

Development of the 6S Dialogue Tool to facilitate person-centred palliative care

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Abstract

Aims: To develop and psychometrically test the 6S Dialogue Tool.

Background: The 6S Dialogue Tool was elaborated to provide knowledge to nurses about patients' preferences in congruence with the 6S person-centred palliative care model, which includes the S-concepts of self-image, symptom relief, self-determination, social relationships, synthesis and strategies. The tool needs to be scrutinized for appropriateness.

Design: A qualitative study investigating construct validity of the 6S Dialogue Tool.

Methods: Forty-six patients in palliative care services in Sweden responded to 15 questions from May 2015 - August 2016. Responses were analysed with qualitative content analysis.

Results: Six categories, capturing the meaning of the 6S-concepts, were formulated: Maintaining everyday life; Challenges in everyday life; Maintaining control; Maintaining selected relationships; Appraisal of life; and Appraisal of the future.

Conclusion: The responses to the 6S Dialogue Tool questions reflect the intent of the 6S-concepts. Nurses should integrate the 6S-concepts and the questions in their approach to facilitate to co-create meaningful palliative care in dialogue with the patient.

Impact: Patients' preferences must be explored to co-create palliative care in accordance with their own needs and beliefs. The 6S Dialogue Tool questions are suitable for obtaining patients' preferences and could be used as an approach in palliative care. Patients, families and nurses will have the potential to co-create palliative care and to improve possibilities for patients to have an appropriate death.

KEY WORDS

6S Dialogue Tool, nurses, palliative care, person-centred palliative care model, self-determination, self-image, social relationships, strategies, symptom relief, synthesis

1 | INTRODUCTION

Palliative care aims to improve well-being for patients at the end of life and their families (WHO, 2002). One way of applying this philosophy in clinical settings is *The 6S-model for person-centered palliative care*, based on the concepts of self-image, symptom relief,

self-determination, social relationships, synthesis and strategies (Ternestedt, Henoch, Österlind, & Andershed, 2017). The relevance of these concepts in a palliative context has previously been described from a professional perspective (Ternestedt, Andershed, Eriksson, & Johansson, 2012), but there remains a need to test the 6S-concepts from the patients' perspective. The 6S Dialogue Tool,

consisting of questions related to the 6S-concepts, has been elaborated to concretize these concepts in daily encounters in palliative care. There is a need to explore whether these questions adequately reflect the meaning of the 6S-concepts.

1.1 | Background

The intent of palliative care and the 6S-model is to help patients to live as well as possible at the end of life and to die peacefully (Ternestedt et al., 2012). Although there are many conceptualizations of what a peaceful death is, we focus on Weisman's concept of *appropriate death* (1988), which is characterized by awareness, acceptance, propriety and timeliness. Awareness and acceptance signifies that patients and families are aware of and accept the situation without losing hope. Propriety means to maintain consistency with the social values of the patient's community and to their personal values and self-esteem; that is, to die one's own death and be able to plan and share decisions, which preserves dignity and autonomy. Timeliness signifies that death comes at an appropriate time and that the person is ready to die (Weisman, 1988). Weisman categorized an appropriate death into six concepts: care, control, composure, communication, continuity and closure. These concepts were translated into six Swedish concepts and adapted for nursing (Rinell Hermansson, 1990) in the 6S-model, which was first applied in Sweden in an inpatient clinic (Ternestedt, 1998). The 6S-model has been used in care planning, documentation, evaluation of care and in the education of staff and has been adopted in different palliative care services in Sweden, Norway and Denmark. In Sweden, Registered Nurses (RNs) working in these services have, together with nurse researchers, established the 6S-network with the aim of spreading and facilitating the use of the model. Scientific papers have been published on parts of the model (Dwyer, Hansebo, Andershed, & Ternestedt, 2011; Jeppsson & Thome, 2014; Ternestedt et al., 2002) as has a book about the entire model (Ternestedt et al., 2012; Ternestedt, Österlind, Henoch, & Andersen, 2012).

The 6S-model for person-centred palliative care is based on the notion that care is co-created between the dying person, who contributes with experiences, knowledge, beliefs and preferences and professionals, who contribute with scientific knowledge and caring experiences. The 6S-concepts represent different dimensions and care needs. *self-image* concerns the patient's view of him/herself and his/her situation, inhabiting both a cognitive and an emotional component and is the obvious starting point for care. To be able to preserve self-image and to live life as well as possible, optimal *symptom relief* is paramount. *self-determination* reflects the patient's psychological need to participate actively in one's own life and decisions. The *social relationships* concept reflects the patient's social needs of engaging in a community. *synthesis* and *strategies* reflect the patient's spiritual and existential needs, which could signify reflecting on the life lived and the life ahead to be able to apply strategies and approaches in encountering one's own death. As the importance of each specific S-concept varies over time, the nurse must be vigilant in responding to the patient's daily condition.

In the 6S-network, there has been continuing discussions about the content and meaning of the 6S-concepts and how they could be

interpreted and documented. It was suggested that the 6S-concepts need to be concretized, to facilitate communication to patients, relatives and newly employed nurses. Therefore, the researchers in the network developed the 6S Dialogue Tool, consisting of questions to pose to the patients about their needs in relation to the specific S-concepts. The questions were modified in 6S-network meetings in a process to establish face validity. The 6S Dialogue Tool is not intended to constitute a questionnaire; rather, it is a tool to help nurses to incorporate the 6S-concepts in clinical practice, to create care in collaboration between the patient and the nurse. This approach might help the patient to live as well as possible at the end of life and to have an appropriate death. However, there is a need to explore whether the questions adequately reflect and could be used to elicit the theoretical meaning of the S-concepts, that is, whether construct validity could be established and how patients respond to the questions.

2 | THE STUDY

2.1 | Aims

The aim of the study was to develop and psychometrically test the 6S Dialogue Tool.

Research questions:

- What is the meaning of the patients' responses to the questions in the 6S Dialogue Tool?
- Is the meaning of the patients' responses to the questions in the 6S Dialogue Tool congruent with the intent of the 6S-concepts?

3 | METHODOLOGY

This is a qualitative study with data collected with structured questions in the 6S Dialogue Tool and answers in an open-ended format. The first research question is reflected in the results section, where the results of analysis of the patients' responses are presented. It is crucial that the questions capture the content and meaning of each of the 6S-concepts. By comparing patients' responses to the specific questions with the intention of the related S-concept, we aimed to determine the construct validity of the questions. The second research question, about the congruence between the results and the 6S-concepts is reflected in the discussion. Achieving construct validity signifies that the questions are linked with the underlying theory and theoretical conceptualization (Polit & Beck, 2018), which is applicable in the present study in that it is explored if the 6S questions are linked to the theoretical meaning of the 6S-concepts.

3.1 | Sample/Participants

The patients were chosen with purposive sampling in order to include patients from different inpatient and outpatient specialized palliative care units in both rural and urban areas. Inclusion criteria were that the patient was admitted to palliative care and able to speak Swedish.

TABLE 1 Overview of the 6S-concepts, original questions, categories, subcategories and revised questions

6S-Concepts	Original questions	Categories	Subcategories	Revised questions
self-image	1. What do we need to know about you to be able to adapt the care in accordance with your needs? 2. What is important for you in everyday life?	Maintaining everyday life	• Protecting routines • Feeling worthy and valued	1. What do we need to know about you to be able to adapt the care in accordance with your needs and preferences?
symptom relief	3. What do you find most distressing at present? 4. How does your illness or symptoms affect your everyday life? 5. What do you usually do to relieve the symptoms?	Challenges in everyday life	• Practical issues • Emotional issues	2. What do you find most distressing at present?
self-determination	6. What is important for you to decide on in your care? 7. What do you want us as staff to help with in your daily life? 8. If you cannot decide anymore, who can decide in your place?	Maintaining control	• Protecting integrity • Participate in care decisions • Proxy decision maker	3. What is important for you to decide on in your care? 4. If you do not decide for yourself, who will make decisions in your place?
social relationships	9. Which people are especially important to you? 10. How can we make it easier for you to spend time with those you wish?	Maintaining selected relations	• Preferred relations • Restricted relations	5. Which people are especially important to you? 6. How can we make it easier for you to spend time with those you wish?
synthesis	11. How do you think about life that has been? 12. What has been important in your life?	Appraisal of life		7. What has been important in your life?
strategies	13. How do you think about the time ahead? 14. Is there anything you want to do, or complete, a place you want to visit or something you want to talk to your close relatives about? 15. How can we contribute to the implementation of this?	Appraisal of the future		8. What do you think about the time ahead?

Registered Nurses in the 6S-network working in 10 units informed their patients about the study and asked whether they were willing to participate. The patients who agreed signed an informed consent form.

3.2 | Instrument

The 6S Dialogue Tool included open-ended questions that represent the 6S-concepts, elaborated by the 6S-network, distributed to patients from May 2015 - August 2016. The distribution took place in two stages to be able to modify the questions. In the first stage, the nurses in the 6S-network posed the questions to 23 patients in palliative care (Table 1). These patients responded to three additional questions about the relevance of the questions, whether any question should be omitted and whether there was need for additional questions. After reading the responses from the patients, the 6S Dialogue Tool was discussed with the 6S-network nurses again and some questions were reformulated, to be more relevant and better capture the intent of the 6S-concepts. After the revision of the questions, the 6S Dialogue Tool consisted of 15 questions. Then in the second stage, another 23 patients responded (Table 1). As the responses from the second group of 23 patients were similar to the first 23,

we assumed that we had reached data saturation. The patients had two options to complete it, some patients were able to complete the questions by writing themselves, while others needed support from the nurses, that is, the RN read the question, the patient responded and the RN documented the patient's answer verbatim.

3.3 | Data analysis

The responses were analysed with manifest qualitative content analysis (Graneheim, Lindgren, & Lundman, 2017; Graneheim & Lundman, 2004). All responses were read several times and discussed. The analysis was performed in both deductive and inductive ways. In the deductive phase, responses were sorted into the 6S-concepts as domains (Graneheim et al., 2017). In the inductive phase, within each S-concept, the text was divided into meaning units that were condensed. The condensed meaning units were labelled with codes. The codes were examined for similarities and differences and were then grouped into subcategories and categories. Through this process, codes, categories and subcategories were discussed between the authors until consensus was reached. The categories and subcategories are presented in the results section under each of the 6S-concepts.

The categories under each of the S-concepts are compared with the original intent of the 6S-concepts in the discussion section.

3.4 | Rigour

Credibility in the present study was obtained by collecting data at 10 different settings across the country by different nurses. Despite coming from different contexts, the responses to the questions, the categories and subcategories were similar across the data (Lincoln & Guba, 1985). Through the analysis process, the codes, categories and subcategories were compared with each other and with the text in an iterative procedure. To illustrate similarities and differences, the categories are presented with quotes from different participants (Graneheim & Lundman, 2004). Dependability signifies the possibility that data might change over time (Graneheim & Lundman, 2004; Lincoln & Guba, 1985), a factor, which has been taken into account in that data were collected over a period of 1 year, but we found no differences. Transferability relates to the possibility that the findings could be transferred to another context, which is dependent on how the study setting has been described. We promoted transferability by presenting a clear and robust description of the participants, the research process and the findings, supported by rich quotations from the data (Graneheim & Lundman, 2004).

3.5 | Ethical considerations

The Research Ethics Committee approval was obtained from the Regional Ethical Committee in Stockholm (Dnr. 2015/5:9).

4 | RESULTS

The sample consisted of 46 patients, 28 women and 18 men, in specialized palliative care, with a median age of 74 years, ranging between 35 and 90 years. The patients considered the questions relevant, advising that no question should be omitted, or no more additional ones included. The findings are presented for each specific S-concept: self-image, symptom relief, self-determination, social relationships, synthesis and strategies.

4.1 | Self-image

The responses to the self-image questions were categorized into a main category; *maintaining everyday life*, which included both an emotional and cognitive component, supported by the two subcategories, *protecting routines* and *feeling worthy and valued*.

4.1.1 | Maintaining everyday life

Maintaining everyday life could relate to the means to attain rest and peace, to eat delicious meals and to be surrounded by beautiful things and pleasant people. Maintaining everyday life was

sometimes difficult; when the illness overwhelmed and dominated, when they were not able to think clearly, when they felt drugged, or when they experienced themselves as an object.

Protecting routines was a subcategory indicating how patients aimed to achieve well-being, while their routines could also be strenuous. Everyday life was limited and the activities needed to be adapted to match their present energy level. The illness caused worry and could be an obstacle for having a good day and some informants thought that their body was steering everyday life. By protecting routines, it was still possible to create well-being and be curious about life. Protecting routines enabled a good life:

Morning, flush after TPN [total parenteral nutrition].

Replace stomach bag. Meet friends for lunch, cinema, go to the concert hall regularly. (20)

Feeling worthy and valued was a very important subcategory and relationships with others was crucial for one's identity and for promoting feelings of being a person. In addition, when personal preferences for the healthcare provision or place of care were respected, these influenced whether the participant could feel valued. As expressed by one participant:

I (and my native family) are academics and keen that all care is scientifically motivated and substantiated. (19)

One way of feeling validated as a person and to feel worthy was when the patient's wish to be autonomous, independent, to manage oneself and to have control of life was respected.

4.2 | Symptom relief

Symptom relief was categorized as *challenges in everyday life* with two subcategories; *practical* and *emotional issues*.

4.2.1 | Challenges in everyday life

Practical issues concerned symptoms, that is, dyspnoea, fatigue, itching, pain, brain fatigue, cough, sleeping difficulties, dizziness, nausea, fever peaks, anxiety and bowel problems. The participants described the consequences related to being unable to do what one wishes, which could signify not being able to write, drive, go outdoors, or having a bad day the day after an activity and the participants sometimes specified which symptoms were hindering them, that is, pain, fatigue, mobility or bowel issues, as one participant responded:

Difficult to participate in activities, since I need access to toilet because of the ostomy. (20)

Emotional issues could relate to their awareness of the illness and that it was incurable, distressing and created worry and depression. Others included feelings of insecurity, to be afraid of falling, or suddenly being overwhelmed by pain.

Never feel safe, the symptoms come quickly and unexpectedly. The trouble consists of chest pain. The trouble often comes at night. (34)

To alleviate symptoms, the participants described taking several actions, for example, "Going by wheel-chair out in the garden and smoking a cigar" (18). Other actions included self-change of medication when they had side effects, changing eating habits, pursuing enjoyable activities, having a massage, resting, distracting oneself, applying breathing regimes or receiving care.

4.3 | Self-determination

Being able to make decisions about everyday life brought a sense of control. The responses to the questions about self-determination were categorized into a main category, *maintaining control* and three subcategories; *protecting integrity, participation in care decisions and proxy decision maker*.

4.3.1 | Maintaining control

Protecting integrity related to daily routines. The participants wanted to live as normal a life as possible and to maintain their habits, such as hobbies, budgeting and cooking. It was important to be able to take care of their personal hygiene for as long as possible. They worried about when they would no longer be able to care for themselves. Some participants managed their hygiene with support from family and friends. Being independent was crucial; being forced to ask for help was difficult. One patient expressed that "*it felt humiliating to ask for help*" (11).

It was important to *participate in care decisions* on different levels. Some participants were keen to make decisions about most matters, such as medication, permission to leave the ward or to terminate dialysis. Other participants wanted to have an open dialogue with healthcare professionals about the disease, its treatments, about what had happened and what was planned. They needed to be respected in the decision-making process. However, some participants wanted to leave the decisions to the healthcare professionals. Some wanted healthcare professionals to help with "*what I need for a decent quality of life*" (45).

Concerning the *proxy decision maker* category, some participants had indicated who should be their proxy when they were no longer able to make decisions. Some took for granted that their relatives should make decisions, but, for others, only the healthcare professionals were assigned this role.

4.4 | Social relationships

The main category within social relationships was *maintaining selected relationships*, with the subcategories; *preferred relationships* and *restricted relationships*.

4.4.1 | Maintaining selected relationships

Relationships mostly concerned those with family and friends, but also those with healthcare professionals. Some relationships were valued more than others.

Preferred relationships were characterized by allowing for open communication, that these relationships enriched the patient's life in different ways, offered security and made the patient feel protected. These could be facilitated by being cared for at home or in a hospice, where relatives could stay overnight. Other facilitators included access to the transportation service, a transportable oxygen supply, symptom relief or help to change the ostomy bandage before meeting with friends. The patients thought that they did not need many individual relationships, but that those they did have should be of good quality. The relationships could even be improved during illness: "*We have a much better relationship now when I have told about the disease*" (41).

Restricted relationships signified that the illness was always present, which influenced relationships and the potential that some were not helpful. Being ill could evoke feelings of being a burden and some relationships were not appreciated:

All the children are fully booked. My husband is busy with me. Have many friends who want to come, but some give me nothing (9)

They wanted to meet with others, depending on their physical condition, but sometimes did not have the strength and could need support from nurses to restrict visits.

4.5 | Synthesis

The main category of synthesis concerned *appraisal of life*, including both good and difficult memories from life.

4.5.1 | Appraisal of life

The good life signified thoughts about how life had been, which was described as being diverse, but most described life as having been good or even wonderful with good memories. They appreciated having a family and been healthy before the disease:

Having children. To be reasonably healthy. To be married and lived in houses (21)

It was important to be able to summarize and have an overview. Appreciating aesthetics in life was also one part of having a good life. A good life also signified personal characteristics, for example, being true to oneself, being honest, responsible, generous, curious and responsive and having a moral outlook and not regretting anything. For some patients, the past was very important, while, for others, the present was more important. Dialogues and relations were important

parts of life and the patients were keen to share memories and stories with relatives. Sharing experiences and leaving things to relatives was very important:

Photos, travel memories, genealogy results, etc. my wife has taken care of. My youngest son has the login to my computer with password. (30)

The difficulties in life mostly concerned how the disease has characterized life from the time of diagnosis and how it overcame life for some of the participants. Some mentioned having bad memories from early childhood and tried not to think about them:

Strange that what was bad during the childhood and adolescence comes back in so clear, hard memories now, so many years afterwards. (36)

For some patients, life could be good in spite of the disease, if they received adequate help.

4.6 | Strategies

The strategies category related to a tension in the participants' *appraisal of the future* and included both having confidence in the future and viewing the future as uncertain and limited.

4.6.1 | Appraisal of the future

Having confidence in the future was shown as having a positive outlook and plans for the future. One patient was knitting sweaters for the children, while others wanted to go on a boat trip, visit a garden centre, go painting in Tuscany, or travel abroad with their children to meet relatives. However, some patients said that they were very ill and did not have any plans, although they wished to be seen as worthy until death:

Wish to keep a dignity in my life even the absolute last time. (19)

Others wanted to complete a project, such as writing a story of a parent's life, complete the renovation of a kitchen or plan one's own funeral. Some patients told about having hope; in the long perspective to get rid of cancer and to have better health; and in the short to be pain-free. Care from others was considered very helpful. The efforts of healthcare professionals could facilitate them completing some of these tasks.

Having an uncertain and limited future could signify an awareness of the limited future and a hope that the time would pass quickly: "I have no future. Want to stay here" (22). The disease was setting the limits for the patients and it was not a good idea to plan anything:

I have realized the fact that everything I have planned for this year and beyond I can forget. (30)

This uncertainty was expressed in that, on some days, death was present and on others, the patient was more hopeful.

5 | DISCUSSION

In the present study, we used patient data to develop categories that delineate the 6S-concepts in more detail and align them with the framework in the 6S-model. The findings are like earlier research and frameworks in palliative care. This could be shown in that three of the categories related to the 6S-concepts concerned maintaining certain aspects, that is, everyday life, control and good relationships. This finding is in line with Weisman's (1988) idea of an appropriate death, of which the notion of propriety signifies maintaining consistency with the individual's personal values and to die one's own death. This is also consistent with the WHO's (2002) definition of palliative care. A good life at the end of life can be achieved when the ill person and the healthcare professional co-create the care in a genuine dialogue, in the spirit of Buber (1958). As there exists no standard to compare the 6S Dialogue Tool questions with, the findings from the present study are discussed in relation to findings from others' research, to justify the questions.

5.1 | Self-image and everyday life

The question that intended to cover self-image resulted in the category *Maintaining everyday life*. Everyday life could be considered important to maintaining self-image and identity in palliative care. According to Nordenfelt (2009), identity and dignity are closely related. Dignity therapy has been developed in Canada and is considered a way of eliciting the personhood in palliative care (Chochinov et al., 2015). To this aim, a Patient Dignity Question (PDQ) was developed, tested for feasibility (Johnston, Gaffney, Pringle, & Buchanan, 2015) and pilot tested (Johnston, Pringle, et al., 2015). The PDQ is worded "what do I need to know about you as a person to take the best care of you that I can?" (Johnston, Gaffney, et al., 2015, p. 71), which is similar to the question in the 6S Dialogue Tool to illuminate self-image. This question also applies to the category, *Maintaining everyday life*, in that healthcare professionals strive to adapt the care they give to the person's life and preferences. When the illness progresses, everyday life could be difficult to maintain, but it is important to be asked for one's view.

5.2 | Distressing challenges

The responses to the question about symptom relief concerned the *Challenges in everyday life* that the symptoms caused. The patients described distressing symptoms and consequences that accompany them, aligning with the current symptom research that acknowledges that symptom experience is multidimensional (Humphrey et al., 2014; Lenz & Pugh, 2014). Another aspect of symptom experience is the meaning assigned to a symptom (Armstrong, 2003), which could be linked to illness awareness. According to Weisman (1988), awareness, hope and meaning are essential elements when

patients and families confront end-of-life problems. The question used to acknowledge symptom relief was: "What do you find most distressing at present?" This question has been used in earlier research to gain knowledge about what is most distressing for patients living with lung cancer (Tishelman, Lovgren, Broberger, Hamberg, & Spranglers, 2010) and patients admitted to hospitals (Fridh et al., 2015). Both patients affected by lung cancer and hospitalized patients responded with descriptions of their life situations. However, in the present study, symptoms and issues closely related to symptoms came up in the responses. The question about what is most distressing is appropriate, as healthcare professionals should prioritize the most distressing symptoms.

5.3 | Control and decisions

The self-determination responses led to the category *Maintaining control*. Participation in care discussions was categorized by Sahlberg-Blom Ternestedt and Johansson (2000) into how the patient could be self-determining, codetermining, delegating or not participating, which is congruent with the results from the present study. When self-determination is handed over to others, it is important for all parties to know who is going to be the proxy decision maker and whether that person is aware of the patient's preferences (Bollig, Gjengedal, & Rosland, 2016). To be informed about the person's preferences about self-determination, there is a need for two questions; one about the person's preferences about decisions and one about who will be the potential proxy decision maker, as there is a need for the patient to trust this person.

5.4 | A desired fellowship

The social relationships questions relate to important persons, as defined by the patient, which is in line with the category *Maintaining selected relationships*. The WHO definition of palliative care includes families and friends as being important to the provision of good palliative care (2002). In palliative care, there is a risk that the ill person could be dependent on family members. In today's society, independence is emphasized, thus dependency could be perceived as something negative, but could, on the other hand, help to find peace in dependence at the end of life (Eriksson & Andershed, 2008). Patients have been found to miss their earlier independence and everyday life is characterized by waiting (Österlind, Ternestedt, Hansebo, & Hellstrom, 2017), which could be regarded as the existential loneliness that people sometimes experience when confronted with their own death (Sand & Strang, 2006; Yalom, 1980). The questions about social relations are congruent with the intent of social relationships in that there is both longing for confirmation and a wish to choose one's company.

5.5 | Storytelling

The question related to synthesis about important things in life, resulted in the category *Appraisal of life*, which concerns to reflect over one's life and this could be made by telling the story of one's

life. A life story can be used as a prerequisite for providing person-centred care and to guide the caregiver to better understand patients (Ekman et al., 2011). Based on the story, healthcare staff can formulate goals for care that align with the patient's needs and values (Weisman, 1988). The life story is created in the moment it is told and changes over time, depending on how it grows, what response the narrator receives and in what situation the story is told. Being flexible and adapting to the patient's pace is a central starting point to promote the patient's ability to preserve his/her self. 1985) described how a person could make sense of his/her life, which implies that the question about what has been important in life is congruent with the meaning of the synthesis concept.

5.6 | Life ahead

The question about strategies resulted in the category *Appraisal of the future*. When facing death, the future is limited, but, according to Weisman (1988), it is important to be aware of the situation without losing hope. At the end of life, functions decrease and dependency on others for care and concern increases. Attitude values become important in an extreme situation that cannot be changed (Frankl, 1985) and can be described as the attitude that a person has towards something inevitable. An encounter with one's own death is such an example, but, according to Frankl (1985), it is possible to deal with difficult suffering with the help of one's attitudes. Yalom (1980) describes feelings of guilt, in that a person has made choices in life that have become detrimental, either for himself or for others. In the light of the synthesis, a person can become aware of how life has been lived until now and how to change things for the life remaining (Weisman, 1988). This could be achieved by being reconciled with things that went wrong, or by repairing relationships. The question, "What do you think of the time ahead", could be appropriate to gain knowledge about what the person feels obliged to deal with and how healthcare professionals might facilitate this.

In summary, the responses to the questions in the 6S Dialogue Tool illuminate the intent of the 6S-concepts and could be regarded as being well in line with the theoretical assumptions of the 6S-model. The 6S Dialogue Tool has been developed as a questionnaire, but the intent was that nurses should integrate the concepts and the questions in a caring approach, to be able to take part of the patient's view of the situation and to plan and co-create palliative care in a dialogue with the patient. This could increase the possibility for an appropriate death for the person (Weisman, 1988).

5.7 | Strengths and limitations

A strength of the study is that, although data were collected in different parts of Sweden and in different settings, there were no discrepancies between the participants' answers. Limitations concern the small sample and the lack of gold standard to justify the 6S-concepts. It could be a limitation that we did not explore the patients' understanding of the 6S-concepts, which might have contributed to more in depth responses. However, our intent was

to explore whether the meaning of the 6S-concepts could be captured with the 6S Dialogue Tool. The present study describes the development of the 6S Dialogue Tool in accordance to CASP (Critical Appraisal Skills Programme, 2018), which could be an important contribution for patients in palliative care.

6 | CONCLUSION

The responses to the 6S Dialogue Tool questions reflect some aspects of the meaning of the 6S-concepts. The 6S Dialogue Tool will help nurses to co-create care in line with the patient's values and beliefs, influenced by the 6S-model for person-centred palliative care. To illuminate the patients' preferences in palliative care, nurses need to be trained to use the 6S Dialogue Tool with caution, in that it is intended to be an approach where the patient is regarded as a unique person. The 6S Dialogue tool has the potential to provide healthcare professionals with knowledge that need to be considered when planning for palliative care with the patients, for example, how everyday life, control and relationships could be maintained, which symptoms that are most challenging and how life could be understood. Although the 6S-model and the 6S Dialogue Tool have been developed for use in palliative care, the approach could be applicable in other settings and aligns with the principles of high-quality nursing care. Healthcare structure need to be designed to facilitate genuine dialogues between patients and nurses. Further studies are needed to explore the validity in other care settings and in various cultures.

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CONFLICT OF INTEREST

There are no conflicts of interest.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE [<http://www.icmje.org/recommendations/>]):

- substantial contributions to conception and design, acquisition of data or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

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