



Challenges and Opportunities to Support Communication and Reduce Background Noise in Long-Term Care

RESEARCH

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ABSTRACT

Context: Using communication tactics and reducing background noise are key staff behaviours to improve communication with long-term care residents, a population with high levels of hearing loss.

Objectives: To identify barriers and enablers to these behaviours in long-term care settings.

Methods: Semi-structured interviews were conducted with 23 staff who provide day-to-day care for residents in a long-term care home in Australia. Data were analysed using a hybrid approach, combining deductive thematic analysis based on the Capability, Oppportunity, and Motivation model of Behaviour (COM-B), with inductive thematic analysis.

Findings: Analysis identified multi-level barriers and enablers influencing aged care staff use of communication tactics and strategies to reduce background noise when interacting with residents. Key barriers included limited knowledge of residents' communication needs and hearing status, variable awareness of the impact of background noise, difficulties adapting communication during busy periods, time and staffing constraints, unclear organisational protocols, environmental challenges, and communication difficulties associated with dementia and behavioural symptoms. Despite these challenges, staff were generally motivated to support effective communication and recognised its benefits for resident well-being, relationships, and care delivery. Important enablers included supportive managers and colleagues, staff experience and communication skills developed through practice, collaboration with families, access to communication-related information in care plans, visual prompts and cues, and positive beliefs about the benefits of communication strategies and noise reduction. Staff also reported that effective communication improved resident

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cooperation, reduced distress, enhanced social interaction, and increased job satisfaction.

Limitations: This study was conducted at two long-term care communities within a single care provider in Australia, which may limit the transferability of our findings to other settings.

Implications: These findings could inform multi-component interventions combining targeted training, clear communication policies, environmental adjustments, and ongoing organisational support that are required to enhance staff communication practices, improve communication with residents, foster meaningful social interaction, improve care delivery, improve residents' mental health and quality of life, and create a supportive work environment.

INTRODUCTION

A US study estimated that up to 90% of long-term care residents are estimated to have hearing loss, although only around 14% use hearing aids (Cohen-Mansfield and Taylor, 2004). Although hearing aids are effective in improving communication, they remain underutilised in long-term care settings (El-Saifi et al., 2025; Norwood-Chapman and Burchfield, 2000). Untreated hearing loss presents a serious barrier to communication and to psychosocial well-being. Hearing loss is associated with reduced quality of life, increased social isolation (Bott and Saunders, 2021), loneliness (Weinstein et al., 2016), depression (Rutherford et al., 2018), and anxiety (Contrera et al., 2017). Hearing loss exacerbates the impact of dementia and is associated with increased levels of changed behaviours (e.g., agitation, aggression, hallucinations) (Maruta et al., 2020). Because at least 50% of long-term care residents experience dementia, the interaction of hearing loss with cognitive impairment is of critical significance for improving quality of life for people living with dementia (Dawes, Littlejohn, et al., 2021; Powell and Reed, 2024).

Long-term care staff have been reported to struggle to complete care tasks and maintain high standards of care due to communication difficulties with residents with hearing impairment (Bennett et al., 2016). Communication difficulties between staff and residents increase the time and effort required for staff to provide care, increase risk of misunderstanding, reduce adherence to treatment, reduce satisfaction with care, and exacerbate health and well-being outcomes for residents (Hoffman et al., 2005; Reed et al., 2020). Effective communication improves residents' quality of life and increases job satisfaction for long-term care staff (Bennett et al., 2015; Nakrem et al., 2011).

Simple communication tactics (e.g., getting a person's attention before speaking with them, communicating face-to-face, avoiding covering one's mouth, speaking slightly louder but not shouting, speaking at a slower pace without over-enunciation) facilitate communication

with people with hearing loss (Mamo et al., 2017; Stevens et al., 2019). One research evaluation of communication in Australian long-term care involved examination of resident care records, observations of staff-resident interactions and surveys of residents and staff (Bennett et al., 2016). The study found that there were few opportunities for residents to engage in meaningful communication with staff. Communication needs of residents (i.e., that the person has a hearing loss) were not well documented in care records, and staff were observed to use communication tactics inconsistently.

High levels of background noise are a feature of many long-term care settings, and background noise is particularly problematic for people with hearing loss (Pryce and Gooberman-Hill, 2012). Sources of noise include announcement systems, televisions, radios, and nearby conversations (Ludlow et al., 2018; Punch and Horstmanshof, 2019). Background noise can be managed (e.g., by turning the television down), but research suggests numerous challenges reducing background noise in long-term care settings. One study involving observations of daytime activities in long-term care settings reported that residents were reluctant to request reductions in background noise (e.g. turning down music) (Pryce and Gooberman-Hill, 2012) and staff were not aware of how background noise affected communication among residents with hearing loss (Pryce and Gooberman-Hill, 2013).

Minimising background noise and consistent use of communication tactics would improve communication with residents. Despite the usefulness of communication tactics and reducing background noise on communication in long-term care settings, we are not aware of published studies that report on the barriers and enablers for these behaviours. The *Capability, Opportunity, and Motivation* model of Behaviour (COM-B) model of behaviour change has been increasingly applied to professional behaviour in relation to hearing and communication across various care settings (Couth et al., 2021; Ismail et al., 2021). The COM-B model conceptualises behaviour as resulting from interactions between *Capability* (physical

and psychological), Opportunity (physical and social), or Motivation (reflective and automatic), and is commonly used to identify barriers and enablers to behaviour (Michie et al., 2011). If a behaviour is not occurring, barriers and enablers in one or more of these COM areas need to be addressed (Michie et al., 2011). The COM-B model has also been used alongside the Theoretical Domains Framework (TDF), which consists of 14 constructs (e.g., knowledge, skills, goals, professional role and identity) aligned with the COM-B components, to better understand the influences on the target behaviour(s) (Cane et al., 2012). The aim of this study was to use the COM-B and the TDF to identify the barriers and enablers that affect long-term care staff's (i) use of communication strategies and (ii) their ability to reduce background noise. Strategies that address these barriers and enablers could then be developed to improve communication with long-term care residents.

METHODS

STUDY DESIGN AND SETTING

This qualitative study used semi-structured interviews to explore capability, opportunity, and motivational barriers and enablers to the use of communication tactics and strategies to mitigate background noise from the perspective of long-term care staff. Long-term care refers to residential services that provide accommodation, meals, personal care, nursing care, and social support for older adults who can no longer live independently because of physical frailty, chronic illness, cognitive impairment, or disability. They typically employ nurses, care workers, and allied health professionals to support residents with ongoing health, functional, and daily living needs. Long-term care settings are known by different names internationally; in Australia, they are called 'residential aged care facilities'. In this paper, we use the term 'long-term care', because this is the most well-recognised term in international research literature.

For the present study, communication tactics were defined as gaining the resident's attention before speaking, speaking face-to-face with the resident and speaking clearer, nearer, and louder. Reducing background noise was defined as requesting permission from the resident to mute the television or radio before talking to residents in their room and muting televisions or music (e.g., radios or stereos) near the dining room during mealtimes.

This study was conducted between May 2023 and August 2023 in two long-term care communities run by a single not-for-profit provider in an urban location in Perth, Western Australia. One community focuses on adults with a range of complex health and support needs, with a capacity of 100 residents. The other is a

dementia-specific home designed for people living with dementia, with a capacity of 60 residents. Both provide 24-hour personal care, accommodation, meals and registered nursing assessment and intervention organised around household-style living units. Ethical approval for this research was granted by the Human Research Ethics Office of The University of Queensland (Ethics ID number: 2022/HE001477). All participants provided written informed consent before participation.

PATIENT AND PUBLIC INVOLVEMENT

During planning and conduct of the study, a panel comprising two family carers of long-term care residents and one resident (i) provided advice about the important issues to focus on in relation to communication with people with hearing loss in long-term care (i.e., communication tactics and background noise), (ii) reviewed the interview questions for staff with respect to wording and content, and (iii) commented on the results and their interpretation. The aim of patient and public involvement was to ensure that the study focused on issues related to communication that were relevant to long-term care residents with hearing loss. One critical reflection about patient and public involvement in this study is that geographical distance made regular, meaningful patient and public involvement more challenging (the lead investigator (PD) and senior postdoctoral researchers (NES and CM) were based on one side of Australia while the study site was on the other). This geographical challenge was mitigated by (i) having local researchers facilitate regular patient and public involvement sessions and (ii) conducting periodic in-person visits to the study site by the lead investigator and the senior postdoctoral researchers.

SAMPLING AND RECRUITMENT

Eligible participants included staff who provide direct care (e.g., care workers, nurses) or indirect care (i.e., shift managers) and work in long-term care in Australia who could provide informed consent and had conversational English. People were excluded if they had not worked in a long-term care setting in the past three months. Maximum variation purposive sampling was applied to ensure diversity across roles (e.g., nurses, care workers), seniority levels, and ethnicity. A research team member (NR) contacted senior managers at the long-term care community, who then engaged staff to invite participation. A researcher (CM) followed up with interested staff to schedule interviews with eligible participants. Recruitment continued until no new themes emerged from the interviews, indicating data saturation (Hennink et al., 2017). Participants were asked if they wanted a summary of the findings, which was provided after completion of the research via written summary to those who answered yes.

DATA COLLECTION AND ANALYSIS

Demographic data collected during the interviews were summarised using descriptive statistics. The COM-B model informed both the semi-structured interview guide and the analysis approach. The interview guide is provided in supplementary materials. Interviews were conducted in-person between May 2023 and August 2023, lasting between 30 and 90 minutes, were audio-recorded, transcribed verbatim by a professional transcription service, de-identified, and cross-checked for accuracy. A matrix was developed in Microsoft Excel to organise and interpret the data, with the COM-B domains and sub-domains—Capability (Physical and Psychological), Opportunity (Social and Physical), and Motivation (Reflective and Automatic)—as the framework. The analysis was informed by the multidisciplinary perspectives of the research team, including audiology (PD), pharmacy and implementation science (NES), and speech pathology, implementation science, behaviour change, and aged care (CM and NR). PD is a Professor of Audiology with expertise in hearing loss, communication, and behaviour change research. NES is a postdoctoral researcher with a background in pharmacy and experience in implementation and aged care research. CM is a speech pathologist with expertise in implementation science and behaviour change, and NR is a speech pathologist with extensive clinical experience in residential aged care. The researchers recognised that their professional backgrounds could influence the framing and interpretation of communication-related issues. Reflexive notes, regular team discussions, and consensus-based coding were used throughout data collection and analysis to critically examine assumptions and ensure that themes remained grounded in participants' accounts. The analysis began with a deductive approach where researchers categorised statements from the transcripts into the matrix to identify staff capabilities, opportunities, and motivations for using communication strategies and reducing background noise. The TDF was then applied to further analyse proximal behavioural determinants. Following this, researchers coded data inductively by identifying relevant subthemes and themes within each TDF domain using Braun and Clarke's thematic analysis method (Braun and Clarke, 2006). The COM-B and TDF frameworks were used deductively to organise data into theoretically informed behavioural domains, after which inductive analysis was undertaken within each domain to identify participant-derived themes and subthemes that reflected the specific barriers and enablers described by staff. Any disagreements regarding domain categorisation were resolved through discussion and consensus.

FINDINGS

At the time of the study, there were 85 care workers undertaking regular shifts who were eligible and received

an invitation to take part. A total of 23 participants were recruited for the study. Most participants were female (91%), born overseas (82%), and spoke a language other than English (74%). Most participants had more than five years of experience in long-term care, with an average age of 42 years, and 43% were care workers (Table 1).

The barriers and enablers to using communication tactics and reducing background noise are described separately below, with illustrative quotes from participants provided to support the themes. Participants are identified by numbers only (e.g., P₁), [square brackets] are used to denote researcher editing for readability. The themes and subthemes for each behaviour within the COM-B and TDF models are outlined in Table 2. Additional participant quotes are available in the supplementary materials.

BEHAVIOUR 1: USE OF COMMUNICATION TACTICS

Psychological Capability

Knowledge

Enablers: Participants recognised that effective communication requires understanding residents' hearing status, communication preferences, dementia

DEMOGRAPHICS	N (%)
Age in years-Mean (SD)	42 (13)
Gender	
Female	21 (91)
Born overseas	19 (82)
Languages other than English	17 (74)
Work title	
Care worker	10 (43)
Nurse (EN or RN)	6 (26)
Allied health professional (Occupational therapist or Speech pathologist)	5 (22)
Manager	2 (9)
Qualifications	
Secondary school education	2 (9)
Diploma, certificate or equivalent	7 (30)
Bachelor's degree or equivalent	10 (43)
Postgraduate qualification (master's or doctoral degree)	3 (13)
Other qualification	1 (4)
Years in profession	
Less than 2	5 (22)
2–5	4 (17)
5–10	5 (22)
More than 10	9 (39)

Table 1 Sample demographics (n = 23).

THEMES	USE OF COMMUNICATION TACTICS	REDUCING BACKGROUND NOISE
Psychological Capability		
Knowledge	• Knowledge of hearing status of residents. • Knowledge of communication tactics including how to adapt communication based on individual resident needs. • Knowledge of dementia and how it impacts communication for residents.	• Staff vary in their level of awareness of how background noise impacts communication for people with hearing loss. • Awareness of policies and procedures governing turning off the TV at bedside. • Noise can adversely affect the behaviour of some residents with dementia. • Knowing how to control music levels in communal areas.
Skills	• Skilled in being able to adapt communication for people with hearing loss. • Communication skills and knowledge acquired on the job.	• Establishing rapport with residents before asking to mute the TV. • Staff know how to turn off the TV. • Staff know how to accommodate different resident preferences regarding having music during mealtimes.
Behavioural regulation	NA	• Staff adapt their schedule to avoid interrupting residents (e.g. not interrupting during a favourite program).
Memory, attention and decision processes	• Some staff forget to adapt their communication with residents.	• Some staff forget to turn off the TV in residents' rooms.
Physical Opportunity		
Prompts and cues	• Wearing hearing aids and glasses remind staff to adapt communication. • Posters remind staff who has hearing loss.	NA
Accessibility	• Accessibility of care plans.	• Staff having access to noise sources in communal area (e.g. music system). • Can be hard to find TV remote in residents' rooms.
Time	• Too busy and not enough time to use communication strategies (due to complex needs of residents and staff shortages). • Communication can be more difficult at busy times of the day.	NA
Resources	• Availability and need for training in communication tactics. • Policies and procedures about communication tactics.	NA
Environmental context and environmental stressors	• Group situations make communication more difficult. • Physical layout. • Face masks and shields impact communication.	• Regulations influence the capacity for staff to mute or turn down music in communal areas.
Social opportunity		
Cultural norm	• Cultural factors impact communication (e.g., inappropriate to touch residents to gain attention in some cultures).	NA
Organisational culture	• Management recognises importance of adapting communication for people with hearing loss.	• Mixed expectations regarding whether to mute music or TV in communal areas (e.g., during doctor visits).
Social support	• Staff modelling communication strategies. • Collaboration between staff. • Share information about communication preferences with colleagues. • Seek and receive advice from family regarding how to communicate with resident. • Staff do (not) read care plans.	• Staff sense that it is appropriate for them to request residents to turn music or TV off.

(Contd.)

THEMES	USE OF COMMUNICATION TACTICS	REDUCING BACKGROUND NOISE
Interpersonal influences	- Residents' communication can vary during the day, depending on mood and fatigue. - Some residents with dementia may exhibit behaviours such as aggression which makes it difficult to use some communication tactics (e.g., getting close, making eye contact, touching to gain awareness). - Residents' reactions prompt use of communication tactics (e.g. vague facial expression).	- Colleagues recognise benefit and react positively to music or TV being muted or turned down in communal areas during mealtimes. - Staff turn the TV or music back on if they notice the residents getting agitated. - Muting the TV or music during mealtime depends on resident preferences. - Residents react differently when asked to mute the TV in their rooms. - Residents react differently when asked to mute the TV in communal areas.
Reflective motivation		
Goals	- Staff are trying to adapt their communication to assist the residents. - Staff are task orientated and therefore may not prioritise communication.	Staff are task oriented and may forget to turn down or off the music and TV.
Beliefs about Consequences	- Adapting communication improves staff-resident relationship. - Adapting communication improves residents' mood, compliance and decreases their defensive behaviour. - Adapting communication makes staff happier and their work easier. - Being physically close to some residents with dementia who experience behavioural changes (e.g. aggression) entails risks for personal safety.	- Staff recognise background noise makes conversation and social interaction difficult. - Belief that reducing noise helps residents and staff hear each other clearly and helps staff to perform care tasks.
Beliefs about capabilities	- Lack of confidence among staff in using communication strategies. - Feeling confident to adapt communication for people with dementia.	NA
Automatic Motivation		
Desires	Long-term care staff want to communicate well to ensure quality of care.	NA
Emotions	- Feeling uncomfortable when communication breaks down. - Fear of aggressive response from residents when using communication tactics. - Effective communication makes staff feel satisfied.	Staff experience negative feelings when turning off the TV (upset, intrusive).
Impulses: habit, routine	Using communication tactics is part of daily routine.	- Some staff routinely mute or turn off the TV at communal area. - Some staff routinely mute or turn off the TV at bedside.

Table 2 Summary of themes and subthemes for each behaviour.

severity, and individual communication needs. Staff described adapting their communication according to residents' individual needs and explained that experience working in long-term care had helped them develop this knowledge. Several participants spoke about the importance of tailoring communication approaches for residents with dementia, including using short, simple instructions and interpreting non-verbal cues. Barriers: Knowledge about effective communication tactics

(e.g., getting a person's attention before speaking to them) varied across participants. Some staff felt that colleagues lacked understanding of alternative communication approaches when initial attempts were unsuccessful.

They [other staff] don't know of a lot of techniques on how to adapt on the fly, how to change really quickly to say you try to get someone to take a

shower, and you try to communicate that, and you spoke to them, and they're not understanding me. 'Okay, well that's it.' And they don't try another way. They don't think of another way to communicate. P3

Participants also talked about how a limited understanding of how dementia affects communication and felt that many challenging resident behaviours resulted from ineffective communication.

I think more [effective communication strategies] for residents with dementia, because that's a very tricky one. Because you end up having a lot of behaviours, unnecessary behaviours, because we just don't know how to communicate with a lot of residents with dementia. P4

Skills

Enablers: Participants described developing communication skills through experience and routine interaction with residents. Staff described learning how to modify communication according to individual needs and described how these skills improved over time through practice. Barriers: Although many participants felt capable of adapting communication, they identified a need for additional education and practical training, particularly in communicating with residents who have dementia or complex communication needs.

Memory, Attention, and Decision Processes

Enablers: Some participants described communication tactics as becoming part of routine practice, reducing reliance on conscious effort. Barriers: Participants spoke about occasionally forgetting to use communication tactics, especially when under time pressure, stressed, or focused on completing care tasks. "I think sometimes these [communication strategies] get a little bit missed due to time constraints." P5

Physical Opportunity

Prompts and Cues

Enablers: Visual reminders supported communication behaviour. Participants reported that hearing aids, notices indicating hearing loss, and other visual prompts reminded them to modify their communication appropriately.

Accessibility

Enablers: Care plans were viewed as a potentially important source of information regarding residents' communication preferences and hearing needs. Barriers: Participants spoke about difficulties accessing electronic care plans, particularly for new or temporary staff unfamiliar with the system. Consequently, staff were sometimes unaware of residents' communication needs.

Resources

Enablers: Participants expressed enthusiasm for additional communication training and viewed this as a practical way to improve care. Barriers: Many staff were unaware of any formal organisational policies relating to communication strategies. "I've not come across, maybe there is, I've just never seen one. Like a policy procedure thing." P1

The absence of clear protocols left staff uncertain about how best to support residents with complex sensory needs.

But I would find that does hinder us. Because if we have someone with hearing and vision loss, then that makes our job more difficult. Because then we're like, 'Well, what do we do? We don't have a protocol in place.' So then we're kind of just guessing on our own. P3

Time

Barriers: Participants consistently identified workload pressures, staffing shortages, and busy periods as barriers to implementing communication tactics.

I think in the morning. It's kind of rush hour. It's kind of like a busy timing. So, we just rush through the room, and we just do the thing very fast and then that's the thing we forget about these things. P13

Environmental Context and Stressors

Barriers: Group activities, small physical spaces, and infection-control measures such as face masks created challenges for effective communication. "It's been hard with the masks on because they can't really ... It muffles the sounds, and they can't read your lips at all." P6

Social Opportunity

Organisational Culture

Enablers: Participants reported that managers generally recognised the importance of communication and supported efforts to improve interactions with residents.

Social Support

Enablers: Collaboration among staff was viewed as an important facilitator. Participants described modelling communication techniques, sharing information about residents' hearing needs, and seeking advice from families regarding communication preferences.

Barriers: Although information was available in care records, participants said that these records were often overlooked. "So I feel that we've got these handover sheets that are pages and pages long.... the information's this big and nobody really reads it." P23

Cultural Norms

Barriers: Participants noted that some communication tactics, such as using gentle touch to gain attention, may conflict with cultural beliefs or communication norms. “I’ve seen, we have people who find it so difficult to touch clients. I do not understand why.” P20

Interpersonal Influences

Enablers: Participants described adapting communication in response to residents’ verbal and non-verbal reactions. Changes in facial expression or signs of confusion prompted staff to modify their communication. Barriers: Residents’ mood, fatigue, dementia, and behavioural symptoms sometimes made communication more difficult. Some participants described concerns about aggressive responses when in close proximity or when touching residents to get their attention.

The only downside I can think of is if you’re in somebody’s face and they happen to be in a mood where they want to smack you, you’re in their face so you’re in closer range. P6

Reflective Motivation

Goals

Enablers: Participants consistently expressed a desire to communicate effectively and support residents’ care. Barriers: Some participants acknowledged that task completion sometimes took priority over communication.

Beliefs About Consequences

Enablers: Participants strongly believed that communication tactics improved relationships, resident well-being, and care delivery. Effective communication was perceived to improve cooperation, reduce distress, and lessen challenging behaviours. “I would say you’re probably less likely to get those challenging behaviours when you gain their attention and speak clearly...” P6

Beliefs About Capabilities

Enablers: Many participants felt confident adapting communication for residents once they had developed experience. Barriers: A minority talked about lacking confidence in using communication tactics. “So sometimes they [staff] need to be a bit more confident about that being clearer, nearer and slower.” P5

Automatic Motivation

Desires

Enablers: Participants viewed effective communication as an essential component of quality care.

Emotions

Enablers: Successful communication generated feelings of satisfaction and accomplishment.

“That makes us happy. Make us satisfied.” P16. Barriers: Fear of behavioural reactions from residents could discourage communication attempts. “When they [staff] have fear around behavioural responses ... that prevents communication.” P22

Habits and Routine

Enablers: Several participants described communication tactics as part of their normal daily practice and an established component of routine care.

BEHAVIOUR 2: REDUCING BACKGROUND NOISE

Psychological Capability

Knowledge

Enablers: Participants demonstrated awareness that background noise can interfere with communication and social interaction, particularly for residents with hearing loss. Staff recognised that television, music, and other environmental sounds can make conversations more difficult and may reduce residents’ ability to focus on communication. Some participants also recognised that excessive noise contributes to behavioural symptoms among residents living with dementia. Staff were generally aware that reducing background noise could improve communication and facilitate care delivery. Many reported routinely asking residents for permission before muting or turning off televisions in residents’ rooms. Barriers: Participants varied in their understanding of the impact of background noise on communication. Some staff described using alternative approaches, such as talking over television noise or positioning themselves in front of the television, rather than reducing the source of noise. “I went to somebody yesterday and I couldn’t figure out how to turn it [the TV] off... I couldn’t find the remote control, and eventually I just had to talk over the top [of the TV noise].” P5 “I remember trying to position myself to be in front of it [the TV].” P5

Staff also talked about uncertainty regarding organisational expectations and policies about when televisions or music should be turned down or switched off.

Skills

Enablers: Participants described several skills that facilitated reduction of background noise. These included building rapport with residents before requesting that televisions be muted, negotiating differing preferences regarding music and television use, and adapting communication approaches when residents declined requests to reduce noise. Staff also demonstrated practical skills in balancing communication needs with residents’ preferences and daily routines. Barriers: Managing competing resident preferences was challenging, particularly in communal living environments where some residents preferred

music while others preferred quieter spaces. Participants reported difficulty determining the most appropriate approach when resident preferences conflicted.

Behavioural Regulation

Enablers: Participants described adapting their schedules and care routines to avoid interrupting residents while they were watching favourite television programs or participating in preferred activities. These adaptations helped minimise conflict while still creating opportunities for effective communication. **Barriers:** No major behavioural regulation barriers were identified beyond competing care demands and resident preferences.

Memory, Attention, and Decision Processes

Enablers: Some participants described routinely considering environmental noise when communicating with residents, suggesting that noise management had become an established part of their care practices. **Barriers:** Participants said that reducing background noise was sometimes overlooked when they were busy, distracted, or focused on completing care tasks.

Probably. When I'm rushing, just get in there, talk, then come out. It does happen. I'm not going to lie. It does happen where you just go in, even with the TV on, talk, they respond or whatever, then go out. P1

Physical Opportunity

Accessibility

Enablers: Participants generally had access to environmental controls, such as music systems in communal areas, allowing them to adjust background noise when appropriate. **Barriers:** Difficulty locating television remotes in residents' rooms was frequently cited as a practical obstacle to reducing background noise. When remotes could not be found, staff often continued conversations despite the television remaining on.

Environmental Context and Stressors

Enablers: Some participants described communal environments where staff were able to adjust music levels according to the needs of residents and care activities. **Barriers:** Participants described how organisational expectations regarding ambience sometimes conflicted with efforts to reduce background noise. Music was often expected to be continuously present in communal areas, limiting staff discretion to create quieter environments conducive to communication.

The music is on all of the time. When it's not on, the commission or the governance team of [long-term care community name] that go around and

do it, they're saying, you know, they're just sitting there in silence. 'Why isn't the music on?' P23

Social Opportunity

Organisational Culture

Enablers: Participants reported situations in which reducing background noise was accepted and supported, particularly during clinical interactions or activities requiring focused communication. Staff recognised that quiet environments facilitate communication and sometimes adjusted environmental noise accordingly. **Barriers:** Participants described inconsistent expectations regarding whether televisions or music should be muted or left on. Some felt uncertain about their authority to reduce background noise and believed that staff often required explicit permission before doing so.

Why can't we have that choice of what's appropriate and what's not? Who's going to make that decision and who's going to say that it's, okay? This is another thing with the carers. They won't do anything unless they've been told it's okay. P23

Social Support

Enablers: Participants said that colleagues generally recognised the value of quieter environments for communication and often responded positively when televisions or music were turned down during mealtimes or care activities. **Barriers:** A lack of explicit guidance and consistent expectations reduced staff confidence in adjusting environmental noise, particularly in shared spaces.

Interpersonal Influences

Enablers: Residents' preferences sometimes supported the reduction of background noise. Participants described examples of residents turning off televisions voluntarily and supporting fellow residents who preferred quieter environments. Participants also said that staff were more likely to reduce background noise during interactions perceived as important, such as consultations with healthcare professionals. "Yet, if they [staff] were to walk in with the doctor, they turn it off." P11. "That's a level of respect and it's very beautiful, but they will turn it off for the doctor, but not for themselves." P23. **Barriers:** Residents reacted differently to requests to turn off televisions or music. Some residents became frustrated, agitated, or refused communication when asked to reduce background noise. These responses were particularly common among residents living with dementia, sometimes discouraging staff from requesting changes to environmental noise.

Reflective Motivation

Goals

Enablers: Participants were generally motivated to create conditions that supported communication and resident engagement. They recognised that reducing background noise could facilitate effective care and meaningful social interaction. Barriers: Staff acknowledged that competing priorities and task-focused work practices sometimes reduced attention to background noise management.

Beliefs About Consequences

Enablers: Participants consistently believed that reducing background noise improved communication, enabled residents and staff to hear each other more clearly, and facilitated care delivery. They reported that quieter environments helped residents focus on eating, social interaction, and other activities while also improving safety.

TV people tend to focus on a TV, and I don't think that's appropriate during mealtime. So, you should have your focus of attention for safety. So social, safety, your own enjoyment, other residents' enjoyment. P3

Barriers: Some staff perceived potential negative consequences of reducing background noise, particularly if residents viewed the removal of television or music as intrusive or restrictive.

Automatic Motivation

Emotions

Enablers: Over time, some staff became comfortable requesting reductions in background noise and viewed this as a routine component of care. Barriers: Participants described feelings of guilt, discomfort, and concern when asking residents to turn off televisions or music. Negative emotional responses from residents sometimes reinforced these feelings.

We feel a little bad, but we used to of it, we used to of that behaviour. They already lead their life, so for me, I don't mind. Initially when I was working, at the starting, of course I was feeling bad. P21

Habits and Routine

Enablers: Several participants talked about routinely muting televisions or reducing music during care interactions and mealtimes. These established practices supported consistent implementation of noise reduction strategies. Barriers: In contrast, some staff described habitual practices of completing care tasks without first addressing environmental noise, particularly during busy periods.

DISCUSSION

This study used the COM-B model and TDF to identify barriers and enablers influencing long-term care staff use of communication tactics and reduction of background noise when interacting with residents with hearing loss. A strength of the study was that a range of professional roles including both direct care staff and managers were included, facilitating insight across levels of care. Although participants described numerous barriers, an important finding was that staff were generally motivated to communicate effectively and recognised the benefits of good communication for residents, families, and staff themselves. The predominance of barriers in the findings should therefore not be interpreted as an absence of enablers. Rather, staff appeared to possess substantial intrinsic motivation and many existing supports, including peer learning, managerial support, family involvement, accumulated experience, visual cues, and positive beliefs about communication. However, these enablers were often insufficient to overcome capability and opportunity barriers embedded within everyday care routines and organisational systems.

From a COM-B perspective, the findings suggest that communication difficulties in long-term care are not primarily a problem of staff unwillingness to engage in communication-supportive behaviours. Instead, supportive behaviours are constrained by interacting capability and opportunity factors. Staff generally understood the value of effective communication and reducing background noise, but they reported inconsistent knowledge regarding communication tactics, uncertainty about how to adapt communication for residents with dementia and hearing loss, lack of clear organisational protocols, difficulty accessing information about residents' communication needs, and competing workplace demands. These findings suggest that interventions focused on increasing motivation are unlikely to produce substantial behaviour change because motivation was often already present. Instead, interventions should focus on strengthening capability and creating opportunities for desired behaviours to occur consistently in routine care (cf. [Anantharaman et al., 2026](#)).

The findings broadly align with previous research showing that long-term care staff often have limited training regarding hearing loss and communication support and that communication needs are inconsistently documented and acted upon ([Dawes, Leroi, et al., 2021](#)). Bennett and colleagues (2016) reported that communication needs were often poorly documented and that communication strategies were inconsistently used in Australian long-term care settings, while Punch and Horstman's (2019) review of international literature identified a general lack of awareness regarding

the communication consequences of hearing loss and environmental noise. The present study extends this literature by applying behavioural science frameworks to explain why these challenges persist. Rather than being attributable solely to lack of knowledge, communication practices appear to be influenced by multiple interacting behavioural determinants, including memory, competing goals, environmental context, social norms, and organisational expectations.

An important contribution of this study is the identification of workflow and environmental barriers that may be overlooked in more knowledge-focused approaches. Participants frequently described communication tactics and noise reduction behaviours being abandoned during busy periods, staffing shortages, or periods of high workload. Behaviourally, this finding suggests that communication is often displaced by competing demands rather than consciously deprioritised. Under conditions of time pressure, staff may revert to habitual care routines focused on task completion. This explanation is consistent with the COM-B model, where opportunity constraints limit enactment of behaviours despite favourable motivation. The finding also aligns with previous work showing that long-term care staff frequently prioritise physical care and regulatory tasks over interpersonal communication when workload pressures increase (Ludlow et al., 2021). The implication is that communication-support interventions must be designed to fit within existing workflows rather than being perceived as additional tasks competing for already limited staff time.

The findings regarding background noise highlight a tension between environmental design, organisational culture, and communication needs. Previous studies have identified environmental noise as a barrier to communication for residents with hearing loss (Pryce and Gooberman-Hill, 2012). However, the current study suggests that noise management is not simply an environmental issue but also a behavioural and organisational one. Staff often recognised the benefits of reducing background noise but reported uncertainty regarding their authority to turn down music or televisions, particularly in communal areas where music was viewed as contributing to ambience. This finding suggests that organisational norms and expectations may inadvertently sustain environments that are less conducive to communication. The observation that staff were more likely to mute televisions for a doctor's visit than during their own interactions with residents is revealing. It suggests that communication needs may be implicitly prioritised according to professional hierarchies rather than resident-centred communication goals. This represents an important and novel contribution of the study because it highlights how social and organisational influences can affect communication practices independently of knowledge or skill.

The study also identified several under-recognised enablers that may provide useful opportunities for intervention. Staff talked about learning communication skills from colleagues, adapting their communication in response to resident feedback, drawing on information provided by families, and developing communication expertise through experience. These findings suggest that communication behaviours are already socially reinforced within some care environments. Rather than relying exclusively on formal education, implementation strategies could build upon existing peer learning networks, local champions, mentoring structures, and opportunities for modelling effective communication behaviours (e.g., McShea and Ferguson, 2023). Such approaches may be particularly valuable in long-term care environments where workforce turnover and competing training requirements may limit the effectiveness of traditional education programs.

The findings have several implications for workforce education. Consistent with previous research (Dawes, Leroi, et al., 2021), participants expressed a need for training regarding hearing loss, dementia, communication tactics, and environmental noise management. However, the present findings suggest that education should move beyond simply increasing knowledge. Training should target behavioural capability by providing opportunities for skill development, behavioural rehearsal, feedback, and problem-solving in realistic care situations. For example, staff may understand the recommendation to gain a resident's attention before speaking but lack confidence in applying the strategy when a resident is distressed, fatigued, or experiencing dementia-related behaviours. Educational approaches that incorporate simulation, peer modelling, coaching, and reinforcement may therefore be more effective than passive information delivery alone (Cariñanos-Ayala et al., 2022).

The findings also have implications for organisational policy and implementation. Several barriers reflected structural conditions rather than individual staff behaviour, including inaccessible care plans, inconsistent protocols, unclear expectations regarding noise management, and lack of environmental supports. Addressing these barriers requires organisational rather than individual-level change. For example, communication needs could be emphasised more prominently within care documentation, visual reminders could be embedded into care environments, and organisational policies could provide explicit guidance regarding communication-supportive behaviours. However, implementation is likely to be challenging because communication behaviours compete with multiple organisational priorities. Sustainable change therefore requires leadership support, integration into existing workflows, and continuing reinforcement through supervision, audit, and feedback mechanisms.

Simply introducing protocols is unlikely to be sufficient if staff lack time, opportunity, or organisational support to enact them.

The study should also be considered within the context of recent reforms in Australian aged care (Australian Government, 2025). Although reforms place increased emphasis on person-centred care, supported decision-making, and residents' rights, they do not include specific requirements regarding hearing loss or communication support. Consequently, communication needs associated with hearing loss risk remaining overlooked despite broader improvements in aged care quality systems. Given the strong association between hearing loss, social participation, quality of life, and care engagement, communication support should be viewed as a core component of person-centred care rather than an optional adjunct.

Overall, the findings suggest that improving communication in long-term care requires more than increasing staff awareness of hearing loss. Staff were generally motivated and recognised the value of effective communication, but behaviours were constrained by interacting capability and opportunity barriers embedded within organisational systems and daily workflows. Future interventions should therefore adopt a multifaceted implementation approach that combines workforce education, environmental modifications, accessible communication information, supportive organisational policies, and reinforcement of existing social and motivational enablers. Such an approach has the potential to improve resident participation, well-being, and quality of care while also enhancing staff confidence and job satisfaction.

DATA ACCESSIBILITY STATEMENT

Data are available from the corresponding author upon reasonable request.

ADDITIONAL FILE

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

- **Supplementary materials.** Topic Guide. DOI: <https://doi.org/10.31389/jltc.576.s1>

ETHICS AND CONSENT

Ethical approval for this research was granted by the Human Research Ethics office of The University of Queensland (Ethics ID number: 2022/HE001477). All participants provided written informed consent before participation.

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COMPETING INTERESTS

The authors have no competing interests to declare.

AUTHOR CONTRIBUTIONS

P.D. conceptualised the study, and all authors were involved in the study design. N.R. conducted the interviews and collected the data. N.E.S., P.D., C.M. and N.R. analysed the data. P.D. and N.E.S. drafted the manuscript, and all authors critically reviewed and approved the final version.

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