad news to patients. All of these feelings could all be unexpected and unpredictable (Adebayo et al. 2013). They could include denial, intense distress, blaming, or fear of emotions, illnesses, and demise. Despite the fact that some studies have indicated that patients want their healthcare providers to be sincere, compassionate, considerate, and affective as well as to allay any doubts they may have (Alrukban et al. 2014), They also demand communication effectiveness in addition to professionalism and clinical skill competence. However, it must not be donecoldly or carelessly (Nonino et al. 2012). So, in the current study, only 28.8% of the participants made sure the patient had no additional questions or doubts at the end of the conversation, but Ferreira et al. (2017) found that the majority of healthcare providers (51.24%) always reserved a time for answering questions.

With the use of clear, understandable language and comprehensive and detailed explanations, communication should take place slowly, gradually, and continuously in order to convey information related to the state of health. it is essential to use simple words, without medical terms, and it is recommended to present the matter with some phrases that indicate the proper transmission of bad news. In our study, Nearly 80.8% of nurses to help the patient accept the bad news, use language that is appropriate. (Ferreira et al., 2017) confirmed our finding that 85.95% of participants speak comprehensibly and clearly while avoiding medical terms when communicating bad news.

to make sure they were understood fully and to demonstrate empathy. Participants believed that dealing with patients' and their families' emotional needs was the most difficult part of BBN. (Rasmus et al.,2020).

### 5.1.2 Awareness

In the current study, the average awareness level of communicating bad news among intensive care unit nurses participating was poor (58.2%), and nearly 70% of the study participants had an average awareness level of between 50% and 66% on the issue of communicating bad news. These results are similar to a study by Dafallah et al. (2020) that assessed Sudanese healthcare providers' awareness and evaluated their methods for informing patients and their families of bad news. According to Dafallah's study, it appeared that 43.8% of participants had awareness related to communicating bad news. This was attributed to a lack of education or training, which is a widespread issue in various nations. In fact, effective communication is among the most crucial abilities for clinicians who work with patients frequently. In particular, when communicating bad news, it's worth noting that education alone won't help with bad news communication unless it's accompanied by training. The training will allow nurses to manage the stress that comes with receiving bad news and will assist them in developing confidence. According to the study, training and education are essential factors in achieving good communication of bad news.

To improve the awareness level among nurses, who in the future will be vital in providing healthcare, about communicating bad news to patients, Continuous educational initiatives are required, and they need to be incorporated into their study programs or on-the-job training as part of their curricula.The majority of participants in the current study stated that they had no formal training in communicating bad news.(Singh, 2018). Hebert et al. (2009) conducted research on the need for education to increase the awareness and knowledge of healthcare professionals, and the majority of participants had not received any formal training in improving their skills for communicating bad news.The majority of the research samples (63%) agreed that formal education is very essential for improving healthcare providers' skills in order to acquire the abilities to communicate bad news, although, in our study, 77.9% of the nurses felt that specific instruction and training in delivering bad news are required, and also 74.1% of the nurses said we need training in communicating bad news. To support the results of our study, according to research by Goncaluz et al. (2017) to assess healthcare providers' perceptions of bad news in Portugal showed that 85% of the study samples reported that communicating bad news it was a challenging task. In addition, It

is suggested that this education be given at the start of their education because 78% of respondents felt that they needed it in order to tell patients the bad news.

Dafallahet et al. (2020) confirmed this as well. Communication of bad news can be influenced by culture, beliefs, patient education level, traditions, and religious beliefs. Families are probably going to be very involved in the patient's decision and choice as a result, which could be the explanation why 34.6% of study participants think bad news should be shared with family.

Although the nurses in the present study considered talking to patients and family members important, 85.3% of them considered talking to the patient important while only 61.6% considered talking to family members important, which is inconsistent with the Sudan Medical Council. 65.6% of participants believed that bad news should be delivered to the patient directly, as well as this related to the increasing tendency to respect patient rights and confidentiality. It seems that Palestinian intensive care unit nurses like to approach patients rather than family members when communicating bad news, which contrasts with Sudan and other Middle Eastern and Far Eastern countries, where the family is informed of breaking bad news rather than the patients themselves. It was also demonstrated by Muneer et al., (2018) study that the majority of healthcare providers (81.8%) believed that patients have a right to be informed of all aspects of their diagnosis. Just 20% of healthcare providers would cover the diagnosis of a patient if the patient's relatives requested it.

lack of preparation. (At this time, it is important to find out the patient's knowledge of his or her illness or condition, as well as whether he or she wants to be informed about it and what concerns him or her) Buckman (2005), among the nurses in our hospitals This might be explained by the nurse’s fears, which were mainly based on how the patient reacted and the possibility of destroying their hopes.conducted a study in brazil by Ferreira et al.,(2017) it was shown that around 50% of the experts did not address all of the issues, indicating a gap in the interaction between health care providers and patients in our study 44.6% of nurses Before begining the conversation, they discover what the patient already knows about the information you will communicate.In contrast, a study carried out in Cuba by Martn Hernández (2009), in which better addressed and investigated these issues by healthcare professionals (72%).

In our study, 44% of nurses feel confident while communicating bad news. This is similar to Singh, (2018), who found that more than 30.7% of nurses feel confident in communicating bad news. Most Nursing staff felt structured protocol is required for breaking bad news, more than 80 % of participants believe that patients should be informed of serious, potentially fatal illnesses as soon as they are diagnosed.

The main obstacles that the nurses felt while delivering negative news to the patient were: the lack of all relevant information related to the illness and the patient; discomfort in dealing with the feelings of the patient or relatives; lack of privacy; patients and relatives not understanding the medical language; and the patient not being treated properly. In our study, 82.5% of nurses are not-comfortable while breaking bad news, and also 47.4% of nurses feel distressed while communicating with patients. Singh, ( 2018) reported that 75 % of healthcare providers' staff thought Passing the bad news to patients and relatives was extremely stressful, although some of them responded that initially, it was stressful, but now it was a routine.

A study by Singht (2018) showed that the varied responses to bad news seen while delivering bad news to patients and their families, nearly 70–80% of staff experienced denial, shock, anger, guilt, blame, agitation, helplessness, a sense of unreality, misinterpretation of facts, and regret/anxiety. In our study, 75.7% of nurses said that Communicating Bad News can cause recipients to feel stressed and anxious.

Breaking news is a component of medicine's art. The bad news is never good news, no matter how well you say it. However, the method of transmission can have a significant impact on both the giver(the nurse) and the recipient (the patient). If done incorrectly, it will harm the patient's wellbeing, reduce their quality of life, and obstruct their ability to contact a healthcare provider in the future.It is a must-have skill for caregivers to learn, and effective techniques for teaching communication skills are available. Fallowfield et al.,(2002). Also, Rosenbaum et al. (2003) reassure us that Patients benefit therapeutically from good communication, while poor communication has a negative effect.Through structured training programs and appropriate feedback for the trainees, communication skills can be improved.The task of breaking bad news is trained through educative lectures, small-group discussions, role-playing, and instruction in the context of patient care in curricula.74% of nurses in our study insure that communicating bad

news, if not done properly, drastically and negatively affects how someone views the future. Patil et al.,(2017) It was noted According to the research, 81% of respondents think that communicating bad news is done improperly could drastically and negatively change a person's outlook on the future.

to improve skills very effectively Role-playing, videos, and other constructive suggestions were used. It should be noted that there is insufficient research to support the current approaches to teaching and training employees how to deliver bad news. Practice and education in breaking bad news may not be effective for enhancing patients' well-being if there is no strong evidence base to support it. Paul et al., (2009).

The presentation of news about cancer is commonly unpleasant, and due to the nature of bad news, medical professionals and other staff who work in the treatment sector experience psychological stress when transmitting this news. A lack of communication skills in reporting bad news among doctors and the treatment staff contributes to some of this psychological stress. 67.3% demand for the availability of a psychology consultant is necessary at the time of or after disclosure of bad news. Mohamed, (2018). In our study, 67.2% of nurses need professionals need to consider impact on patients, their families, and themselves. According to Patil et al.(2017), 82% of participants believed that healthcare professionals needed to keep in mind how bad news can affect patients and their families. Mohamed (2018) In this study, our respondents (65.3%) strongly agreed that nurses should take the psychological state of patients when delivering bad news. This is similar to a study conducted in Iran when they asked their respondents what they thought was most likely to cause patients to refuse sharing bad news, and they were concerned about their emotional and anxiety responses.

Jameel et al., (2012) study showed that Pakistan's postgraduate healthcare providers are unaware of the complexity of the Breaking Bad News process. The residents were willing to receive training in these soft skills, and after attending the structured programs, they demonstrated a remarkable improvement in their perceptions and skills, which is a strong and encouraging finding from the study. These studies, along with our own, clearly demonstrated the critical role that structured training in communication skills plays in enhancing students' levels of confidence and lowering their stress and anxiety. Increased patient satisfaction and an improved nurse-patient relationship are

other effects of better communication skills. Our nurses feels they can confidently communicating Bad News 44% and 77.9% believes that special education and training is required for communicating bad news.

### 5.1.3 Conclusion

Communicating bad news is a difficult process that need adequate awareness and knowledge. In the current study, the average knowledge level of communicating bad news in intensive care unit nurses was poor (62.3%) and the average awareness level of communicating bad news in intensive care unit nurses was poor (58.2%).

There were a large number of nurses who claimed that they had not received any training about the process of communicating bad news. Therefore, a vital element in the success of communicating bad news is training, but unfortunately, in our study, 83% of nurses had no formal training in communicating bad news., which can be attributed to a lack of knowledge. Therefore, Holding classes that cover how to deliver bad news will produce in professionals that are more prepared and self-assured..

Although 77.9% of the nurses thought that specific education and training in communicating bad news was necessary., 74.1% of nurses felt training in communicating bad news was needed. Communicating bad news can cause stress and anxiety, not only in the recipient but also in the provider. Approximately half of our study participants felt distressed when communicating bad news.

Although the nurses in the present study considered talking to patients and family members important, 85.3% of them considered talking to the patient important while only 61.6% considered talking to family important. This study emphasizes the need for developing nurses' knowledge and awareness about communicating bad news. Communicating bad news should become an integral part of all nursing school curricula as well as nursing program offerings and continuing medical education.

## 5.2 Limitations

1. Comparison and discussion are difficult as there is no similar research conducted in Palestine or other countries in the world.
2. It was difficult for this study to evaluate the actual practice of nurses in communicating bad news because there was no standard tool for practice and no communication bad news units in the hospitals involved.
3. The mismatch between the practice of communicating bad news and undergraduate ethics and law education.
4. The study indicates that our interns are willing to learn communication skills to improve their clinical encounters.
5. One of the study's limitations is that it was performed on nurses employed by government hospitals and cannot be generalized to all nurses. The second is that the questionnaire in use only shows nurses' opinions; it does not demonstrate how well they communicate bad news. People do not always act in accordance with their beliefs.

## 5.3 Recommendations

According on the study's findings, the following recommendations had been made:

1. Communicating bad news should be done by nursing to most sick patients in the ICU.
2. Update and provide further education for nurses in ICU.
3. Communicating bad news should be one of the nursing license renewal courses.
4. Universal protocol for communicating bad news to critically ill patients should be followed Breaking bad news is a fundamental nurse’s skill.
5. Additional research in to communication bad news in critical care units as a foundation for continuous advances in everyday nursing practices.
6. Frequent assessments of communicating bad news by nurses should be maintained and documented in nursing documentation.

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## Appendices

## Appendix A

## Questionnaire

نموذج موافقة الاشتراك بالبحث العلمي:

اسم الباحث: معاذ ريان – طالب ماجستير تمريض عناية مكثفة - جامعة النجاح الوطنية.
المشرف: الدكتور عدنان سرحان
جامعة النجاح الوطنية – ماجستير تمريض .
**عنوان البحث :**
Knowledgeand Awareness of Palestinian Critical care Nurses about Communicating bad news

**مدى امتلاك الممرضين الفلسطينيين العاملين في العناية المكثفة لمهارات توصيل الأخبار السيئة للمرضى وعائلاتهم .**
عزيزي المشارك / عزيزتي المشاركة :
أنت مدعو/ة للمشاركة ببحث علمي كجزء من الحصول على درجة الماجستير , الرجاء أن تأخذ الوقت الكافي لقراءة المعلومات التالية بتأن قبل أن تقرر إذا كنت تريد المشاركة أم لا .بإمكانك طلب إيضاحات أو معلومات إضافية عن أي شيء مذكور في هذه الاستمارة أو عن هذه الدراسة ككل من الباحث . من حقك الرفض أو المتابعة في الاشتراك في هذه الدراسة في أي وقت تشاء.
لا داعي لذكر الاسم أو أي معلومات شخصية حساسة. ونود إعلامكم بان المعلومات المأخوذة منكم هي لغاية البحث العلمي فقط.

توقيع المشترك: ..................

الباحث:معاذ عزت رزق ريان 0598165722

**البيانات الديموغرافية :**

**الفئة العمرية :**

20-30سنة 31-40 سنة 41-50 >50سنة

**الجنس :**

أنثى ذكر

**الحالة الاجتماعية :**

مطلق او خيارات اخرىمتزوج أعزب

**مؤهل التمريض :**

ماجستير أوأعلابكالوريوس دبلوم

**الراتب الشهري :**

750 >$ 750-1000 $ >1000 $

**مكان السكن :**

مخيمقريةمدينة

**قسم العمل :**

وحدة العناية المكثفة وحدة العناية القلبية

**الخبرة العملية :**

اقل من 5 أعوام 5-10 أعوام 10-15 أعلى من 15 عامعام

**هل تدربت على طريقة توصيلالأخبار السيئة :**

لا نعم

**إذا نعم ,فترة التدريب :**

أسبوع واحد او اقل أكثر من أسبوع

**المؤهل العملي:**

ممرضمسؤلممرض خبيرممرض

**مكان العمل:**

☐ وحدة العناية المكثفة في المستشفى الوطني ☐ وحدة العناية المكثفة في مستشفى رفيديا

☐ وحدة العناية المكثفة في مستشفى رام الله ☐ وحدة العناية القلبية في مستشفى رام الله

☐ وحدة العناية القلبية في مستشفى الوطني ☐ وحدة العناية المكثفة في مستشفى

☐ وحدة العناية المكثفة في مستشفى قلقيلية

**اسئلة المعرفة بنقل الاخبار السيئة للمريض**

| السؤال | ابدا<br>0 | نادرا<br>1 | احيانا<br>2 | غالبا<br>3 | دائما<br>4 |
|---|---|---|---|---|---|
| 1.هل تختار مكان خاص وهادئ مسبقا قبل إيصال الخبر السيئ؟ | | | | | |
| 2.هل تتأكد من عدم حدوث تشتيت متوقع(هاتف ، استشر زميل ، وما إلى ذلك)؟ | | | | | |
| 3.هل المدة مخطط لها مسبقا؟ | | | | | |
| 4.هل تقوم بتقديم نفسك للمريض ف البداية؟ | | | | | |
| 5.هل تخاطب المرضى بأسمائهم؟ | | | | | |
| 6.هل تنظر في عين المريض اثناء الكلام والاستماع؟ | | | | | |
| 7.هل تقوم قبل ان تبدأ المحادثة باكتشاف معرفة المريض مسبقا حيال الاخبار السيئة التي ستنقلها اليه؟ | | | | | |
| 8.من اجل معرفة ماذا يعلم المريض وما هو مقدار ما يريد معرفته هل تستخدم أسئلة مثل قبل انا ابدا الكلام هل تريد مني ان اخبرك أي شيءتسألني أي شيء؟ | | | | | |
| 9.قبل نقل الخبر السيئ هل تستطيع ان تعرف بأي طريقة سيؤثر الخبر على المريض اجتماعيا او على حياته العملية؟ | | | | | |
| 10.في حالة ان المريض لا يرغب او ليس متاكد بانه يريد ان يعرف الخبر هل ستعطيه وقتا ليفكر في الامر ؟ | | | | | |
| 11.هل تميل الى تنويع الخطاب مع المريض لتهيئته بسلاسة في سياق الكلام؟ | | | | | |

| 12.هل ستأخذرأي المريض بعين الاعتبار؟ | | | | | |
|---|---|---|---|---|---|
| 13.هل تستخدم لغة سهلة تسمح للمريض بان يستوعب الخبر السيئ؟ | | | | | |
| 14.هل تقوم بنقل الخبر السيئ بطريقة منظمة ومنسقة ولا تدلي باية معلومة أخرى حتى تتاكد بان المريض قد استوعب كامل المعطيات ؟ | | | | | |
| 15.هل تقوم بسؤال أسئلة لتتبين شعور المريض؟ | | | | | |
| 16.في حالة شعور المريض بالخوف او القلق هل تقوم بقول وإظهار وعيك لردوده ؟ | | | | | |
| 17.عندما يقوم المريض بالرد بتوتر او خوف او حزن او عدائيا هل تستطيع ضبط نفسك وتواصل الاصغاء ؟ | | | | | |
| 18.هل تقوم بإظهار الدعم والتفهم للمريض بلغة الجسد او الإيماءات؟ | | | | | |
| 19. عندما تقوم بنقل الأخبار السيئة هل تصف أفكارك بكل ثقة ؟ | | | | | |
| 20.اذا حدث معارضة من المريض هل ستنتظر لمعطياتهم وتجد حلا للمشكلة؟ | | | | | |
| 21.هل تستطيع ان تلاحظ المشاعر التي ترافق المريض بعد تلقيه الخبر السيئ؟ | | | | | |
| 22.هل تقوم بالتاكد بعد انتهاء المحادثة بانه لا يوجد اية شكوك لدى المريض؟ | | | | | |
| 23.هل تقوم بتكوين خطة للعناية عند الضرورة مع المريض في حالته الجديدة؟ | | | | | |
| 24.هل تستطيع ان تستكشف التحديات المحتملة بعد قيامك بنقل الخبر السيئ وهل لديك إستراتيجية لتجنبه مستقبلا؟ | | | | | |
| 25.هل تودع المريض بعد الانتهاء من المحادثة؟ | | | | | |

**اسئلة مدى وعي الممرضين بنقل الاخبار السيئة للمريض :**

| السؤال | اعارض بشدة 0 | اعارض 1 | محايد 2 | موافق 3 | موافق بشدة 4 |
|---|---|---|---|---|---|
| 1.هل تحتاج تدريب من اجل نقل الاخبار السيئة؟ | | | | | |
| 2.قام الممرضين في البداية بنقل الاخبار السيئة للمرضى. | | | | | |
| 3. نقل الخبر السيئ يستطيع ان يسبب التوتر والاجهاد في نقله؟ | | | | | |
| 4.الممرضين يحتاجون الى مختصين لاعتبار الأثر على المرضى وعائلاتهم وانفسهم. | | | | | |
| 5.يغير نظرة الشخص إلى المستقبل: بشكل جذري وسلبي إذا لم يتم بشكل صحيح . | | | | | |
| 6.هل تكون مرتاحا خلال نقلك للأخبار السيئة؟ | | | | | |
| 7.هل ترى ان تدريب او تعليم لنقل الاخبار السيئة يعتبر ضروريا؟ | | | | | |
| 8.هل تشعر أنه يمكنك بثقة نقل الأخبار السيئة؟ | | | | | |
| 9.هل تشعر أنك قادر على نقل الأخبار السيئة؟ | | | | | |
| 10.الحديث مع المريض ضروري؟ | | | | | |
| 11.الحديث مع أقارب المريض ضروري؟ | | | | | |
| 12. قد تكون رعاية المريض المحتضر مجزية للممرضين؟ | | | | | |
| 13.يجب ان لا يقلق الممرضين عندما يتوفى المريض؟ | | | | | |
| 14.اشعر بالتوتر اثناء حديثي مع المرضى الذين يحتضرون؟ | | | | | |
| 15.القليل ما يستطيع فعله الممرض للمرضى الذين يحتضرون؟ | | | | | |
| 16.يجب اخبار المرضى بانهم يحتضرون؟ | | | | | |
| 17.انا اتجنب الحديث مع المريض الذي يحتضر ؟ | | | | | |

**Demographic data:**

**Participant Age:**

☐ 20-30 years ☐ 31-40 years ☐ 41-50 years ☐ >50 years

**Gender**

☐ Male ☐ female

**Marital status**

☐ Married ☐ single ☐ divorced or other

**Nursing qualification**

Dip☐a or less Ba☐lor Ma☐r or more

**Monthly salary**

☐50 $ ☐-1000 $ ☐000 $

**District**

☐ city ☐ illage ☐ amp

**Department of work**

☐ Intensive Care Unit ☐ Cardiac care unit

**Working experience**

☐ Less than 5 years ☐ 5-10 years ☐ 11-15 years ☐ above 15 years

**Training towards Communication bad news**

☐ Yes ☐ No

**Period of training course**

☐ 1 week and less ☐ more than1 week

**POSITION**

☐ Nurse ☐ Senior Nurse ☐ Head Nurse

**Place of work:**

☐ vatani hospital (ICU) ☐ eedia hospital (ICU)

☐ Ramallah hospital (ICU) ☐ Ramallah hospital (CCU)

☐ vatani hospital (CCU) ☐ Salfeet hospital (ICU)

☐ qilia hospital (ICU)

knowledge for communication bad news:

| Question | Never<br>0 | Rarely<br>1 | Sometimes<br>2 | Often<br>3 | Always<br>4 |
|---|---|---|---|---|---|
| 1.Do you choose a quiet and private place before hand to communicate bad news? | | | | | |
| 2. Do you ensure that there will be no foreseeable interruption occurring (phone, consult by a colleague, etc.)? | | | | | |
| 3. Do you plan the duration? | | | | | |
| 4. Do you introduce yourself to the patient first? | | | | | |
| 5. Do you call the patients by their name? | | | | | |
| 6. Do you look at the patients face or in the eyes while you talk or listen? | | | | | |
| 7. Before starting the conversation, do you find out what the patient already knows about the news that you are going to communicate? | | | | | |
| 8. To find out what the patient knows and how much they want to know, do you use questions such as:<br>Before I talk, do you want to tell me anything or ask me something? | | | | | |
| 9. Before communicating bad news, do you find out in what way the news may affect the patient's personal, Social or work life? | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 10. In the event that the patient is unsure they wish to be informed, do you give the patient time to consider it? | | | | | |
| 11. Do you tend to facilitate dialog with the patient or let them vent/blow off steam talking? | | | | | |
| 12. Do you keep in the mind the opinion of the patient? | | | | | |
| 13. Do you use appropriate language to allow the patient to digest the bad news? | | | | | |
| 14. Do you communicate the bad news sequentially and in an organized manner, not giving more Information until you are sure that the information already given has been digested? | | | | | |
| 15. Do you ask a question to find out how the patient is feeling? | | | | | |
| 16. In terms of the feelings, fears and worries of the patient, do you verbally express your awareness or Responsiveness? | | | | | |
| 17. When the patient's response is anxiety, fear, sadness or aggression, do you maintain an attitude of active Listening? | | | | | |
| 18. Do you show support and understanding non-verbally? | | | | | |
| 19. When you communicate bad news, do you present yourself assertively, expressing your thoughts Confidently? | | | | | |
| 20. If a disagreement with the patient exists, do you wait for their input and find a solution to the problem? | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 21. Do you observe the emotions that have emerged in the patient following the communication of bad News? | | | | | |
| 22. Do you ensure that at the end of the conversation the patient has no further doubts or questions? | | | | | |
| 23. Do you establish, if necessary, a care plan together with the patient to address the new situation? | | | | | |
| 24. Do you explore the possible occurrence of challenging situations after the communication of bad news and establish a strategy for future action? | | | | | |
| 25. Do you farewell the patient at the end of the conversation? | | | | | |

Awareness of communicated bad news

جامعة النجاح الوطنية

كليـة الدراسات العليا

# مدى امتلاك الممرضين الفلسطينيين العاملين في العنايـة المكثفة لمهارات توصيل الأخبار السيئـة للمرضى وعائلاتـهم

إعداد

معاذ ريان

إشراف

د. عدنان سرحان

قدمت هذه الرسالة استكمالا لمتطلبات الحصول على درجة الماجستير في تمريض العناية المكثفة، من كلية الدراسات العليا، في جامعة النجاح الوطنية، نابلس– فلسطين.

2022

# مدى امتلاك الممرضين الفلسطينيين العاملين في العناية المكثفة لمهارات توصيل الأخبار السيئة للمرضى وعائلاتهم

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## الملخص

**الخلفية:** "الأخبار السيئة" تشير إلى أي معلومات يتم تقديمها للمرضى وعائلاتهم قد تؤثر بشكل مباشر أو غير مباشر إلى أي اضطراب شديد غير مرغوب فيه يمكن أن يؤثر على آرائهم وموقفهم من الحياة في المستقبل. أصبح نقل الأخبار السيئة معترفًا به على نطاق واسع كمرحلة ويشير إلى أي معلومات غير سارة أو مزعجة أو صعبة تؤثر على تصورات المرضى عن حاضرهم ومستقبلهم.

**الهدف:** تهدف هذه الدراسة إلى تقييم مدى امتلاك الممرضين الفلسطينيين العاملين في العناية المكثفة لمهارات توصيل الأخبار السيئة للمرضى وعائلاتهم.

**الطريقة والإجراءات:** لاستكشاف كيفية توصيل ممرضات الرعاية الحرجة للأخبار السيئة، تم استخدام التصميم الكمي المقطعي. تم استخدام استبيان مصدق يحتوي على أسئلة لتقييم وعي ممرضي الرعاية الحرجة ومعرفتهم بإيصال الأخبار السيئة للمرضى وعائلاتهم في مستشفيات شمال الضفة الغربية (نابلس ورام الله وسلفيت وقلقيلية). تم تجنيد جميع الممرضين العاملين في وحدات العناية المركزة في مستشفيات نابلس ورام الله من مختلف وحدات العناية المركزة ووحدة العناية القلبية.

**النتائج:** مائة وسبعة وسبعون ممرض شاركوا في هذا البحث. أظهرت النتائج أن متوسط مستوى المعرفة لممرضين الرعاية الحرجة المشاركين في الدراسة كان ضعيفًا (62.3٪). لا يوجد فرق في متوسط مستوى المعرفة في توصيل الأخبار السيئة بين الممرضات يمكن أن يعزى إلى الخصائص الديموغرافية

للممرضات المشاركات في الدراسة، حيث أن متوسط مستوى الوعي لدى الممرضات المشاركات في الدراسة حول موضوع توصيل الأخبار السيئة. كانت ضعيفة (58.2٪)، وأنه لا يوجد فرق في متوسط مستوى الوعي على إيصال الأخبار السيئة بين الممرضات يمكن أن يعزى إلى الخصائص الديموغرافية للممرضات المشاركات في الدراسة.

**الخاتمة:** توصلت الدراسة إلى ضعف معرفة الممرضين ووعيهم بكيفية توصيل الأخبار السيئة. كانت أهم مؤشرات الممارسة هي معرفة الممرضة ووعيها بتواصل الأخبار السيئة في وحدة العناية المركزة والبروتوكول أو السياسة. بالإضافة إلى ذلك، كانت العقبة الأكبر أمام توصيل الأخبار السيئة بين الممرضين هي افتقارهم إلى المعرفة.

**الكلمات المفتاحية:** أخبار سيئة، معرفة التمريض، توعية، وحدة العناية المركزة، وحدة العناية القلبية.