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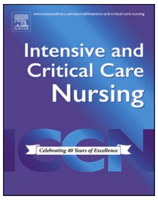

Research Article

Practice recommendations for culturally sensitive communication at the end of life in intensive care: A modified eDelphi study

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ABSTRACT

Background: Clinicians need specific knowledge and skills to effectively communicate with patients and their family when a patient is dying in the ICU. End-of-life communication is compounded by language differences and diverse cultural and religious beliefs.

Aim: The aim was to develop and evaluate practice recommendations for culturally sensitive communication at the end of life.

Method: Modified two-round eDelphi study. An Australian national sample of 58 expert ICU clinicians of nursing and medical backgrounds participated in an online survey to rate the relevance of 13 practice recommendations. Ten clinicians participated in a subsequent expert panel interview to provide face validity and comprehensive details about the practical context of the recommendations. Survey data were analysed using descriptive statistics, interview data using deductive content analysis.

Results: All 13 practice recommendations achieved item content validity index (I-CVI) above 0.8, and scale content validity index (S-CVI) of 0.95, indicating sufficient consensus. Recommendations prioritising use of professional interpreters and nurse involvement in family meetings achieved near perfect agreement amongst participants. Recommendations to facilitate family in undertaking cultural, spiritual and religious rituals and customs, advocate for family participation in treatment limitation discussions, and clinician access to professional development opportunities about culturally sensitive communication also achieved high level consensus.

Conclusion: These practice recommendations provide guidance for ICU clinicians in their communication with patients and families from culturally diverse backgrounds.

Implications for clinical practice: Clinicians want practice recommendations that are understandable and broadly applicable across diverse ICU contexts. The high consensus scores confirm these practice recommendations are relevant and feasible to clinicians who provide end-of-life care for patients and their family members. The recommendations also provide clear guidance for ICU leaders, managers and organisational policy makers.

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Introduction

In the intensive care unit (ICU), end-of-life communication occurs every day [1], with global ICU mortality rates reported to be as high as 40 % [2], increasing substantially to near 100 % in low socioeconomic areas and regions with limited or no access to ICU facilities and technology [3]. When a patient is dying, doctors and nurses need specific knowledge and skills to effectively communicate with the patient and family [4]. End-of-life communication is complex, compounded by language differences and diverse cultural and religious beliefs [5–7]. Cultural diversity relates to more than race and ethnicity, and includes a person's country of birth, ancestry, language, religiosity, beliefs, customs, values and behaviours [8,9]. Ineffective end-of-life communication with patients who are culturally diverse, and their families, has significant implications, such as miscommunication and misunderstanding [10] and clinician-family conflict [6,11–13]. Conversely, effective communication reduces clinician burden and enhances family experiences of end-of-life care [4].

Internationally, medical [14,15] and nursing [16] guidelines exist for end-of-life care provision. There are also multiple studies that report practices and professional guidelines related to the provision of end-of-life communication in the ICU [17–20]. Yet, there is a paucity of research examining practices related to cultural diversity, specifically culturally sensitive communication at the end of life. There is also a clear need for practice recommendations specifically focused on culturally sensitive communication. For the purpose of this research, culturally sensitive communication is defined as "effective verbal and nonverbal interactions between individuals or groups, with a mutual understanding and respect of each other's values, beliefs, preferences and culture, to promote equity in healthcare with the goal of providing culturally sensitive care" [8], p. 384].

The overall aim of this modified eDelphi study was to develop evidence-based practice recommendations for culturally sensitive communication at the end of life in the ICU. Study objectives were to (1) measure the relevance of each practice recommendation with a panel of expert clinicians; and (2) achieve consensus and agreement on the feasibility, acceptability and meaningfulness of each recommendation.

Materials and methods

Design

The research was a two-round modified eDelphi study to develop and validate evidence-based practice recommendations for culturally sensitive communication at the end of life. The modified eDelphi technique is a multi-stage, iterative process, where a set of experts are asked their perceptions, opinions and experiences on a particular issue [21]. The modified eDelphi begins with carefully preselected statements, this approach uses a panel of experts to achieve consensus on a topic by engaging in multiple rounds [22]. For this study, a two-round modified eDelphi technique was used, where expert clinicians were asked to review 13 practice recommendations that were administered via an online survey followed by an online panel interview (eDelphi) from January to March 2024.

Development of practice recommendations

The practice recommendations were informed by three consecutive pieces of work. First, a concept analysis of international literature [8] explored the concept of culturally sensitive communication in healthcare. Second, a systematic review [23] explored how culturally sensitive communication is used by ICU clinicians when communicating with patients and families at the end of life. Third, a multimethod, multicentre project was conducted across four tertiary ICUs to investigate the practice of culturally sensitive communication at the end of life [24,25]. Thematic integration was used to iteratively synthesise the findings of each piece of work to develop the practice recommendations. The synthesis was initially completed by the first author, then independently reviewed by other members of the research team, with differences discussed and revisions negotiated until 13 practice recommendations were agreed on.

Population and sampling

Following organisational approvals, purposive sampling was used to recruit nurses and doctors through two Australian national professional intensive care organisations; the Australian College of Critical Care Nurses and the Australian and New Zealand Intensive Care Society, with combined reach exceeding 15,000 clinicians across 191 Australian ICUs in public and private health sectors [26]. Clinicians were asked to self-assess their suitability according to the inclusion criteria, to ensure participants were especially knowledgeable about, or experienced with, culturally sensitive communication at the end of life [27]. Purposive sampling occurred according to position level and years of experience, as outlined in Table 1.

Recruitment

Following ethical approval, representatives from the Australian College of Critical Care Nurses and the Australian and New Zealand Intensive Care Society sent an email invitation to participate to all members. For sufficient content validity, a minimum of 15 participants were required for the survey [28], and an ideal number of 10 participants to provide face validity during the expert panel interview [29].

Data collection

Participation included two rounds: Round One – a survey, and Round Two – a subsequent expert panel interview. For research rigor and accurate validation of the results, participants who completed Round One were invited to participate in Round Two.

Round one – Survey

A plain language statement was used to advise potential participants that involvement was voluntary. A link was provided to the online survey, with consent implied upon completion. As part of the survey, participants could also select to be involved in the Round Two expert panel interview. Expert clinician demographic data were collected, including age, gender, position in the ICU and years worked. Participants then rated 13 practice recommendations on a five-point Likert scale. Space was provided at the end of the survey for participants to provide additional comments. After one week, 58 expert clinicians, including 47 nurses and 11 doctors had completed the survey and provided their contact details to participate in the expert panel interview and the survey was closed. Only survey responses, completed in entirety, were included in data analysis.

Table 1
Inclusion and exclusion criteria.

Inclusion criteria	Exclusion criteria
Involved in the care or support of one patient who died, and their family member/s AND Registered nurse with a postgraduate qualification in intensive care or critical care, OR at least three years' experience working in intensive care or critical care settings OR Doctor such as a registrar* or consultant, who has had experience in managing patients in intensive or critical care settings	Resident doctors

*Note: Registrar is a doctor who is enrolled in a specialty training program.

Round two – Expert panel interview

Due to scheduling challenges across Australian time zones, not all participants could attend one interview, therefore five interviews were required to achieve the expert panel of 10 participants for face validity [29]. Interviews were conducted by the first author after the survey results were analysed. The purpose was to achieve face validity related to the wording and meaningfulness of each practice recommendation [29]. The interviews also provided an opportunity to ensure comprehensive understanding about the interpretation of the recommendations. Interviews were recorded and transcribed verbatim for analysis and ranged from 29 min to 46 min in duration.

Data analysis

For the Round One survey, categorical data were analysed and reported as proportions (%), normally distributed continuous data reported as means and standard deviations, and non-normally distributed continuous data reported as median and interquartile range. Demographic data were reported in aggregate form to protect participant confidentiality. The level of agreement for the practice recommendations were analysed using I-CVI (item content validity index) and S-CVI (scale content validity index). The I-CVI represents the proportion of agreement on the relevance of each practice recommendation, between zero and one [29], with a score of over 0.8 indicating sufficient content validity [30]. The S-CVI represents the overall proportion of agreement of the 13 evidence-based practice recommendations by expert panel members [29], with a score of over 0.9 indicating sufficient content validity [31].

Participants rated the relevance of each practice recommendation according to a five-point Likert scale, ranging from one (not at all relevant) to five (extremely relevant) [32]. For each practice recommendation, the I-CVI was calculated by computing the number of participants rating each practice recommendation as four 'very relevant' or five 'extremely relevant' on the five-point Likert scale divided by the total number of participants. Consensus was reached when the agreement index was 0.80 or more [32]. Whilst the intent was to use the Round Two expert panel interview to specifically discuss items where the agreement index was between 0.7 and 0.8 for a practice recommendation, as all practice recommendations scored 0.8 or higher, this was not necessary [32].

For the Round Two expert panel interview, clinicians confirmed consensus and agreement through open discussion of each practice recommendation. Deductive content analysis was used to analyse the expert panel interviews [33]. A deductive approach to interview analysis with the use of prior theoretical knowledge was deemed appropriate as the interview transcripts were analysed using the practice recommendations as a theoretical framework [34]. Illustrative quotes from interview participants are used to provide practical exemplars of the practice recommendations. The expert panel interviews were also analysed for examples of culturally sensitive communication more broadly, with findings presented thematically.

Ethics

Ethical approval to undertake this study was obtained (HEAG-H 96_2022). Support was also obtained from the Australian College of Critical Care Nurses and the Australian and New Zealand Intensive Care Society. Participants were provided with a plain language statement that included information about consent, and management of information to maintain confidentiality by providing potential participants with an explanation of what data were to be collected, and how the data would be managed and stored. To maintain confidentiality, all re-identifiable data were kept separate to the re-identifying key. Only the named researchers had access to the data. No identifiable data were included in dissemination of findings.

Results

Round one – Survey

Fifty-eight expert clinicians, including 47 nurses and 11 doctors participated in the modified eDelphi survey. The average age of survey participants was 47.2 (*SD*=10.7) years, and 81 % (n = 47) were female. The median years working as a nurse or doctor was 22.0 (IQR 14–31) years. The sample included participants from all states and territories of Australia (Table 2).

All 13 evidence-based practice recommendations achieved I-CVI above 0.8 and S-CVI of 0.95, indicating sufficient content validity. As each recommendation scored an I-CVI above 0.8, achieving consensus and meeting the requirement for inclusion, no changes were made prior to the expert panel interview (Table 3).

Round two – Expert panel interview

Five nurses and five doctors participated in the expert panel interview. The median years working as a nurse or doctor was 23.5 (IQR 18.5–31) years. Table 4 lists nurses' and doctors' characteristics.

Practice recommendations

In the expert panel interviews, participants discussed the importance of the 13 practice recommendations for the provision of culturally sensitive communication at the end of life. Table 5 provides a description of each practice recommendation, with illustrative quotes from participants. Quotes are attributed to the nurse (N) or doctor (D), followed by the interview (I) number. Overall, participants indicated that communication at the end of life with patients and family from culturally diverse backgrounds should be guided by "…*local knowledge of the cultures in your ICU… international guidelines are useful, but need to be broad*" (D1, I1). There was consensus amongst participants that the practice recommendations presented in the survey were broad enough to ensure the provision of culturally sensitive communication at the end of life "…*because every situation is different, and specific instructions may not apply in any context*" (D1, I5).

Table 2
Survey participant characteristics (N=58).

Characteristic	n	%
Nurse position		
Nurse	17	36.2
Clinical Nurse Specialist	16	34.0
Nurse Educator	6	12.8
Nurse Manager	5	10.7
Clinical Nurse Consultant	2	4.3
Nurse Researcher	1	2.1
Doctor position		
Consultant	9	81.8
Fellow	1	9.1
Senior Registrar	1	9.1
State or territory		
Australian Capital Territory	2	3.4
New South Wales	21	36.2
Northern Territory	3	5.2
Queensland	14	24.1
South Australia	3	5.2
Tasmania	2	3.4
Victoria	10	17.2
Western Australia	2	3.4
Not documented	1	1.7
Work profile		
Full-time	36	62.1
Part-time	20	34.5
Casual	2	3.4
Work setting		
Public hospital	41	70.7
Private hospital	9	15.5
Both public and private hospitals	8	13.8

Table 3
Practice recommendations.

For culturally sensitive communication at the end of life, members of the ICU treatingˆteam should:*	I-CVI
Take time to assess their own culture, values, beliefs, preferences and perspectives and how these may influence communication with patients and/or family members from culturally-diverse backgrounds	0.88
Assess and document patient and/or family preferences related to cultural, religious and spiritual beliefs and customs important to family and/or significant others	0.93
Facilitate time, space and privacy for family and/or significant others to undertake cultural, spiritual and religious rituals and customs	1.00
Assess and document patient and family preferred language in the medical record to prompt and promote professional interpreter use for those who speak a language other than English	0.98
Use professional interpreters for all communication with patients and/or family, where there is an actual or perceived language barrier	0.94
Assess and document patient and family religion and preference for religious leader/personnel involvement	0.91
Where possible, make use of private spaces, such as offices or meeting rooms for private and/or sensitive conversations and family meetings	0.98
Involve social workers and/or other social support personnel, such as pastoral care, in patient care and communication, commencing on admission	0.95
Advocate for family participation in meetings with the treating team to ensure their cultural needs and preferences are understood	0.96
Invite family members to participate in treatment limitation discussions according to their preference	0.98
Ensure the bedside nurse attends family meetings so that family members are supported	0.98
Have access to professional development opportunities, including formal education and in-house inservices, to build knowledge about cultural diversity, cultural awareness and culturally-sensitive communication	0.98
Have access to training opportunities such as simulation in culturally-sensitive communication, to support learning and practising of skills in culturally sensitive communication	0.83

*For each practice recommendation, the provision of culturally sensitive communication at the end of life applies to the care that is provided to patients and their family members before and after death.

ˆThe ICU treating team refers to clinicians, including nurses and doctors, and interdisciplinary team members, including (but not limited to) social workers, speech pathologists, physiotherapists, pharmacists and dieticians.

Note. Item content validity index is represented as I-CVI.

Table 4
Expert panel interview participant characteristics (N=10).

Characteristic	*M*	*SD*
Age	47.1	8.4
Gender	**n**	**%**
Female	7	70.0
Male	3	30.0
Participant profile		
Registered Nurse	5	50.0
Doctor	5	50.0
State or territory		
Australian Capital Territory	1	10.0
New South Wales	3	30.0
Northern Territory	2	20.0
Queensland	2	20.0
Tasmania	1	10.0
Victoria	1	10.0
Work profile		
Full-time	9	90.0
Part-time	1	10.0
Work setting		
Public hospital	5	50.0
Private hospital	3	30.0
Both public and private hospitals	2	20.0

Table 5
Evidence-based practice recommendations and illustrative quotes.

Recommendation	Illustrative quotes
Recommendation 1: Take time to assess their own culture, values, beliefs, preferences and perspectives and how these may influence communication with patients and/or family members from culturally-diverse backgrounds	"You do learn from your mistakes, so it's just helping us to always look at constant self-reflection and receiving feedback." (N1, I4) "Making sure you've looked at your own personal biases before you interact with your family." (D1, I5)
Recommendation 2: Assess and document patient and/or family preferences related to cultural, religious and spiritual beliefs and customs important to family and/or significant others	"Every patient has their own culture and you can't judge that from looking at them or their family, so we should ask" (D2, I1) "People may look like they're of a particular cultural background, but don't ever assume, that's really important. You need language around asking those questions. 'How can we best serve your loved one and you as a family? Is there anything that you can tell us about your family, your culture, spirituality, faith?', then just let that sit and see what they come back with" (N1, I3) "You don't have to be an expert in every culture to be good at this, I think realising that each patient has something that is important and having the presence of mind to realise that this is important, to ask the patient or the family what else about this person is important so we can provide them with better care". (D1, I1)
Recommendation 3: Facilitate time, space and privacy for family and/or significant others to undertake cultural, spiritual and religious rituals and customs	"This patient was the cook of the family, he would make a big feast and the family would gather… he was dying and … the family asked if they could have a feast in the ICU… so we had this massive feast and everyone said goodbye to him." (N1, I3)
Recommendation 4: Assess and document patient and family preferred language in the medical record to prompt and promote professional interpreter use for those who speak a language other than English	"When you have access to recommendations like this it forces you to go through a thought process… Have you thought of whether we need an interpreter? Does the family speak English? Having a checklist, even if it's a little bit generic, allows you to tailor it to your circumstance in your unit for that meeting." (D1, I5)
Recommendation 5: Use professional interpreters for all communication with patients and/or family, where there is an actual or perceived language barrier	"It's more difficult to get a formal interpreter than informal, we're often using colleagues that speak the same language, or family, because they're there all the time… you might get a formal interpreter for official meetings… because you want to make sure of that clear message." (N1, I5) "I think [the practice recommendations] captures it well… especially with the focus on access to intermediaries who are able to talk in both languages… talk human and clinician." (D3, I1)
Recommendation 6: Assess and document patient and family religion and preference for religious leader/personnel involvement	"If we don't know or if we're not expected to know what a different religion want, then that means that it's open for us to ask and then that helps family participate in that process." (N1, I5)
Religion 7: Where possible, make use of private spaces, such as offices or meeting rooms for private and/or sensitive conversations and family meetings	"It would be great for facilities to allocate specific family rooms… basic resources where these family meetings happen, unfortunately, realistically, there is limited space in our organisations… things that could be done better are usually done in a sub-optimal environment." (N1, I2)

(*continued on next page*)

Exemplars of culturally sensitive communication

In addition to commenting on the practice recommendations, participants provided broad exemplars of culturally sensitive communication from their clinical practice. Exemplars are presented according to

Table 5 (*continued*)

Recommendation	Illustrative quotes
Recommendation 8: Involve social workers and/or other social support personnel, such as pastoral care, in patient care and communication, commencing on admission	"The social worker, the support people, it depends on the family and the family dynamics and the local resources, but a good resource when needed, it can be a bit tricky after hours, and on weekends and so on." (D1, I5) "We would get palliative care involved at the end and we should have had this sorted at the beginning, we should have had Aboriginal liaison officers involved, this patient wanted to return to country but now they're going to die in a hospital." (N1, I4)
Recommendation 9: Advocate for family participation in meetings with the treating team to ensure their cultural needs and preferences are understood	"We need to have those conversations, so the patient and the family know… I've just seen it too many times in ICU, where the patient's family come to us and say they had no idea that this was going to happen, then at the last minute we're trying to organise a Rabbi to come in." (N1, I4)
Recommendation 10: Invite family members to participate in treatment limitation discussions according to their preference	In the context of involving families in treatment limitation discussions "…we try to humbly inquire about what their culture means, what does their faith, their spirituality, what does that actually mean to them? I want to know, what is your family culture as well? We really want to be very individual and offer them everything that we can." (N1, I3)
Recommendation 11: Ensure the bedside nurse attends family meetings so that family members are supported	"The bedside nurse is an absolute must in family meetings. The questions are often asked to the nurse afterwards and if the bedside nurse was not present, they can't really fill in the gaps." (D1, I5) "The bedside nurse needs to know what's happening and sometimes needs to advocate because often you've had the discussion, you know what they're thinking, where everybody's leading." (N1, I5)
Recommendation 12: Have access to professional development opportunities, including formal education and in-house inservices, to build knowledge about cultural diversity, cultural awareness and culturally-sensitive communication	"There is obviously education out there and professional development opportunities, but I would like to see more of a proactive requirement. The more opportunities and awareness should be a part of the practice that we do and not seen as an additional extra." (N1, I2)"I can only speak as a medical clinician… an intensivist… the way that end-of-life communication was taught when I came through leaves a lot to be desired." (D1, I1)
Recommendation 13: Have access to training opportunities such as simulation in culturally-sensitive communication, to support learning and practising of skills in culturally sensitive communication	"More training on the how and the time, the time to do it in the appropriate manner, the space to do it in the appropriate manner, but yeah, the education to have the skills to do it, but the right time and place. (N1, I1)

three themes with illustrative quotes used to represent participant voice: (1) respectfully communicating with family, (2) reflective practice, and (3) facilitating cultural and religious wishes.

Respectfully communicating with family. When a patient is dying in the ICU, they are often unresponsive due to circumstances surrounding their illness or injury, supportive therapy including mechanical ventilation, or sedative medications; therefore, communication mostly occurs with family members. Preparing to communicate with family includes *"…just being aware that they [family] are from a culturally diverse background allows you to think through what you would do and how you will approach the family"* (D1, I5). To aid in communicating effectively with family, and being sensitive to individual cultural needs, the significance of having clearly documented end-of-life care plans was emphasised *"…so that there is a form of communication around the patient and family's needs, particularly around culture and spirituality… it's got to be written down somewhere so it can be constantly referred to and handed over"* (N1, I1).

Communication with the family of a dying patient should be approached "*in a way that they understand it and feel comforted by the way that it is explained*" (D1, I1). There was also an overarching perception that clinicians need to be comfortable with asking questions of family in a culturally sensitive way, for example "*…it's more about ways of asking… opposed to actually having the answers, as the patients and their families have the answers*" (D2, I1). Being comfortable to ask questions of family was also important:

> "*…it's about communicating and asking, what do you need? What would you like? What can we do? What does that mean for culturally sensitive needs and how we do that with appropriate communication, and then communicate that to the rest of the team*" (N1, I1).

Conducting a pre-brief and debrief before and after family meetings was discussed as effective in enhancing clinicians' communication:

> *"We always do a debrief. How do you think that went? Who read the room? Sometimes you can see all the family, they might have 40 family members. So just debriefing of how it went, what can we do better, did we provide everything that the family needed?"* (N1, I3)

The role and use of professional interpreters in family meetings was also discussed by participants. A doctor discussed the need to *"take longer, lots of pauses, short sentences, simple language, keep checking for understanding"* so the professional interpreter can get *"the nuances, the right phrases in, so that nothing is lost in translation, because the interpreter is not a medical person, and more importantly, they can't read my mind"* (D1, I5). The same doctor discussed a situation where they were caring for a patient whose family spoke a language other than English and how they could have used the practice recommendations to prompt professional interpreter use in a family meeting:

> *"The family spoke reasonable English, but in between our conversations the wife would ask the husband in Hebrew to explain things, so I should have asked before and maybe should have organised a Hebrew interpreter. …if I had a checklist to go through before a family meeting as a prompt to ask the family, and if they said no, well you actually asked the question"* (D1, I5)

Nurse participants also discussed using professional interpreters to facilitate culturally sensitive communication, however challenges to their use were acknowledged *"…it's hard for Aboriginal and Torres Strait Islander peoples [Indigenous Australians] because they've got so many different languages. If you have an interpreter on call, they might not speak that particular dialect, therefore it's difficult to get interpreters on call"* (N1, I4). Another nurse described their experience of using professional interpreters in discussions where end-of-life care was being approached for the first time with families. This nurse discussed the length of time it takes for initial conversations about end-of-life care, and how using a professional interpreter increases that time, and the challenges associated with *"the interpreters telling you they are only booked for one hour"*. The nurse then stated:

> *"When we're delivering bad news, you can't squeeze that into an hour, some families need a lot more time, some families don't… it seems a time pressured conversation because there's always that in the background, we only get the interpreter for an hour and if we want to book them again, we need to see who is available, so that is a challenge"* (N1, I3)

Reflective practice. Reflective practice was highlighted as a way of communicating with cultural sensitivity, for example, "*we need to realise that we don't know about other people's cultures and instead of looking at it* *as a barrier, we need to think about what we can do to improve our own knowledge*" (N1, I4). Another nurse discussed asking, *"open ended questions of families, then you can see what their priorities are; they're not our priorities… we need to ascertain what their priorities are at end of life"* (N1, I3). Similarly, "*it's important that we recognise everyone as a human being and treat everyone with respect, irrespective of what our differences are… as soon as you've got that basic principle in your interactions, you can't go wrong*" (D1, I5).

The importance of taking a step back and asking, *"does the patient want this, is it culturally appropriate?"* (N1, I4) was also described. Conversely, a doctor discussed reflective practice as *"not being too sensitive, sometimes we do things that have no benefit to the patient, for the families, and society as a whole, just because we are trying to correct what was done badly before"* (D1, I5). Education was also seen as a priority to promote reflective practice:

> "*…the front line staff need this front and centre of their mindset with education awareness, because when these situations are upon us is not the time to be researching what to do, you already need to be in that space*" (N1, I2).

Practice that is not reflective, can lead to ineffective communication and associated implications including "*…poor care, futile therapy, or other things that are not patient-centred*" (D1, I5), and "*it can create more harm that not doing it at all*" (D1, I1). Ineffective communication also has implications for clinicians "*…that's probably one of the reasons for people wanting to give up ICU… that moral burden when you go back home and you wonder, have I actually helped anyone or have I harmed them*" (D1, I5). When acknowledging the importance of end of life communication, a doctor discussed *"…having witnessed firsthand how badly communication can be done when I am sitting within the dominant culture, the findings from this study will hopefully move that forward, but we do need to acknowledge there is no single universal answer"* (D1, I1). Finally, it was discussed that regardless of whether the patient is at the end of life, that reflective practice includes:

> *"Practising with respect and seeing the patient as an actual person and including that in the handover. It might be "this is Jim, he is a truck driver from wherever", or "this is whoever, who used to work as a circus performer in 1940", or just something about them that is only relevant to that person and it somehow gives a sense of who they are in their day to day life. Maybe one sentence which gives an indication of who that person is that sees them as an actual human being instead of a person with a severe brain injury, or a person with pneumonia, or the person in bed seven"* (D2, I1).

Facilitating cultural and religious wishes. One of the first steps in facilitating cultural and religious wishes is understanding the diversity within the definition of culture, related to the "*…intersectionality in how culture applies, not just to major ethnic groups, but also rooted within society which includes people from rural and remote areas, or people who are gender diverse, and so on"* (D1, I2). Another essential step in facilitating cultural and religious wishes starts at the:

> "*…community level including the cultural and religious leaders and getting them on board so people are aware of this, not after the patient or loved one is in ICU or has had a catastrophic event and is being considered for organ donation, it should be something that they've heard of before, so when you come into hospital, there's already some sort of work done, at least at the community level that everyone would have the same opportunities"* (D1, I5).

Participants discussed several examples where they had assisted families to undertake cultural and religious wishes at the end of life. A nurse discussed asking families *"is there anything that we haven't thought of that they would actually like to do in the room?"*, and that "*…our ICU is pretty much open to anything, there's not much we exclude. We'll have dogs that come in, things that are really important to that person. We'll have smoking ceremonies for some Indigenous patients*" (N1, I3).

A strategy in assisting families to undertake cultural and religious rituals includes involving a cultural leader, or liaison, for example *"…if I am in the Northern Territory and I want information about Aboriginal and Torres Strait Islander peoples, I go to the Aboriginal Liaison Officers and they will help me, and if they don't know, they'll source it"* (N1, I4). The same nurse stated that the Aboriginal Liaison Officers were not only helpful for facilitating the cultural and religious needs of the dying patient and their family, but also *"from a staff point of view for being able to educate us as well"* (N1, I4). Additionally, a nurse described searching for new ideas to enhance the way cultural and religious wishes are facilitated by implementing an:

> *"…end of life trolley which is like the old fashioned drinks trolley. We have things that will appeal to everybody, Bibles, Qurans, we have nice tea, China teacups. We've got beautiful coffee, diffusers, we can do handprints, take locks of hair, ECG strips. We're really trying to connect when we talk to these families, it doesn't matter whether they're from a particular cultural background, we offer anything* (N1, I3).

Finally, when reflecting on facilitating cultural and religious wishes and addressing the needs and fears of patients and their families at the end of life, it was emphasised "*…You only die once… when you refocus that attention to actually critically addressing someone's needs… you can give people a really good death*" (D2, I1).

Discussion

This is the first known study to evaluate practice recommendations for the provision of culturally sensitive communication at the end of life in the ICU. The national sample of expert clinicians, representing all states and territories in Australia, helped validate and contextualise the recommendations for use in clinical practice. These practice recommendations were intended for use in Australian ICUs, with scope to operationalise these according to specific ICU contexts and tailored to individual needs and preferences [35]. The practice recommendations were developed from a concept analysis [8] and systematic review [23], both comprising international literature, as well as a multimethod, multicentre, whole population data project [24,25]. As such, applicability to international settings is likely to be high.

Participants in this study emphasised the clinical usefulness of the practice recommendations as a checklist of items to prompt clinicians before and after family meetings. Clinicians want practice recommendations that are clear, understandable, and broad enough that they can be used in diverse intensive care contexts. It is therefore a major strength of this study that all 13 practice recommendations achieved a high level of consensus for their relevance to clinical practice, requiring no modification, indicating the practice recommendations are straightforward and feasible for use in clinical settings.

Professional interpreter use is considered the gold standard where language barriers exist [36–38], therefore it is not surprising participants in this study rated Recommendation Five so highly, yet they are not always used in clinical practice due to availability and the sudden nature of patient deterioration requiring urgent family meetings [23–25]. When professional interpreters are not used, there is a risk that patients and family that require an interpreter service are unable to actively participate in decisions about their care and do not receive care that meets their preferences, leading to a reduction in the quality of end-of-life care [39].

Participants confirmed the essential role of nurses in family meetings, a finding present in other work [24,40,41]. Although nurse involvement was a rated as a priority, the role of nurses in family meetings was reported to be that of an observer, rather than an active participant. Nurses are essential to advocate and provide support for family, and also after meetings as the family may have unanswered questions [13,40,42,43]. Yet, research indicates that nurses are not always involved in family meetings due to clinical care requirements, or simply not being invited to participate [43,44]. However, when nurses are involved, their role could be enhanced as an active member of the treating team with important expertise [23,45].

Recommendations to support family who wish to undertake cultural, spiritual and religious rituals and customs [4,46], and to advocate for family to participate in treatment limitation discussions also achieved high levels of consensus amongst participants in this study. Family involvement in treatment limitation discussions leads to enhanced family satisfaction with communication [35,47]. When family are not consulted or included, conflict can ensue, exacerbating anxiety and distress [13].

Finally, having access to professional development opportunities achieved a high level of consensus. Yet, participants reported their previous experiences with professional development in this area, whether through formal education or informal mentoring, as not being overly helpful to enhance their communication practices. Participants also acknowledged limited access to education opportunities to assist them to provide culturally sensitive communication at the end of life, similar to other studies [48,49]. Professional development opportunities should include education that has clearly defined objectives designed to consider the level of experience of participants, and be structured to include practice recommendations from professional intensive care organisations and societies including the Australian College of Critical Care Nurses, the Australian and New Zealand Intensive Care Society, and global peers such as the European Society of Intensive Care Medicine and the European Association of Critical Care Nursing [50].

Limitations

This study has some limitations. All 13 practice recommendations achieved a high level of consensus amongst participants, which may indicate potential bias in that only clinicians interested in the topic volunteered to participate. This may limit generalisability of the findings. The modified eDelphi included two-rounds with expert participants; the first round obtained a large sample size, however, in the second round, only 10 experts participated due to work schedules and other arrangements. Participants were recruited Australia wide, and the sample was not extended to international participants. Yet, due to the diversity in participant geographical locations in the sample, and the high level of cultural diversity in the Australian population in terms of country of birth, preferred language and religion, these findings should be generalisable to international populations. This study is a consensus of clinicians; patients and family were not asked about what they want for culturally sensitive communication at the end of life, however, literature including the perceptions of patients and families were used to develop the practice recommendations. The main strength of the study is the use of the modified eDelphi technique which enabled individual expert clinicians from across Australia to participate. The subsequent discussions with expert clinicians were also valuable to enhance understanding.

Conclusion

In this modified eDelphi study, we validated 13 evidence-based practice recommendations for the provision of culturally sensitive communication at the end of life in the ICU. In clinical practice, the recommendations provide guidance for clinicians in their communication with patients and family from culturally diverse backgrounds. This work is significant for policy makers at an organisational level, for clinicians who provide end-of-life care to improve the quality of communication, and for the overall end-of-life care experience for patients and families.

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Data availability statement

The authors confirm that the data supporting the findings of this study are available within the article.

CRediT authorship contribution statement

Laura A. Brooks: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Resources, Validation, Visualization, Writing – original draft, Writing – review & editing. **Elizabeth Manias:** Conceptualization, Formal analysis, Methodology, Resources, Supervision, Validation, Writing – review & editing. **Bodil Rasmussen:** Conceptualization, Formal analysis, Methodology, Resources, Supervision, Validation, Writing – review & editing. **Melissa J. Bloomer:** Conceptualization, Formal analysis, Methodology, Resources, Supervision, Validation, Writing – review & editing.

Declaration of competing interest

Melissa Bloomer is associate-editor for Intensive & Critical Care Nursing and was involved in the editorial review or the decision to publish this article. The other authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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