



Staff-Family Communication Methods in Long-Term Care Homes: An Integrative Review

RESEARCH

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ABSTRACT

Context: Communication methods have been trialled to promote staff-family relations and facilitate person-centred care for residents living in long-term care homes. A review and synthesis of the common methods will inform the development of staff-family communication methods, policy and best practice guidelines.

Objectives: 1) synthesise and summarise common communication methods, and types(s) of delivery, used for staff-family communication in long-term care homes; and 2) identify any challenges that impacted the implementation of the communication method(s).

Methods: An integrative review was employed to incorporate papers with diverse research designs. It involved a comprehensive database and grey literature search, and study selection based on inclusion criteria. Data from included studies were extracted, coded and categorised by common communication method, delivery type(s) and challenges; studies were assessed for quality.

Findings: A total of 3,183 potential papers were retrieved from seven international databases. Twenty-four original papers from six countries meeting inclusion criteria were reviewed and assessed for quality ($M = 30$; $SD = 3.8$). Common communication methods (structured education, meetings and takeaway resources) and challenges to implementation (confusion, misunderstanding and disagreement; lack of time; and technological difficulties) were identified and summarised.

Limitations: The exclusion of papers published more than 20 years ago, geographical concentration of studies in high-income countries, and absence of stakeholder consultation may limit the generalisability and depth of the findings.

Implications: Staff professional development and education, technology training and support, and accessibility of information in pamphlets and resources for family are crucial for facilitating staff-family communication in long-term care homes.

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INTRODUCTION

Interpersonal communication is defined as the process or act of exchanging, expressing or conveying information from one person, or group of people, to another with the goal of negotiating meanings, identities, and relationships (Braithwaite and Schrodt, 2021). This process occurs in a variety of health care settings (e.g., hospitals, clinics, assisted living facilities), between individuals and groups (e.g., health care professionals, patients, residents, family members), and uses a combination of approaches (e.g., oral, written, non-verbal) to help deliver quality care.

The ability to effectively convey information has been identified as a necessary skill among health care professionals who work in long-term care (LTC) homes (Arnold and Boggs, 2019) to provide individualised and coordinated services that meet the interrelated, multidimensional, and ongoing care needs of older adult residents with physical and/or cognitive impairments (Bolt et al., 2021). Communication and co-operation between staff and family members is critical to foster a supportive housing environment for residents that encourages collaboration, and promotes person-centred care (i.e., considering resident preferences rather than simply performing tasks on their behalf (Majerovitz et al., 2009)). Person-centred care in LTC homes has led to marked improvements in resident well-being via the reduction of anti-psychotic medication (Roberts et al., 2015), and enables the creation of tailored care plans, shared decision-making and greater satisfaction among family, residents and staff regarding care preferences (Roberts et al., 2015; Giosa et al., 2022).

FAMILY/CARE PARTNER INVOLVEMENT IN LTC HOMES

Care contributions by family caregivers, also known as family/care partners, have greatly benefited LTC resident health and well-being (Coe and Werner, 2022). In this review, the term *family/care partner* describes someone who provides unpaid care to a resident in LTC (e.g., spouses, adult children, other family members and friends) and embodies a 'caregiver identity' (i.e., a unique role or relationship that stands apart from their conventional familial or friendly ties). Caregiver identity theory (Montgomery et al., 2016) can be used to explain how communication and relational dynamics between staff and their loved one(s) contribute to the formation of their 'caregiver identity' and the varying degrees of involvement they choose to adopt. Contributions of family/care partners to resident care have been shown to reduce the risk of hospitalisation, promote participation and engagement in leisure activities, and preserve resident quality of life and well-being (Hayward et al., 2023). Their role in supporting LTC staff became evident in their absence when COVID-19

related restrictions did not permit family as visitors to LTC homes (Thirsk et al., 2022).

THE IMPORTANCE OF STAFF-FAMILY COMMUNICATION

Effective staff-family communication is pivotal for building trust, collaboration and ensuring quality of care for LTC residents (Hovenga et al., 2022). It also fosters greater family involvement and creates a unified caregiving environment. Poor staff-family communication in LTC homes, a recurring theme identified by the literature, has caused many family/care partners to feel ignored and created confusion in decision-making for resident care (Harper et al., 2021). Further complicating the situation, LTC staff shortages and turnover exacerbated by the COVID-19 pandemic (Coe and Werner, 2022) left many family/care partners 'in the dark' and dissatisfied about their loved one's care and well-being (Harper et al., 2021). Breakdowns in staff-family communication not only introduce logistical hurdles in resident care but may also affect the development of a family/care partner's 'caregiver identity' (Cooper, 2021). For example, if a staff member neglects to inform a deeply involved family/care partner about a minor fall their loved one experienced, it can result in the family/care partner feeling alienated from the care team. This exclusion can undermine the family/care partner's self-assurance and effectiveness in their role, potentially prompting them to reconsider their value and involvement in their loved one's caregiving. Given the ongoing precarious LTC staff complement in the post-COVID era (Molinari and Pratt, 2023), these gaps in communication alienating family/care partners from provision of unpaid care could have lasting adverse effects on resident well-being.

INTERVENTIONS TO IMPROVE STAFF-FAMILY COMMUNICATION

Studies have created and tested various interventions (e.g., programs, curricula, tools and techniques), each with its own combination of methods, to enhance communication among staff and family/care partners in LTC. However, a current and comprehensive synthesis of the common communication methods used for each study intervention, along with the types of delivery, is lacking. Further, common challenges, which may influence the implementation of communication methods, have not been summarised to inform LTC home staff-family communication policy and best practice guidelines to promote person-centred care, and optimise resident well-being. Therefore, the objectives of the current review were to: 1) synthesise and summarise common communication methods and type(s) of delivery used for staff-family communication in LTC homes; and 2) identify any challenges that impacted the implementation of the communication method(s) in LTC homes.

METHODS

An integrative review was chosen for this study because it permits the inclusion of quantitative, qualitative and mixed-method study designs with diverse methodologies (Whittemore and Knafl, 2005) and has the potential to capture complex and varied perspectives, along with emergent phenomena and trends, pertaining to our objectives. A critical synthesis of all relevant publications was developed in five stages according to the methodological approach outlined by Whittemore and Knafl (2005): 1) formulation of the problem; 2) conducting a database search; 3) data evaluation; 4) data analysis; and 5) presentation of findings. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR) checklist was used to assist in the writing of this review (see Appendix A) (Tricco et al., 2018).

FORMULATION OF THE PROBLEM

A current and comprehensive synthesis of the common communication methods, or the types of delivery, for staff-family communication in LTC homes was not found in the literature. Additionally, a summary of the challenges with implementation of these communication methods for staff-family relations was missing from the literature. These gaps in knowledge hinder the development of informed LTC home staff-family communication policies, best practice guidelines and future studies aiming to evaluate effectiveness of communication interventions, which are crucial for fostering person-centred care and maximising resident well-being.

LITERATURE AND DATABASE SEARCH

Search strategies were developed in consultation with a Research and Instructional University Librarian at Western University. A literature and database search was conducted on December 22, 2022, and updated on February 2, 2024. Research databases (Medline [OVID], PsychInfo [OVID] Embase [OVID], CINAHL [Ebsco host], Scopus, Nursing & Allied Health database [Proquest], and the Education database [Proquest]) were searched using the following key terms along with relevant and appropriate variations: *family care partner*, *staff*, *long-term care* and *communication*. A sample search strategy can be found in Appendix B. Reference lists of all included papers were hand searched.

A grey-literature search was conducted using an online search engine (Google), and three external databases (i.e., Canadian Health Research Collection, Open Grey and the Canadian Institute for Health Information). Two phrases were entered into the search engine and each database separately ('communication methods between family and staff in long-term care'; 'communication methods between family and staff in nursing homes'). The first 10 pages of results generated from the Google search and all results from the three databases were reviewed.

SELECTION PROCESS

Papers were selected based on the following inclusion criteria: 1) the paper outcomes involved both LTC staff and family/care partners; 2) the setting was a LTC home or equivalent (i.e., any place a person resided while receiving care on a permanent basis including but not limited to nursing homes, skilled nursing centres, inpatient behavioural health facilities); and 3) the paper implemented an intervention designed to address communication between LTC staff and family/care partners. The database and grey-literature searches were open to studies (i.e., primary studies, literature reviews, systematic reviews and meta-analyses) and records (i.e., programmatic quality improvement initiatives, reports and policy or position papers/editorials) due to the uncertain nature of the existing literature on the topic and to account for potential variability and breadth of insights these sources could offer. Studies and records were excluded from review if they were published more than 20 years ago, not written in English, or were only available as a published abstract.

All included papers were uploaded into Covidence systematic review management software (©2024 Covidence) where duplicates were removed. Two authors (AJS and JU) and one student research assistant independently screened the titles and abstracts yielded by the search for relevance. Upon completion, two authors (AJS and JU) then conducted a full-text review to confirm that the papers accurately met the study inclusion criteria. Reasons for exclusion of sources of evidence during the full-text review were recorded and reported in Figure 1. Disagreement regarding paper inclusion between the two study authors was resolved through discussion.

DATA EXTRACTION

Data from included papers were extracted by two authors (AJS and JU) and a student research assistant within Covidence using a pre-developed, author-designed, data extraction framework (see Appendix C). The data extraction framework elicited specific details from the included papers about the study participants, study aim, study methodology/methods, and key findings specific to the review objectives. Extracted data were compiled in a summary table (Table 1). Review of the compiled summary table was completed by a student research assistant and two authors (AJS and DC) with additions and modification of content, as necessary. Ambiguity or disagreement regarding the data extracted between the two authors was resolved through discussion.

DATA ANALYSIS, SYNTHESIS AND PRESENTATION

Segments of data were labelled with codes describing the general essence of the intervention used by the paper. Codes were refined using an iterative process and combined into themes to better represent common content emerging from the data. This open coding process allowed for identification of common communication

Table 1 Description of data extracted from the template including information pertaining to study design; participants; setting; aim or objective; intervention; and main findings.

NH – nursing home; EoL – end of life; LTC – long-term care; SDM – substitute decision maker; RPN – registered practical nurse; DM – decision making; PSW – personal support worker; PSE – patient safety event.

AUTHOR, YEAR, & COUNTRY	STUDY DESIGN	PARTICIPANTS AND SETTING	COMMUNICATION INTERVENTION	STUDY AIM(S) OR OBJECTIVE(S)	MAIN FINDINGS
Aasmul, Husebo and Flo., 2018 – Norway	Randomised controlled trial	297 NH patients 105 health care providers 37 NHs in Norway	Communication, Systematic pain assessment and treatment, Medication review, Organisation of activities and Safety (COSMOS)	To describe the content of advanced care planning in the COSMOS study. To describe the evaluation of the implementation process of the intervention in Norwegian nursing homes.	Intervention was successfully implemented in 62% of the patients by month 4, which means that they had fulfilled the following criteria: patient and family were invited to a meeting with the physician or the primary nurse, and family was contacted monthly by phone or in the unit. Monthly communication with family and documentation of the communication were the two most frequently conducted items. The new routines for monthly contact helped the staff to keep families systematically updated, which substantially improved contact with family members, including those living far away. Lack of time emerged as a prominent barrier, particularly time to train and involve colleagues.
Aasmul et al., 2018 – Norway	Randomised controlled trial	545 NH patients 117 staff members 37 NHs in Norway	COSMOS	To investigate the effect of an advanced care planning intervention on communication among NH staff, patient, and family.	Organised meetings between the family, patient, and nurses were conducted more frequently in the intervention compared to the control group at month 4. Monthly contact between family and nurses was more frequent in the intervention group. Nurses and families were more satisfied with their communication in the intervention compared to the control group. Staff distress was reduced in the intervention group at month 4. The intervention effect at month 4 did not persist during follow-up at month 9.
Ampe et al., 2017 – Belgium	Mixed methods	90 NH staff members 18 NHs in Belgium	we DECide	To pilot we DECide in terms of influence on advance care planning policy and practice in NH dementia care units. To investigate barriers and facilitators for implementing we DECide.	Advance care planning policy was significantly more compliant with best practice after we DECide; policy in the control group was not. Advance care planning was not discussed more frequently, nor were residents and families involved to a higher degree in conversations after we DECide. Barriers included staff's limited responsibilities. Facilitators included support by management staff, and involvement of the whole organisation.
Durepos et al., 2018 – Canada	Qualitative research	66 LTC staff 28 family members 4 LTC homes in Ontario, Canada	Family care conferences	To explore and describe: 1) Family care conference content, including concerns discussed and care planned. 2) Processes including documentation and multidisciplinary participation that guide EoL communication in family care conferences.	The family care conferences addressed an average of 71% of the content domains, with physical and EoL care addressed most frequently, and loss/bereavement addressed the least. Two goals and five interventions were documented and planned on average per family care conference. Examination of the processes supporting EoL communication found: (1) advantages to using family care conference forms versus electronic charts; and (2) high levels of multidisciplinary participation overall but limited participation of PSWs and physicians.

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AUTHOR, YEAR, & COUNTRY	STUDY DESIGN	PARTICIPANTS AND SETTING	COMMUNICATION INTERVENTION	STUDY AIM(S) OR OBJECTIVE(S)	MAIN FINDINGS
Durkee-Lloyd, 2022 – Canada	Qualitative research	27 LTC facility administrators 74 LTC facility staff 101 & 110 family members NHs and special care homes in New Brunswick, Canada	Face to face, email, social media, bulletin board, communication book, telephone, mail, text message, website	To assess the communication strategies used to communicate COVID-19 related information in LTC facilities located in the Canadian province of New Brunswick.	Overall satisfaction with the information received by staff and families, however the frequency and format in which information was communicated were inconsistent. All participants indicated that too much information and poor-quality information was a challenge. The importance of digital platforms to provide COVID-19 information was consistently identified as a successful communication strategy.
Einterz et al., 2014 – United States of America	Non-randomised experimental study	18 NH residents 18 SDMs 2 NHs in North Carolina, USA	Goals of Care (GOC) Decision Aid	To examine the feasibility and relevance of the GOC decision aid intervention. To test initial effects on quality of communication and surrogate decision-making.	89% of the SDMs thought the decision aid was relevant to their needs and not difficult to use. SDMs reported a small but significant increase in quality of communication with staff. SDMs reported significant increases in concordance on primary goal of care with NH team and more of them were very involved with decision making about GOC after the intervention. The number of palliative care domains addressed in the resident care plan increased.
Francisco et al., 2022 – Australia	Qualitative research	4–8 family members, staff members, general practitioners, or palliative care planning coordinators per case conference 6 LTC facilities in Sydney and Brisbane, Australia	Facilitated case conferences	To explore interactions between multidisciplinary health care clinicians and families during facilitated case conferences on EoL care for residents with advanced dementia.	The overarching theme that emerged from case conference analyses was 'bridging medical and person-centred perspectives.' Subthemes included: details of day-to-day care versus establishing goals of care; expression of emotion versus retreat from emotion; and expressed cues and missed opportunities. Facilitation by palliative care planning coordinators sometimes served to bridge alternate perspectives during case conferences.
Garnett et al., 2022 – Canada	Qualitative research	7 family/care partners 8 LTC staff 3 PIECES mentors 2 RPN champions 2 Older adult research partners 2 LTC homes in Ontario, Canada	PIECES (Physical, Intellectual, and Emotional health); maximising the Copabilities of an individual to support quality of life; integrating the living Environment of a person; and encompassing a person's self, including beliefs, culture, and life story) clinical care planning tool delivered virtually	To describe experiences and implementation facilitators and barriers in delivering a novel RPN-led virtual adaptation of the PIECES care-planning approach to address behavioural expressions in two Canadian LTC homes during the COVID-19 pandemic.	Participant experiences suggested that implementation fostered individualised care, included family as partners in care, increased interdisciplinary collaboration, and improved staff practices. Virtual PIECES, as delivered, lacked opportunities for family member feedback on older adult outcomes. Implementation facilitators included the provision of mentorship and leadership at all levels of implementation and suitable technological infrastructure. Barriers were related to availability and use of virtual communication technology (family members) and older adults became upset due to lack of comprehension during virtual care conferences.

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Halcomb, 2009 – Australia	Qualitative research	4 general practitioners 11 residential care staff 9 family members/carers 2 residential aged care facilities	Multidisciplinary case conferencing	To evaluate the feasibility, acceptability and sustainability of a multidisciplinary case conferencing model for residential aged care.	<p>The conference was seen as an important event to promote information exchange between professionals, residents and family members.</p> <p>Some residential care staff identified that they were unable to contribute effectively to some conferences due to insufficient notice of the conference.</p> <p>Family members expressed that they were surprised and felt a bit intimidated with the number of health professionals in attendance and would have preferred this to have been explained to them before they attended.</p> <p>The value of communication between various care providers and between care providers and the resident/family and the notion of greater collaboration in the provision of care were highlighted.</p> <p>All participating family carers expressed positive experiences and identified that attending the conference had given them confidence in the role of these meetings as a forum to ask questions and raise concerns related to the residents' health.</p>
Havaei et al., 2023 – Canada	Mixed methods	85 residents 6 family caregivers Two LTC homes in British Columbia, Canada	The Synergy tool	To implement and evaluate the impact of the Synergy tool on residents' care delivery in two ethnically diverse LTC homes in large urban areas within British Columbia, Canada, including evaluation from an economic perspective.	<p>Quantitative findings from Synergy scores revealed considerable variability for resident acuity/dependency needs within and across units; and falls decreased during implementation.</p> <p>The six-month economic evaluation demonstrated some cost savings by comparing Synergy tool training and implementation costs with savings from resident fall rate reductions.</p> <p>Qualitative analyses yielded three positive impact themes (improved care delivery, better communication, and improved resident-family-staff relationships), and two negative structural themes (language barrier and staff shortages).</p>
Hutchinson et al., 2017 – Australia	Qualitative research	17 residents 38 family members 7 LTC facilities in Victoria, Australia	Tri-focal Model of Care	To report resident and family member perceptions of partnership-centred care in association with implementation of the Tri-focal Model of Care in the LTC setting.	<p>Residents reported experiencing improved partnership approaches to care, although there were factors that impacted on having a good experience.</p> <p>Family members described a desire to remain involved in the resident's life by establishing good communication and rapport with staff; something important for partnership-centred care.</p> <p>Family members described experiencing a partnership with staff, giving them confidence to assist staff and be included in decisions about the resident.</p>
Kaasalainen et al., 2021 – Canada	Mixed methods	55 DM residents 35 family members 3 LTC homes in Ontario, Canada	Conversation Starter Kit (CSK) booklet	To determine if the use of the CSK booklet improved family member self-efficacy regarding decision-making, and satisfaction with quality care. To determine what extent residents and family members used the CSK booklet for DM residents, family of DM residents, family of non-DM residents. To determine the impacts of using the CSK, and what adaptations are needed to make it easier to use as reported by residents and family/friends.	<p>Residents reported more engagement in advance care planning after completing the CSK booklet, particularly related to asking questions to health care providers about health care decisions.</p> <p>Family members reported feeling very certain that they would be able to make decisions on behalf of the resident but felt less certain after completing the booklet, implying the booklet raised their awareness of the types of decisions they might need to make, hopefully prompting them to be more prepared for decisions in the future.</p>

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Kellett et al., 2010 – Australia	Qualitative research	7 family caregivers 7 LTC staff 1 LTC facility	Family Biography Workshop (FBW)	To describe the FBW process. To present a descriptive qualitative assessment of the FBW.	For family caregivers, reviving memories of their loved one(s) as 'whole' persons enabled some to 'stand outside' and see beyond the disease-saturated context. For staff, 'opening possibilities' of 'seeing' the resident within the family context empowered them to engage in genuine participatory practices. Residents benefited from being connected as staffs' 'know how' in initiating and engaging developed. Results supported the effectiveness of HFS as an educational tool for unregulated health care providers. Quantitative data showed statistically significant improvements in participants' self-efficacy scores related to communicating about death and dying and EoL care. Qualitative data indicated that the experience was a valuable learning opportunity and helped participants develop insights into their own values, beliefs, and fears providing EoL care.
Kortes-Miller, 2016 – Canada	Mixed methods	18 unregulated care providers 2 LTC homes	High-fidelity simulation (HFS)	To describe the development, implementation, and evaluation of a pilot educational intervention utilising HFS to improve unregulated care providers' confidence and skills communicating about death and dying in LTC homes.	Five themes included: (1) general reflections on nursing care; (2) implementation of the CMDC intervention; (3) positive outcomes of the CMDC intervention; (4) challenges in the implementation of the CMDC; (5) difficulty sustaining care and tensions between participants' perspectives of care. Family members confirmed several behaviour changes in staff following the CMDC training. Implemented ideas included a visitor's book in the residents' rooms to facilitate communication between staff and family members and individualised pictorial charts of a resident's history placed within his or her room to improve staff knowledge about the resident's background and interests. Staff and family members who attended the CMDC training workshops reported significant increases in the quality of staff-family relationships.
Moyle et al., 2013 – Australia	Qualitative research	12 nursing staff 6 residents 7 family members 3 LTC facilities in Brisbane, Australia	Capabilities Model of Dementia Care (CMDC)	To assess the experience of the CMDC implementation as reported by nursing staff, residents of the LTC facilities and family members.	Perception of staff empathy increased from baseline to the 2-month post-test, and again to the assessment at 6 months, for those in the treatment group but not for controls. A decline in depression from baseline to 6 months relative to an increase for controls approached significance. Perceptions about the supportiveness of family behaviours improved between baseline and 2 months for the intervention group and declined for the control group. For predicted likelihood of quitting the job in 12 months, a decline occurred in the treatment group between baseline and 2 months, whereas an increase occurred in the control group.
Pillemer et al., 2003 – United States of America	Randomised controlled trial	932 relatives 655 staff members 20 NHs	Partners in Caregiving	To assess the effectiveness of a cooperative communication intervention for nursing home staff and family members of residents.	

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Robison et al., 2007 – United States of America	Randomised controlled trial	388 family members 384 NH staff 20 NHs	Partners in Caregiving	To assess the effectiveness of a cooperative communication intervention for nursing home staff and family members of dementia residents living in a special care environment.	Intervention families descriptions of the ease of talking with staff increased after the workshop and remained elevated at 6 months, whereas those of control families were static. Scores on the Staff Behaviours Scale increased over 6 months for intervention families but did not change significantly for control families. Conflict with families decreased for intervention staff after the workshops, conflict rose for control staff, in the short term. By 2 months, treatment staff showed a trend to a decline in feelings of depression, but control staff's depression symptoms increased. By 6 months, control and intervention groups no longer differed on either measure. Combined family and staff ratings of the program were very positive.
Stephens et al., 2022 – United States of America	Mixed methods	6 residents 1 physician 5 family members 6 NH nurses 3 NHs based in California, USA	Palliative Care Telehealth	To determine the technical feasibility and acceptability of palliative care telehealth for NH residents seen by a palliative care team in the hospital in the previous 30 days. To understand participants' experiences using technology.	Observations and focus groups revealed overall acceptability and appreciation of the intervention across stakeholders. Family members believed the video visit allowed for more interaction with health care providers in general and allowed for clarification of certain issues regarding resident care.
Stirling et al., 2014 – Australia	Qualitative research	5 nurses 12 action group members 11 family members 10 expert advisors 1 aged care facility	The Discussion Tool	To detail the development and pilot evaluation of a tool aimed at facilitating communication between aged care facility staff and family members of a resident with dementia.	The tool facilitated a more open dialogue between dementia palliation resource nurses and family members. Both resource nurses and family members gained confidence in discussing the death of their relative with dementia, and in relevant cases discussed specific decisions around future care. Family members and nurses reported satisfaction with these discussions.
Sun et al., 2022 – Canada	Mixed methods	21 PSWs 5 LTC homes in Ontario, Canada	Communication at End-of-Life (Ceol) Education Program	To assess PSWs' knowledge and confidence in delivering palliative and EoL care after their participation in the Ceol Education Program. To identify factors that facilitated or hindered PSWs' capacity to engage in palliative and EoL care in LTC homes.	Significant improvements in all three domains (attitudes and beliefs towards death and dying; relationships with families and residents; active participation in EoL care) were observed. PSWs' elevated confidence in speaking with families of the residents about EoL, discussing goals and plans with the residents, and realising that a "good death" is possible. Time constraints and staff shortages were recurrent themes that hindered many participants' ability to provide resident-centred care.
Sussman et al., 2019 – Canada	Mixed methods	33 LTC staff 4 LTC homes in Ontario, Canada	Condition-specific pamphlets	To report findings on the usability and staff use of 5 condition-specific pamphlets of high prevalence in LTC: dementia, heart failure, chronic obstructive pulmonary disease, renal failure, and frailty.	The pamphlets were reportedly accurate, relevant, and easy to understand. Following 6 months of availability, most staff in LTC read the pamphlets, found the information useful, and planned to share them. Half of the staff questioned their role in pamphlet distribution, and most had not distributed them. Regulated staff expressed more comfort sharing the pamphlets than care aides and support staff.

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Veerbeek et al., 2008 – The Netherlands	Non-randomised experimental study	271 patients and family relatives 2 NHs 2 hospitals 1 residential care organisation 1 home care organisation	Liverpool Care Pathway (LCP)	To investigate the effects of using the LCP on communication during the last 3 days of life and on the level of bereavement in relatives after the patient's death.	The evaluation of the relatives did not reveal substantial changes in communication after the introduction of the LCP. Communication was evaluated similarly in both periods, except that in the intervention period more relatives found the information about the patient's situation and care comprehensible when compared with the baseline period. Most relatives in both periods were positive about the way information was provided to them, the decisions that were made about the patient's care or treatment, and the caregivers consideration of the patient's personal or religious beliefs. After the death of the patient, somewhat more relatives in the intervention period were told how to get further support with bereavement when compared with the baseline period. Relatives in the intervention period had significantly lower levels of bereavement when compared with relatives in the baseline period.
Vu et al., 2022 – United States of America	Mixed methods	13 staff 1 urban skilled NH	Laptop, tablet, facemasks with clear window, audio amplifier + headphones + voice enhancer, TV, LCD monitor and lightweight headphones	To implement a simple intervention at a skilled-nursing setting that increased the quantity of available technology to help staff and residents engage with families and other medical professionals during COVID-19 restrictions.	85% of staff strongly agreed that the new equipment improved staff-family communication. Enhanced communication helped families become more familiar with the resident care needs and goals during discharge. Additional technology also made it easier for residents to connect virtually with outside consulting physicians, thereby saving time and transportation costs.
Wagner et al., 2018 – United States of America	Mixed methods	77 nurses 88 NHs in California, USA	Communicating about resident adverse events (COMRADE)	To test an intervention aimed at educating nurses who work in NH settings to improve their communication of patient safety events to NH residents and family members. To examine whether nurses' knowledge and execution of the communication process improved because of the education.	Nurse participants improved their knowledge of PSE communication, especially about the cause of the event. what they would say to the resident/family member, and future prevention of the PSE. Qualitative subgroup analysis revealed an increased number of empathic statements were noted post-intervention.

methods while capturing the breadth in types and modes of staff-family interactions. Common themes and patterns within each paper were sorted into communication methods and types of delivery. Information from each paper pertaining to communication challenges was coded and grouped using a similar process. Methods, types of delivery and challenges were synthesised and reported descriptively. This process was completed by one author (AJS) and reviewed by a second author (DC) for accuracy and completeness.

QUALITY REVIEW

The quality criteria tool by Hawker *et al.* (2002) was used to assess the included papers. The tool, which outlines quality criteria for both quantitative and qualitative studies, consists of nine subscales: abstract and title; introduction and aims; method and data; sampling; data analysis; ethics and bias; results; transferability/generalisability; and implications and usefulness of the paper. The criteria item in each of the nine subscales was rated on a 4-point ordinal scale described as good (4), fair (3), poor (2) and very poor (1). Each study therefore could receive a total score within a range of 9–36 (Hawker *et al.*, 2002). A score of 28–36 is associated with good quality studies, 20–27 for fair studies, 10–20 with poor quality studies and less than 10 for very poor-quality studies (Hawker *et al.*, 2002). Since the aim of this review was not to assess method effectiveness, an equal weighting approach was applied to each paper during the data synthesis and interpretation. This helped mitigate potential biases that might have arisen from

preferentially valuing certain types of evidence over others. One of the authors (AJS) and a student research assistant completed the appraisals separately and discussed the ratings until consensus was achieved.

RESULTS

STUDY SELECTION

The initial and follow-up database searches (Medline, PsychInfo, Embase, CINAHL, Scopus, Nursing & Allied Health database & Education database) identified a total of 2,574 and 609 papers, respectively, after duplicates were removed. Papers were most often excluded because they focused on paediatric populations, were not conducted in a LTC home or equivalent, did not evaluate or explore an intervention designed to address communication, or did not include LTC staff and family/care partners. A total of 208 papers, 18 records from websites and one record from an organisation (Government of Canada) were extracted for a full-text review. Of these, 24 studies and zero records met the inclusion criteria (Figure 1).

METHODOLOGICAL QUALITY OF THE INCLUDED STUDIES

On the Hawker *et al.* (2002) quality assessment scale, 22 of the 24 studies met criteria for a 'good' quality rating. Two studies were rated as 'fair' quality (Vu *et al.*, 2022; Halcomb, 2009) because they were lacking detail and clarity pertaining to participant characteristics, methods used and background information. On average studies

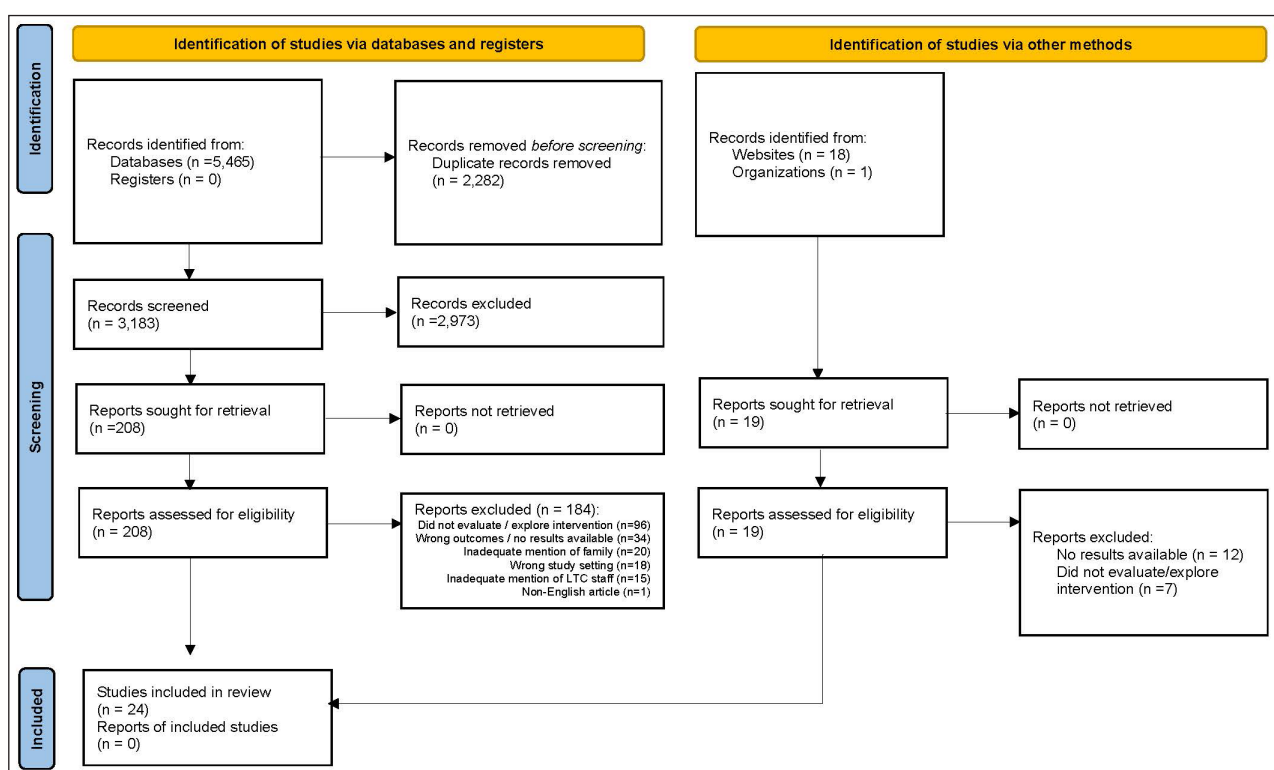


Figure 1 PRISMA flow diagram of the process of the integrative review identification, screening, and eligibility of studies.

scored 30/36 ($SD = 3.8$ with a range of scores between 21–35 on the quality scale (i.e., a range of fair to good quality). Final quality ratings along with their categories are presented in Figure 2.

STUDY, LOCATION AND PARTICIPANT DESCRIPTION

The 24 included studies employed 22 unique interventions and over¹ 4,765 study participants representing LTC home staff (e.g., nurses, personal support workers and other care workers), residents, family/care partners and other contracted health care professionals (e.g., occupational therapists, physical therapists and physicians). Eight of the studies were conducted in Canada, six in the United States of America, six in Australia, two in Norway, one in Belgium, and one in the Netherlands. Nine studies used qualitative methods, six studies used quantitative methods and nine studies used mixed method design. Papers that used qualitative research methods ($n = 18$) collected data using individual and group interviews ($n = 16$), field observations ($n = 4$) and open-ended surveys or questionnaires ($n = 5$). Papers that used quantitative research methods ($n = 15$) collected data using surveys or questionnaires ($n = 12$), structured interviewing ($n = 3$) and health-related variables (e.g., measurements for activities of daily living or health instability), which were scored by independent researchers or staff ($n = 2$). Table 1 describes the study design, research setting, participant types, aim(s) and objective(s), and main findings of each included paper.

COMMUNICATION METHODS

Three common methods (i.e., structured education, meetings and takeaway resources) along with their types of delivery (i.e., in-person, virtual, hybrid, paper, electronic) were identified from the included studies. Representation of the communication methods and delivery types used by the included studies is provided in Figure 3.

Structured education

Ways of delivering this method included structured seminars, workshops, training sessions, modules and classes or equivalent group-based learning organised by the study researchers. Structured educational sessions were either conducted in a single day ($n = 2$) or over multiple half-day or shorter sessions ranging from one week to a year in duration ($n = 13$). The sessions were often facilitated by study researchers, subject matter experts or trained facilitators. Participants in these sessions included various combinations of LTC staff, family/care partners and residents. Delivery of structured education was provided in various formats, including in-person ($n = 12$), virtual ($n = 2$) or hybrid which consisted of a combination of in-person and virtual sessions ($n = 1$).

Meetings

Meetings were any informal gathering, case conference, scheduled appointment or formal discussion that

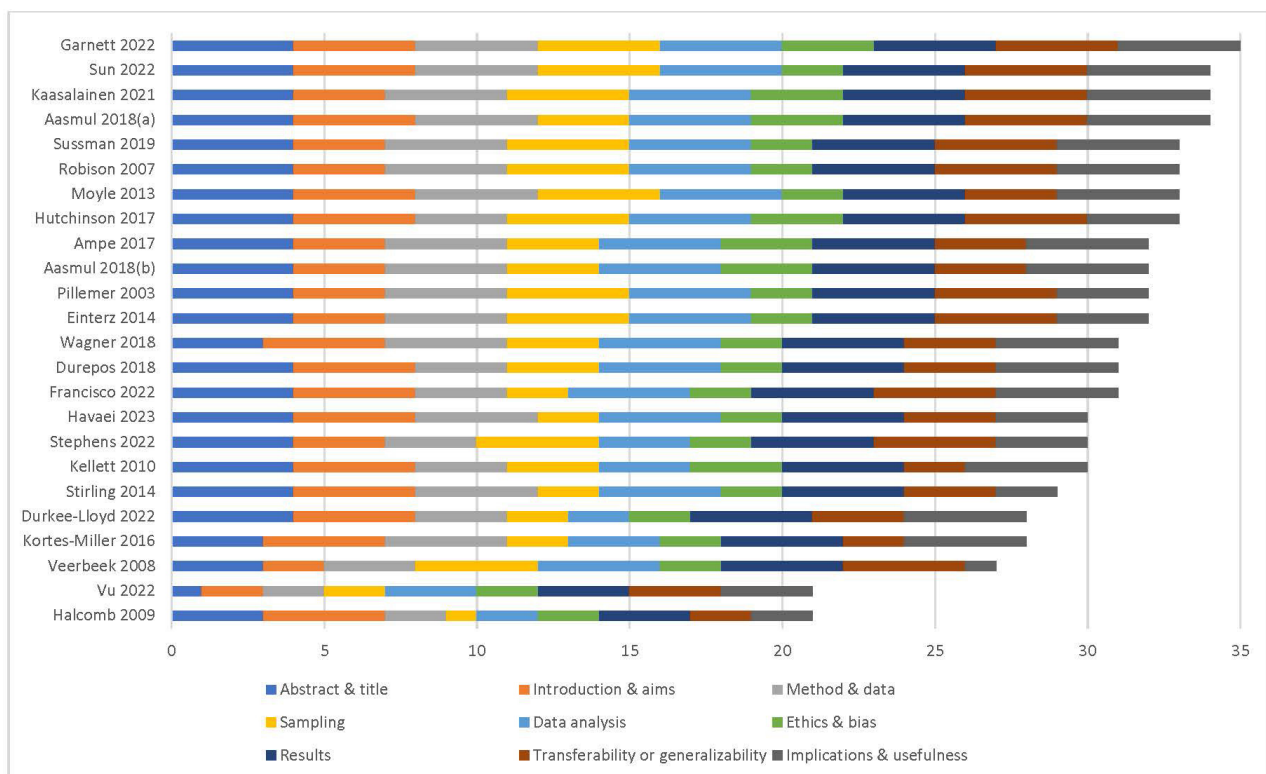


Figure 2 Quality assessment of each included study using criteria from Hawker et al., (2002). The items in each subscale were rated on a 4-point ordinal scale described as good (4), fair (3), poor (2), and very poor (1). Each study therefore could receive a total score within a range of 9–36. A score of 28–36 is associated with good quality studies, 20–27 for fair studies, 10–20 with poor quality studies, and less than 10 for very poor quality studies.

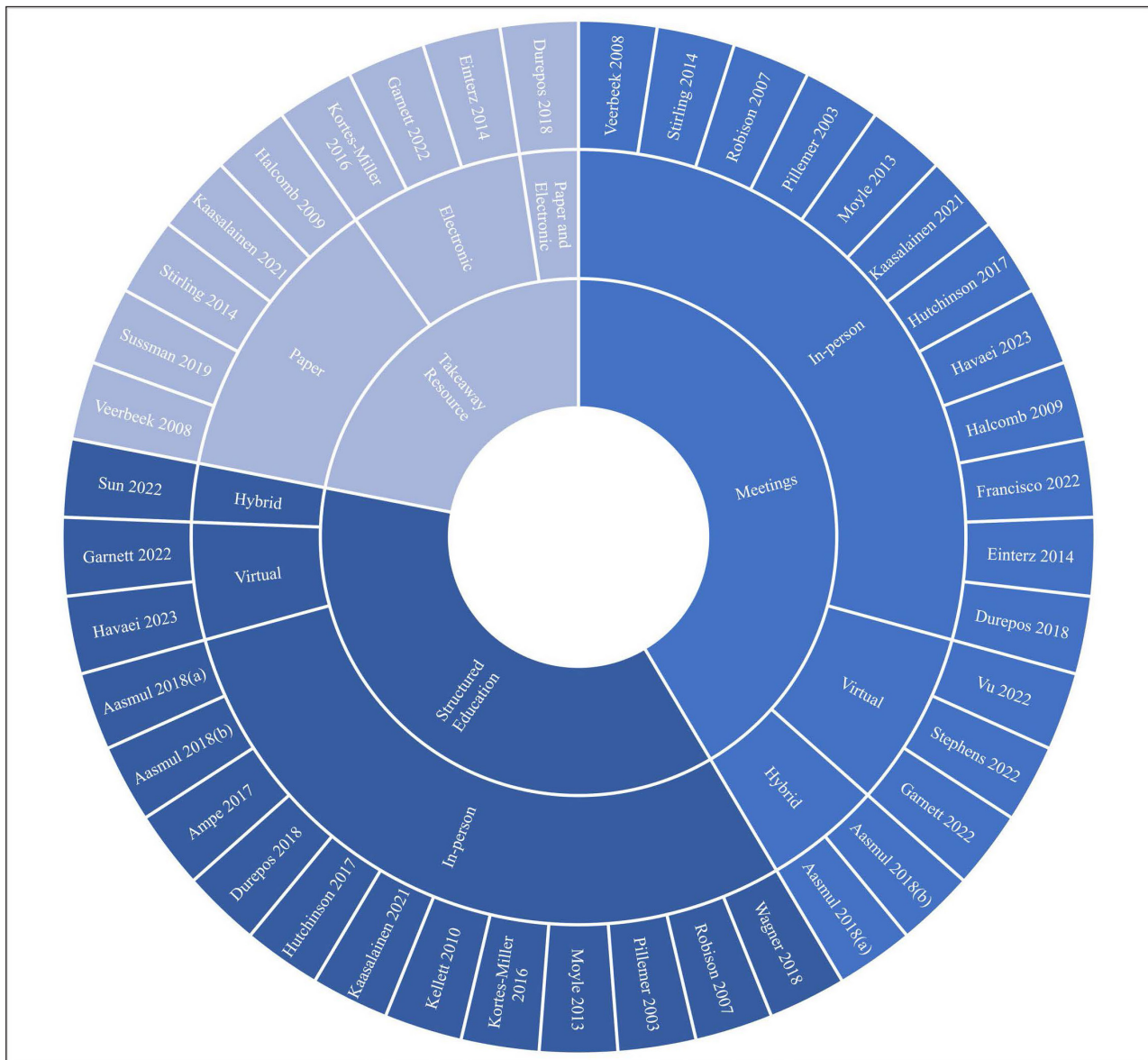


Figure 3 A summary of the three common communication methods and delivery types found in the included studies to facilitate resource staff-family/care partner communication in LTC. Studies which included each method and delivery type in their design are identified.

always included family/care partners and LTC staff and occasionally involved residents. Meeting attendees were apprised of resident health status, changes in procedures or other pertinent information necessary for the coordination of resident care. Unlike the 'structured education' method, meetings were intended as brief points of contact between staff and family for information exchange rather than as planned educational or information discussion sessions. Meetings took place in-person ($n = 12$), virtually ($n = 3$) using software solutions such as ZOOM and VSee™ (VSEE LAB, Inc.) or in a hybrid delivery type ($n = 2$). Meetings varied in structure (i.e., some used an agenda and minutes, while others used a more informal approach with open discussion). The frequency of meetings ranged from weekly to quarterly and the number of attendees per meeting ranged anywhere from two to more than ten participants.

Takeaway resources

Some studies used pamphlets, brochures, videos, emails, voicemails, online posts or other resources to provide participants with information that they could take with them or access as they needed. These were delivered to participants on paper ($n = 5$), electronically ($n = 3$) or using both paper and electronic methods ($n = 1$). Takeaway resources were for the most part designed to be self-explanatory, informative and easy to understand; thus, they did not necessarily require explanation or context from researchers, subject matter experts or trained facilitators. The purpose of providing these resources was to ensure that family/care partners and LTC staff had relevant and accurate information at hand for reference as needed which could: 1) facilitate communication and correspondence with fellow participants and/or 2) help participants better understand the needs of the residents and how to contribute to their care.

CHALLENGES WITH IMPLEMENTING COMMUNICATION METHODS

Three challenges to implementing communication methods, as reported by both staff and family/care partners, were identified. They included: 1) confusion, misunderstandings and disagreements; 2) insufficient time; and (3) difficulties with technology. Representation of the challenges to implementation of the communication methods in the included studies are provided in Figure 4.

Confusion, misunderstanding, and disagreement between staff and family/care partners

The most frequently cited challenge in the studies was confusion, misunderstanding and/or divergent

values, perspectives and beliefs among staff and family, leading to ineffective information exchange ($n = 15$). Particularly, staff and family who spoke little or no English faced challenges in understanding and effectively communicating information (Aasmul, Husebo and Flo, 2018; Havaei et al., 2023; Sun et al., 2022). Additionally, differing care goals and expectations led to misunderstanding and uncertainty (Ampe et al., 2017); for example, some staff neglected to distribute information pamphlets to families (Sussman et al., 2019).

Resistance to implementing study methods was identified when staff believed that there was already sufficient interaction with families (Moyle et al., 2013). Also, staff noted that some families were not ready to come to terms with significant changes in the lives of their

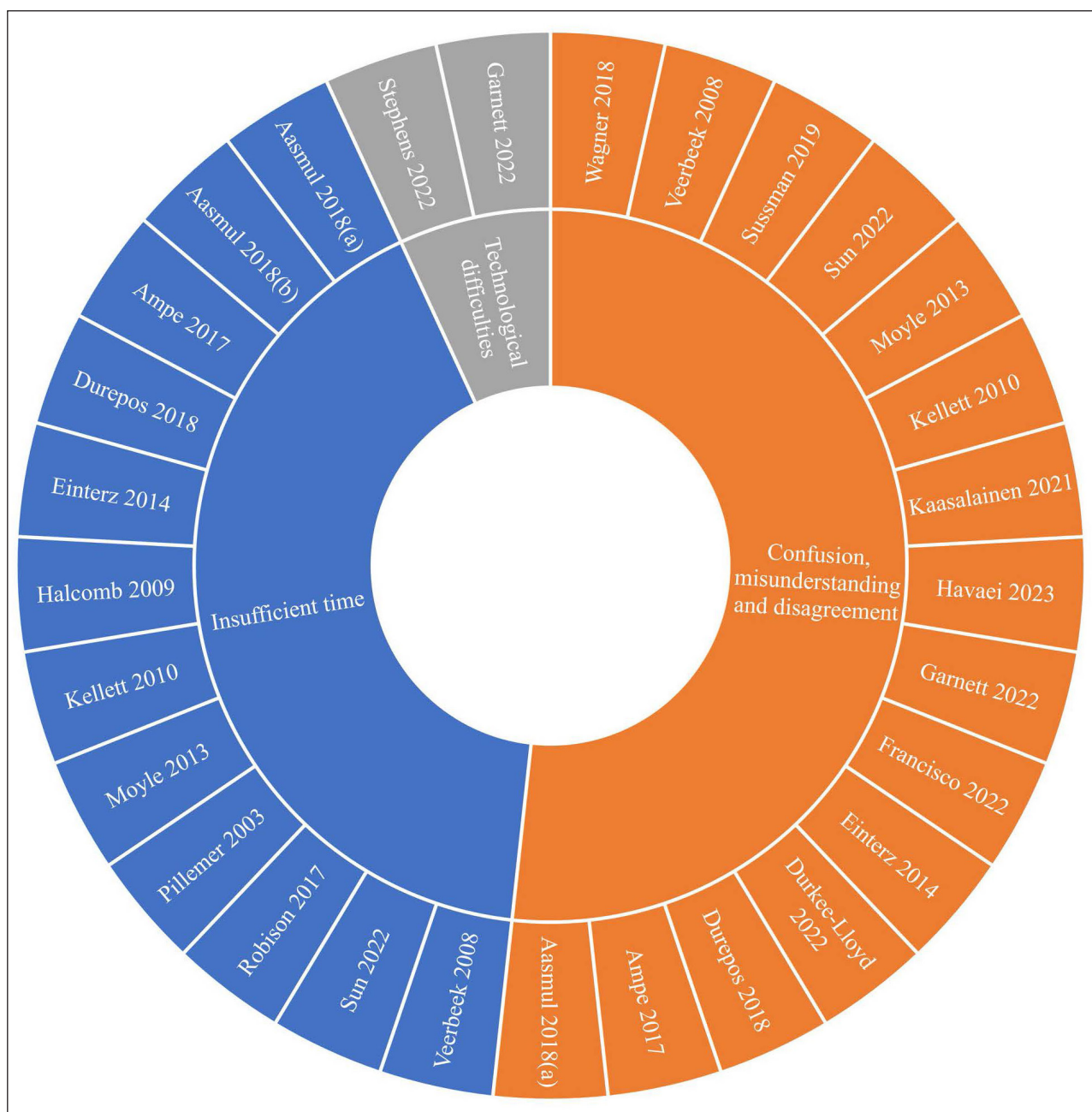


Figure 4 A summary of three challenges related to communication method implementation used by health care staff to promote information sharing with family/care partners (and vice-versa) of older adult residents living in long-term care homes.

loved one(s) (Kellett et al., 2010; Sun et al., 2022; Sussman et al., 2019) and thus were not capable of participating meaningfully in care discussions (Aasmul, Husebo and Flo, 2018). This was particularly relevant when the staff's assessment of what was best for the resident differed from the family's view creating tension in decisions surrounding end-of-life care (Durepos et al., 2018), for example.

Family/care partners were sometimes sceptical regarding the implementation of staff-family communication methods. For instance, some expressed that they already understood the intervention explained to them or did not find it relevant or useful (Einterz et al., 2014). This disconnect was further evidenced by the lack of consistent engagement from family/care partners, who did not regularly attend training sessions or participate in care-based discussions (Durepos et al., 2018; Einterz et al., 2014; Garnett et al., 2022; Kaasalainen et al., 2021). Differences in communication styles contributed to misunderstanding among family/care partners. For instance, some family participants described nurses' tones and explanations as 'robotic' which was perceived as a lack of empathy (Wagner et al., 2018). Technical language or jargon was problematic for some family participants, hindering their ability to comprehend information (Francisco et al., 2022; Kaasalainen et al., 2021; Veerbeek et al., 2008; Wagner et al., 2018). Families reported a lack of clear and consistent updates regarding the status of their loved one (Durkee-Lloyd, 2022).

Insufficient time

Lack of time for communication was mentioned among both staff and/or family/care partners ($n = 12$). For family/care partners, this was often linked to competing family or personal obligations (Pillemer et al., 2003). Moreover, insufficient time to grieve, and acknowledge the change in a loved one's living situation, was difficult to process for some family members (Verbeek et al., 2008). Work demands secondary to short-staffing, and limited funding to backfill staff vacancies, were cited as reasons by LTC staff for lack of time (Ampe et al., 2017; Durepos et al., 2018; Halcomb, 2009; Kellett et al., 2010; Moyle et al., 2013; Sun et al., 2022). Staff and family participants reported that limited time impacted implementation of communication methods when completion involved multiple steps, extensive planning was needed, or additional training was required before they could be successfully implemented (Halcomb, 2009; Pillemer et al., 2003). For example, a communication method that involved training staff members on new procedures or protocols was difficult to implement because it required scheduling colleagues in their unit for training outside of normal work hours (Aasmul, Husebo and Flo, 2018; Aasmul et al., 2018; Einterz et al., 2014). Some communication methods required periodic 'boosters' (i.e., targeted refreshers or updates to the study intervention) to maintain effectiveness over time;

an activity difficult to implement for some staff (Robison et al., 2007).

Difficulties with technology

Studies found that technical issues ($n = 2$), such as screens freezing on a tablet or phone, background noise and inability to see all participants on a single screen, disrupted or prohibited the communication exchange (Garnett et al., 2022; Stephens et al., 2022). Some communication methods requiring technology lacked on-site or help-line technical support and/or training, which made them more challenging to implement (Stephens et al., 2022).

DISCUSSION

The objectives of this paper were to: 1) synthesise and summarise common communication methods and their delivery types used for staff-family communication in LTC homes and 2) identify any challenges that impacted the implementation of the communication methods in LTC. This search produced 24 studies and identified 22 different combinations of communication methods intended to address family-staff communication within LTC. Three communication methods and three challenges were identified. Our findings bring together what is currently known about staff-family/care partner interaction and may inform future best practices and policies to optimise communication between family/care partners and staff within LTC homes.

EDUCATION

Education, a principal method in this review, was identified by a previous study which reviewed interventions designed to enhance teamwork, communication and task management in other health care settings (Buljac-Samardzic et al., 2020). The importance of education, specifically learning designed for family/care partners, is a key element when viewed through the lens of caregiver identity theory. Family/care partners may require training in needed skills within LTC, such as proper handling or transfers, and knowledge to understand medical terms used by staff. Thus, future communication methods should include education, training or resources tailored to these skills and knowledge which may minimise challenges and expectations in staff-family interactions.

Further, it is essential to consider the emotional and physical challenges of caregiving. Family/care partners often perceive their roles not as formal caregivers but as simply fulfilling family obligations (Montgomery et al., 2016). Methods should also include some form of counselling or support group, to nurture the family/care partner with their 'caregiver identity' and help them feel more comfortable communicating with staff. Many LTC homes have family councils already established which

can offer invaluable peer support, sharing experiences and coping strategies among families. Recognising, validating and celebrating their unique contributions to resident care can help boost their confidence and sense of value, and foster greater interaction and collaboration with LTC staff. Providing them with a special badge or other visible recognition while in the home would help them be viewed by others as *#morethanavisitor* (Thirsk et al., 2022) and increase the likelihood that their contributions will be acknowledged and respected by staff. Future methods, policies, and best practices designed to improve staff-family communication in LTC must holistically address the multidimensional needs of family/care partners, from skill acquisition to emotional support, to foster an environment that both appreciates and validates their 'caregiver identity' and optimises staff-family communication.

TECHNOLOGY

Almost all studies included in this review, published in 2020 or more recently (except Francisco et al., 2022 and Kaasalainen et al., 2021), incorporated technology within their method(s). We hypothesise that the increased use of technology in communication methods resulted from health care policy and regulations restricting in-person interactions to safeguard vulnerable LTC residents during the COVID-19 pandemic (Thirsk et al., 2022). Technological platforms, such as ZOOM and VSee, enabled millions of people to shift communication in their day-to-day lives online to help slow the spread of the COVID-19 virus. While efforts were made by LTC staff to maintain contact with families during the first wave of the pandemic via the use of such platforms (Durkee-Lloyd, 2022; Vu et al., 2022), some family/care partners reported negative experiences with virtual platforms which included but were not limited to poor internet connectivity and privacy concerns (Garnett et al., 2022). Some suggested that the use of online platforms during the pandemic led to a new barrier called 'Zoom fatigue', where attending multiple videoconferences was reported as exhausting and diminished the richness that non-verbal social cues (e.g., facial expressions, body language, etc.) provided to the communication exchange (Nesher Shoshan and Wehrt, 2022). Effective technology implementation in LTC hinges on computer/tablet and internet access, familiarity with use of computer and communication software, problem-solving ability or support for internet connection and software, and organisation of the physical environment to promote privacy and effective communication exchange (Chu et al., 2022). Although technology is essential for advancing LTC communication methods, the value of in-person interactions should not be overlooked.

CULTURAL CHALLENGES

Cultural and linguistic differences contributed to misunderstandings between staff and family/care

partners. Incorporating life course theory, that is, recognising the interconnectedness of personal histories and socio-cultural contexts (Elder Jr, 1998) can provide insight into how conflicting understandings of older adults and staff-family communication methods might arise in LTC homes. For instance, a LTC staff member's professional training and life experiences might shape their communication in ways that seem at odds with the family/care partner expectations. Further, LTC workforce shortages in North America have been filled with internationally educated health care staff introducing multi-cultural work environments (Xiao et al., 2018). These emigrated workers, predominantly in lower-paid roles with limited training opportunities (Cangiano et al., 2009), bring unique cultural experiences, shaped by economic, social, and political influences, to the LTC setting. These experiences can influence their perceptions and interactions with family/care partners. One study not included in the review found that non-English speaking staff relied heavily on non-verbal cues such as gestures, body language and facial expressions (Xiao et al., 2018) which added complexity to communication, and increased the risk for misinterpretation and misunderstanding. Moreover, family/care partners may possess beliefs about older adults different from staff, stemming from their cultural background. LTC home administration should take a proactive role in addressing potential cultural influences by consistency in staff-resident care assignment to increase familiarity between staff-family. Familiarity plays a key role in relationship building and trust which are fundamental to fostering effective communication in health care settings (Majerovitz et al., 2009). Recognising the intersections of personal histories, socio-cultural contexts and institutional dynamics can guide more empathetic and effective interventions to address these risks to effective communication.

NAVIGATING TIME CONSTRAINTS

Within the contemporary context of LTC, the challenge of time scarcity in staff-family communication is an operational challenge arising with understaffing, elongated shifts, and the regularity of overtime (von der Warth et al., 2021). This is particularly relevant for nurses, working shifts of 12 hours or longer, who find maintaining continuity in care assignments and thereby opportunities for communication with families significantly reduced compared to nurses working eight-hour shifts (Emmanuel et al., 2020). Frameworks to address LTC staffing challenges using care-related capacity planning have been proposed (Dieleman et al., 2023); however, their application requires attention to the uniqueness of each LTC home (i.e., number of residents and staff, size and layout of the building, geographical location). Thus, it is important to tailor staffing-related solutions to the specific needs and circumstances of each LTC home,

ensuring that strategies are both effective and adaptable to the unique challenges they face.

Time scarcity was a challenge for family/care partners, particularly for those who are employed and/or live at a distance from the LTC home. While many family/care partners might be interested in attending educational workshops, in-person care meetings, or accessing informational resources, their other commitments and priorities render such participation challenging. To address this without increasing the burden on LTC staff or families, one solution may be to leverage existing resources. LTC home management could create centralised hubs of information and resources in hard copy, such as a pamphlet and information sheet repository on a wall, and/or online on their website, including recorded webinars, modules, newsletters and blog posts. Such initiatives would empower families to access crucial materials and guidance at their convenience when time permits, thereby bridging the gap between need and availability. By addressing staffing concerns and improving information flow and accessibility, LTC homes can support quality in staff-family communication, which may influence family engagement and improved care outcomes for residents.

IMPLICATIONS FOR RESIDENT HEALTH AND WELL-BEING

Given the potential for sudden and rapid changes in LTC resident health, the importance of providing clear, timely and efficient updates and discussions between staff and family/care partners is essential. Innovative communication methods should encourage 'real-time' updates and flexible interactive delivery types between staff and family/care partners. Such types might include the adoption of secure messaging apps or platforms that facilitate text, audio and video formats. Future apps should ensure user-centred co-design with family/care partners to accurately capture and fully address their needs (Park et al., 2022). Websites should be created with universal design in mind as older adults may have difficulty using online information sources (Lowndes and Connelly, 2023). Further, as the complexity of residents' health condition and needs increase, so does the necessity for communication that includes language which is straightforward and accessible. Utilising plain language, along with translations for family/care partners whose first language is not English, can empower residents and their families via enhancing their understanding of complex medical terminology (Peter et al., 2024). This could support families to participate in health-related decisions more actively, thereby strengthening staff-family relationships and fostering person-centred resident care. The importance of developing adaptable communication strategies that can keep pace with the evolving health scenarios of residents is critical to ensure effective staff-family dialogue is maintained, even under challenging circumstances.

LIMITATIONS

While this review has provided valuable insights into current family-staff communication methods, some methodological factors may have influenced the results. The study protocol was not formally peer-reviewed or registered. Potential biases or areas for improvement could have been identified before the review was conducted, thereby enhancing its utility. Communication methods in the literature to date were predominantly 'staff led', meaning that there was little information about how family/care partners viewed the implementation or acceptability of these methods. Family/care partners should have a larger role in shaping the design and implementation of communication methods to ensure their needs and preferences are addressed as well as LTC staff. Additionally, the exclusion of papers published more than 20 years ago may have limited information about in-person communication methods. Staff-family communication would likely have been in-person within smaller communities, in a time of different health care system pressures, and different social etiquette and norms or expectations for care in LTC homes. The decision to exclude papers published greater than 20 years ago was made to reflect the current challenges in LTC, familial geographies and social context. Limiting the literature to English-only content resulted in the exclusion of at least one known paper written in French that may have provided relevant and unique information about communication between family/care partners and LTC staff. The papers included in this review were mostly written by authors in high income countries located in North America, Australasia and Western Europe. This cultural and geographical limitation may have implications for the generalisability of the research findings for other parts of the world. Lastly, key stakeholders such as family/care partners and LTC staff were not consulted during thematic categorisation which may have limited our understanding and interpretation of the findings.

FUTURE RESEARCH

Our findings prompt the need to further explore and investigate staff-family communication and relationships within LTC. Implementation of each method identified by this review was highly dependent on situational context, institutional processes, and the social culture of the LTC home. These contextual factors were not examined in this review and thereby communication method effectiveness could not be determined. To maximise caregiver involvement and advance future policy and best practices, communication methods geared towards promoting person-centred care and enhanced LTC staff-family communication would be a next step. A comparative study designed to evaluate the impact of virtual versus in-person methods on staff-family communication and person-centred care

outcomes would provide insight into effectiveness of communication methods. An ethnographic research inquiry would: 1) help detail family/care partner experiences in LTC and 2) provide much needed perspective and insight into the current state of staff-family communication in care relationships to optimise quality of life and well-being of LTC residents. Such findings may guide future research to optimise person-centred care and develop care partner programs and/or LTC organisational policies to promote best practices and engage staff and family/care partners together in caring for older adults.

CONCLUSION

To the best of our knowledge, this review is the first to synthesise current methods and challenges of LTC staff-family/care partner communication. Understanding how to improve communication between family/care partners and staff is crucial for enhancing person-centred care in LTC homes and resident well-being. Future research should address the identified challenges and integrate effective strategies to inform policy development and best practices that will ultimately improve quality of resident care.

ADDITIONAL FILE

The additional file for this article can be found as follows:

- **Supplementary File.** Appendices A–C. DOI: <https://doi.org/10.31389/jltc.282.s1>

NOTE

- 1 The exact total of participants from the included studies in this review could not be determined due to incomplete sampling data from Francisco et al. (2022).


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COMPETING INTERESTS

The authors have no competing interests to declare.

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