



RESEARCH

Perceptions of Long-Term Care Nurses and Nursing Assistants about Communication Related to Residents' Care

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Context: Research shows ineffective healthcare team communication is linked to sentinel and adverse healthcare events (Gooch 2016; Robson 2016; Wagner et al. 2018). Long-term care (LTC) facilities face unique challenges of caring for frail elderly (Young 2003), who are at increased risk for cascading negative health events beginning with functional decline (Lakshmi 2014). Frequent, effective nursing team communication is essential to providing safe care for these individuals. (Castle 2007; Cortes et al. 2004; Foulkes 2011; Griffin et al. 2016; Howe 2013; Madden et al. 2017; Siegel & Young 2010).

Objective: The purpose of this study was to use findings from a survey of staff to inform a quality improvement initiative (Appendix A) to enhance nursing team communication. The study explored the perceptions of LTC nursing staff (i.e., registered nurses (RNs), licensed practical nurses (LPNs), and unlicensed assistive personnel (UAPs)) about their communication related to resident care.

Methods: A cross-sectional, descriptive survey design was used to explore perceptions of nursing staff working in a LTC setting about their communication.

Findings: All levels of nursing staff contributed useful information regarding nursing staff communication, including their contributions, their communication, the frequency of communication, and the methods of communicating.

Limitations: This study was done at one LTC facility, which limits the generalizability of the findings, though the study can be replicated easily at the city, state, regional, or national level to explore LTC nursing team communication in public and private facilities, including government LTC facilities (i.e., for veterans).

Implications: Evidence-based standardized communication tools succinctly implemented for communication between nursing staff will bridge patient care communication barriers and positively impact teamwork, leadership, and workplace culture while improving resident and facility outcomes.

Keywords: effective nursing communication; barriers to nursing communication; evidence-based communication tools; nursing team communication; nursing team report

Background

Sentinel or adverse patient events are generally caused by communication gaps, which can cause functional decline, co-morbidity, debility, disability, morbidity, and mortality for patients, as well as exorbitant healthcare costs (Gooch 2016; Johnson et al. 2015; Lakshmi 2014; Madden et al. 2017; Wagner et al. 2015). Ineffective team communication stifles team collaboration and causes distrust among team members (Castle 2007; Kusmaul & Bunting 2016; Larson n.d.; Rubin et al. 2009). It is the most critical factor in negative client outcomes, worker injuries, and misuse

of resources (Gooch 2016; Johnson et al. 2015; Lakshmi 2014; Madden et al. 2017).

Communication and Long-Term Care (LTC)

Most residents in LTC facilities have multiple co-morbidities that make them high-risk for cascading adverse events (Lakshmi 2014; Young 2003). Poor communication practices in LTC, which include limited knowledge of the resident's condition, fragmented communication, high staff turnover, and inadequate administrative support, all contribute to poor resident and facility outcomes (Castle 2007; Griffin et al. 2016; Madden et al. 2017; Udod & Lobshuk 2017). Therefore frequent, concise communication, especially nursing, is imperative to prevent adverse events in this frail elderly population (Cortes et al. 2004; Gooch 2016; Lakshmi 2014; Madden et al. 2017; Young 2003).

Traditional nurse and nursing assistant classroom instruction may be insufficient preparation for today's fast-paced, complex healthcare environment (Cortes et al. 2014; Gooch 2016; Kourkouta & Papathanasiou 2014; Rubin et al. 2009; Shelton 2016; Wagner et al. 2018). Studies show when LTC facilities prioritize investing time and resources towards improving nursing communication and workplace culture, it also enhances both resident and facility outcomes (Foulkes 2011; Gooch 2016; Larson n.d.; Nancarrow et al. 2013; Shelton 2016).

Research shows that evidence-based communication tools improve nursing team communication, which in turn improves staff attitudes, job satisfaction, and retention (Castle 2007; Larson n.d.; Nancarrow et al. 2013), further raising the quality of resident care (Cortes et al. 2004; Fisch et al. 2014; Horn et al. 2010; Robson 2016). Communication tools are most beneficial when they are simple and serve to standardize nursing communication processes (Daniels 2016; Howe 2013; Madden et al. 2017; Regan 2017; Robson 2016). Research has identified many successful, evidence-based communication tools and bundles, such as SBAR Tool, Debriefs, Closed-loop, Interdisciplinary Rounds, Safety Huddles, and I'M SAFE Checklist (Daniels 2016; Fisch et al. 2014; Gooch 2016; Howe 2013; Larson n.d.; Nancarrow et al. 2013; Shelton 2016). It is important to note that these tools are most effective when implemented with clear expectations and guidance from nursing administration (Cortes et al. 2004; Daniels 2016; Fisch et al. 2014; Howe 2013; Walker et al. 2010).

Purpose of the Study

The study's purpose was to understand issues relating to nursing team communication in a large long-term care facility, with the ultimate goal of a Quality Improvement (QI) programme to address deficits. The study site was in Nebraska, USA, and owned by an organisation with other long-term care facilities. The study explored the perceptions of nursing staff (i.e., Registered Nurses, Licensed Practical Nurses, and Unlicensed Assistant Nurses, and Nursing Assistants) about their communication with one another regarding resident care. The findings of the study provided a foundation for the QI initiative because the study focused on the perception of communication among all facility nursing staff regarding patient care.

Research Question

The research question guiding the study was *What are the perceptions of nursing staff (i.e., registered nurses (RNs), licensed practical nurses (LPNs), and nursing assistants (NAs), unlicensed assistive personnel (UAPs), or certified nursing assistants (CNAs)) who work in a long-term care setting about their communication with one another about residents' care?*

Methods

The study was conducted using a cross-sectional, descriptive survey design. Participants recruited at the study site met the following inclusion criteria: at least 19 years of age, employed at LTC facility study site either full-time,

part-time, or as needed (i.e., per diem). In January 2019, there were 213 prospective participants (see **Table 1** below). Investigators hoped for a response rate of at least 20%, or 43 respondents, to represent all members of the nursing team (i.e., RNs, LPNs, and UAPs). The response rate was much higher than expected: 50% (107 respondents).

Participants were recruited for the study following receipt of approval by the parent institution's Institutional Review Board (IRB). The co-investigator contacted the study site director of nursing requesting and obtaining a roster of all RNs, LPNs, and UAPs, and so on, then prepared an envelope for each prospective participant that contained an *Invitation to Participate*, *The Rights of Research Participants* information, and the paper-pencil survey. The study site verified this method of disseminating important information as useful. The co-investigator approached each prospective participant in person on their work units and determined each person's eligibility by verifying whether they were at least 19 years of age, the legal age in Nebraska for consent to participate. Staff under the age of 19 would require their parent's signature to participate in our study. The co-investigator provided a brief verbal overview of the study, encouraged them to read the *Invitation to Participate*, and asked if they had questions. The co-investigator continued to distribute envelopes until all eligible prospective participants received one.

Data Collection

Data were collected using the paper-pencil survey and placed in secure survey collection boxes (i.e., a box that could not be opened but had a slot in the top for respondents to submit their surveys) around the study site. These

Table 1: Prospective Participants.

Position	N	%
Nurses		
Full-time Registered Nurse (RN)	29	14
Part-time RN	14	6
PRN RN	10	5
Full-time Licensed Practical Nurse (LPN)	12	6
Part-time LPN	2	1
Unlicensed Assistive Personnel (UAP)		
Full-time Nursing Assistants (NA)*	53	25
Part-time NA*	65	30
PRN (working as needed) NA*	28	13
Total	213	100

* Includes NA-Medication Aides.

Note: The total number of prospective participants includes those under the age of 19. These individuals were excluded from the study. When the co-investigator hand-delivered the envelopes containing the *Invitation to Participate*, including *The Rights of Research Participants*, to the prospective participants, she verified with the individual that he or she was at least 19 years of age. Individuals who were not at least 19 years of age did not receive an envelope.

boxes remained available for two weeks. The instrument used to collect data included a 3-item demographic questionnaire (i.e., age, role, and tenure at the facility) and an 18-item content survey. The rationale for requesting the respondent's role at the study site was integral to data analysis. Understanding and differentiating between RNs, LPNs, and UAPs/CNAs/NAs perception of team communication was essential to use the data to design QI initiatives at the study site because of the positive relationship between clear, collaborative communication and successful quality improvement initiatives, positive resident outcomes, and enhanced employee satisfaction.

This survey consisted of different content items. The literature recommends questions that research human factors in communication, such as each nurse's understanding and perception of patient need, communication elements, situational awareness, and mutual support (Carrington 2012; Robson 2016). First were content items concerning routine nursing staff communication in LTC facilities regarding when, what, and how they communicated. Second were items asking respondents' perceptions regarding how their team members viewed their contributions to care and how they felt their team members delivered safe patient care and comfort level requesting or offering others' assistance. Lastly, items asked the respondents to identify their familiarity with different evidence-based communication tools found in the literature (Daniels 2016; Fisch et al. 2014; Gooch 2016; Howe 2013; Larson n.d.; Nancarrow et al. 2013; Robson 2016; Shelton 2016).

Ethical Considerations

No identifying information was requested or recorded during the study's data collection phase to minimize the risk of losing confidentiality or privacy for all study participants. All data collected were reported as an aggregate.

Results

The paper-pencil survey had 110 respondents, but the investigators based the demographic profile on 107 participants due to excluding three incomplete surveys not included in the final analysis.

Demographic Profile of the Respondents

The demographic profile showed the distribution of nursing staff with UAPs (57.94%, **Table 1**), representing the most respondents; RNs (29.91%, **Table 1**), the second most respondents; and LPNs (12%, **Table 1**), the fewest respondents. In this nursing facility, the RNs and LPNs were responsible for the residents' overall care, including changes in conditions, medications, treatments, physician orders, tests, documentation, and so forth. The UAPs assisted residents with activities of daily living (ADLs) according to the individual's plan of care. These nursing roles, though different, are intrinsically intertwined. The demographic profile also shows the amount of time nursing staff worked at the facility. The largest group (51.40%, **Table 1**) worked there for less than three years, the next largest group (36%) worked there between three and seven years, and the smallest group (6.54%, **Table 1**) worked at

least seven years with a majority of this group (5.61%) working over ten years. **Table 2** profiles the respondent by their positions in the organisations, and it can be seen that over half were UAPs.

Survey Results

The survey used a 4-Point Likert scale with Never (1), Sometimes (2), Frequently (3), and Always (4). The mean scores for the survey items ranged from 3.784 to 2.623, with most mean scores above 3.000 (**Table 3**). Some of the 107 respondents did not answer all survey questions (see **Table 3** for a breakdown of the number of respondents per survey item).

Table 2: Distribution of Respondents by Positions in the Organisation.

Nursing Role	N	%
Registered Nurse (RN)	32	30
Licensed Practical Nurse (LPN)	13	12
Unlicensed Assistive Personnel (UAP)	62	58
Total	107	100

Note: One (1) respondent did not self-identify his or her nursing role.

Table 3: Mean Scores for Survey Items 4 to 17.

Item Number & Content	Respondents N	Item score %
16. Helping when Needed	102	3.8
17. Comfortable Discussing Residents' Needs	106	3.8
4. Communicate Once-Start of Shift	105	3.7
5. Communicate Once-End of Shift	105	3.7
9. Communicate about Problems	104	3.6
8. Communicate about Resident Status	106	3.6
15. Colleagues Trained-Safe Care	105	3.6
7. Communicate Every 4 hours	98	3.5
14. Colleagues Open to My Information	106	3.2
13. Communicate about ADLs	106	3.2
6. Communicate Every Hour	104	3.1
11. Communicate about Resident's Plan of Care	106	3.0
10. Communicate about Test Results	106	3.0
12. Communicate about Medications	106	3.0

Note: N-values marked with an asterisk (*) reflect items that were left blank by one or more.

Findings

The highest-scoring item, 16 (3.8/4) (see **Table 3**), reflects that members of the nursing staff believe they help when needed. The second highest-scoring item, 17, reflects that members of the nursing staff believe they are 'comfortable discussing residents' needs with the nursing team' (i.e., RNs, LPNs, and UAPs). The third highest-scoring item, 4, shows the nursing team communicates at the start of the shift. The lowest scoring items reflect nursing staff who believe they communicate least frequently about medications (12), test results (10), and residents' plan of care (11).

Respondents identified how often they communicated with other nursing team members (e.g., beginning of the shift, end of the shift, every hour during the shift, or every four hours during the shift). The most common communication times were the beginning of the shift (3.8/4), the end of shifts (3.7/4), every hour (3.1/4), and every four hours with the fewest respondents ($n = 98$).

Most respondents reported communicating with other nursing team members about (resident) problems (3.7/4, **Table 3**), although not everyone answered this question. Slightly fewer respondents reported communicating with other nursing team members regarding resident status (3.6/4 **Table 3**). The three lowest respondent scoring items concerned communication about medications (item 12, 3/4), communication about test results (10), and communication about the resident plan of care (11).

Most of the respondents completing the questions about communication tools reported familiarity with more than one tool identified in the survey; however, only 94 out of the 107 respondents answered this item (**Table 4**). No single communication tool stood out from the others as more familiar to the nursing staff. Eight respondents identified the SBAR (situation, background, assessment, recommendation) tool, interdisciplinary rounds, and safety huddles as being the communication tools with which they were most familiar.

The respondents identified useful communication tools for specific time frames (e.g., during the shift, shift changes, and the three- to seven-day time frame). They identified which communication tools they were familiar with. The verbal report was identified by 71 respondents (64.5%) as the most useful communication tool at

shift change and by 66 respondents (60%) as the most useful communication tool during the shift. Electronic point of care tool (POC, e.g., Point Click Care) was identified by 40 respondents (36.4%) as the most useful tool for information exchange over the three- to the seven-day period (when different staff members are working). The 24-hour report (written) or an alert tool was identified by 36 respondents (32.7%) as the most useful information exchange tool over the three- to seven-day period. All but one respondent answered the items related to these communication tools. The remaining tools (e.g., debriefs, Closed loop, and the I'M SAFE Checklist) were identified as familiar by one to four respondents (**Table 4**). Three respondents checked all communication tools (**Table 4**).

Discussion

High nursing staff turnover may reflect long-term care in general in the state and even wider afield. Job satisfaction and retention are significant problems in LTC where employees often leave a work environment where they do not feel empowered or supported by their supervisors, with the literature identifying nursing management's critical role in retaining LTC staff (Howe 2014; Kusmaul & Bunting 2016; Madden et al. 2017; Rubin et al. 2009; Udod & Lobschuk 2017). Although some staff turnover could reflect young people working during school, the small percentage of staff remaining long term could indicate ineffective nursing communication and its negative impact on employee morale (Castle 2007; Howe 2014; Johnson et al. 2015; Kusmaul & Bunting 2016). Unclear role expectations, excessive nursing demands, insufficient recognition, nurse management inaccessibility, and ineffective interpersonal and professional communication contribute to poor nursing team communication (Castle 2007; Howe 2014; Rubin et al. 2009; Siegel & Young 2010; Udod & Lobschuk 2017).

Effective nursing communication at the beginning and end of shift shows a regular pattern of positive nursing team communication, which the literature states improve safe, person-centred care (Daniels 2016; Fisch et al. 2014; Regan 2017; Wagner et al. 2018). Gaps in nursing communication noted at the hourly and mid-shift times indicate interrupted communication times where negative resident, staff, and facility outcomes could occur (Cortes et al. 2004; Fisch et al. 2014; Regan 2017). The literature describes the positive effect of implementing additional validating communication times where staff can briefly refocus on resident needs to improve quality of care with the result of resident and nursing team feeling supported (Cortes et al. 2004; Howe 2014; Kusmaul & Bunting 2016; Lakshmi 2014; Robson 2016; Siegel & Young 2010). A compassionate, transparent workplace culture allows for greater staff understanding, awareness, and workplace pride, which improves the safety and quality of resident care (Foulkes 2011; Kusmaul & Bunting 2016; Robson 2016).

Staff often communicate about resident problems and change in status, which the literature relates with positive resident and facility outcomes (Gooch 2016; Johnson et al. 2015; Madden et al. 2017; Wagner et al. 2018). Staff also identified gaps in nursing communication

Table 4: Nursing Staff Familiarity with Communication Tools.

Communication Tool	N	%
SBAR Tool	8	7.30%
Debriefs	4	3.60%
Closed loop	1	0.90%
Interdisciplinary Rounds	8	7.30%
Safety Huddles	8	7.30%
I'M SAFE Checklist	1	0.90%
All Communication Tools Listed	3	2.70%
More than 1 Communication Tool	61	55.5%

regarding resident medication and test results, essential components of resident care. This information is critical for licensed nurses and some UAPs, certified as medication aides (MAs), who pass scheduled medications in the facility, but it may not apply to all UAPs. The literature states that evidence-based communication tools help LTC facilities improve patient-care communication and simplify its implementation because they help standardize processes, employ user-friendly documentation, prioritize critical information, and formalize nursing communication (Daniels 2016; Fisch et al. 2014; Horn et al. 2010; Regan 2017; Walker et al. 2010; Yeatts et al. 2004).

Staff feel comfortable offering and receiving help indicating points of positive communication as well as adequate staffing levels, which also enhance communication, care transitions, nursing education, and training opportunities (Castle 2007; Cortez et al. 2004; Foulkes 2011; Kusmaul & Bunting 2016; Larsen n.d.; Udod & Lobschuk, 2017). Their reservations regarding colleagues' training in safe care and openness to their input hint at a lack of transparent workplace culture. The literature stresses the importance of the nurse leaders' role in promoting standardized facility-wide nursing training and expectations to support the nursing team as they implement resident care plans (Howe 2014; Larson n.d.; Madden et al. 2017; Udod & Lobschuk, 2017; Yeatts et al. 2004). Poor communication practices in LTC include limited understanding of the resident's condition, fragmented communication, high staff turnover, and inadequate administrative support; all contribute to poor resident and facility outcomes (Castle 2007; Madden et al. 2017; Udod & Lobschuk 2017).

One respondent stated UAPs have vital knowledge regarding resident care, but their input often goes unnoticed. While another said, 'It can be hard to communicate with staff who do not like you'. When experienced nursing staff respond to coworkers' questions and recognize their contributions while assisting during resident care, they promote a culture of teamwork where staff and residents feel valued (Griffin et al. 2016; Larson n.d.; Madden et al. 2017; Regan, 2017). As workplace cultures allow for open, transparent communication with no tolerance for bullying, healthy nursing-CNA dyads form, causing both staff and residents to feel appreciated (Castle 2007; Daniels 2016; Gooch 2016; Griffin et al., 2016; Howe 2014; Larson n.d.; Regan 2017; Robson 2016; Shelton 2016).

Barriers to consistent documentation are excessive nursing tasks, care plan gaps, changing communication patterns, and non-standardized communication forms (Howe 2014; Johnson et al. 2015; Madden et al. 2017; Siegal & Young 2010). One respondent reported that a useful, thorough report was the key to a safe shift. Two nurse respondents felt their patient-care communication at shift change could improve with a more comprehensive nursing report sheet. Evidence-based practice communication tools aim to enhance the quality of care and consistent nursing documentation through bundles, standardized forms, checklists, and so forth (Howe 2013; Johnson et al. 2015; Madden et al. 2017; Robson 2016; Siegal & Young 2010).

Research supports the importance of all communication types (verbal, written, and electronic) and the need to

formalize nursing expectations to provide quality resident care (Foulkes 2011; Madden et al. 2017; Robson 2016; Walker et al. 2010). Verbal communication seems more useful for new information over a shorter time frame with similar nursing work teams. Written and electronic communication was most helpful over the following three- to seven-day period as a source to communicate critical resident information over a longer time frame with new nursing work teams. LTC facilities that implement evidence-based communication tools improve awareness of resident care plans, staffing consistency, and administrative support (Castle 2007; Cortez et al. 2004; Robson 2016; Siegel & Young 2010).

Recommendations: Future Research

Studies describe the positive effect of frequent use of targeted, evidence-based nursing communication tools on staff attitudes, job satisfaction, retention, and ultimately resident health outcomes (Castle 2007; Cortez et al. 2004; Robson 2016; Siegel & Young 2010; Wagner et al. 2018; Yeatts et al. 2004). Due to the fast-paced emergence of new technologies, research in this area should be ongoing in all nursing practice areas. Further exploration of LTC nursing staff communication is critical to avoid adverse events and to promote quality care in this challenging environment. Replicating this study at the state or national level to further explore nursing team communication in public, private, and government (i.e., veterans') LTCs would be beneficial. Nursing professionals may also benefit from studies examining the use of evidence-based communication tools during key communication times: during the shift, at shift changes, during the next one- to two-day period as follow-up occurs, and over the next three- to seven-day period where staff and communication changes can affect resident continuity of care.

Recommendations: Practice

This study's findings suggest nursing staff in this LTC facility favour communication at the start and end of the shift and communication as needed during the shift, depending on the resident status. The respondents' familiarity with several of these evidence-based communication tools (e.g., SBAR, Interdisciplinary Rounding, and Safety Huddles) suggests that one or more of these tools may enhance nursing staff communication within the facility. One respondent commented that although it is convenient to receive shift reports from other MAs/CNAs and not licensed nurses, they are unsure if the report is complete. Two other respondents recommended huddles or rounding with nurse management, charge nurses, and CNAs at the beginning and end of day and evening shifts. Interdisciplinary Rounding attended by nursing aides, nurses, and nurse managers may further enhance team communication and foster a more positive workplace culture (Daniels 2016; Fisch et al. 2014; Gooch 2016; Howe 2013; Larson n.d.; Nancarrow et al. 2013; Shelton 2016).

Respondents acknowledged the value of verbal communication at shift change and during the shift but favoured written and electronic communication for the three- to seven-day period. Respondents stated that staff

could be hard to find in the afternoon because they are frequently in residents' rooms. Adding a mid-shift Safety Huddle (i.e., every four hours) may incorporate a necessary communication time to increase effectiveness throughout the shift. The most frequent topics discussed were (resident) problems and changes in resident status, and the least frequent topics were residents' test results and medications.

While the respondents believe they offer and receive help when needed and are comfortable discussing resident needs, they hinted at having reservations about whether all nursing staff members provide safe care and whether other nursing staff valued their input. Ongoing nursing staff education regarding the definition of nursing members' roles and responsibilities and positive interpersonal team communication may contribute to nursing team safe care and safe environment perceptions. Research supports evidence-based nursing team communication effectiveness in improving safe, person-centred care (Gooch 2016; Kourkouta & Papathanasiou 2014; Rubin et al. 2009; Shelton 2016; Wagner et al. 2018).

Study Limitations

The study occurred at one large LTC facility, limiting the generalizability of its findings. The study could be easily replicated at the city, state, regional, or national level to explore LTC nursing team communication in public and private facilities, including government LTCs (i.e., veterans). Researchers used a paper-pencil survey because of the facility's computer location and respondent privacy concerns. A computer survey that allowed for respondent privacy may gather more responses from all shifts.

Conclusion

Although research is plentiful regarding communication between healthcare settings along the continuum of care, between interdisciplinary teams, and between physicians and nurses, there is less research focused on the communication between all the nursing staff team in the LTC setting. Effective communication between all nursing staff in the LTC facility is essential to provide quality patient care and to prevent adverse patient events. The purpose of this study was to explore the perceptions of LTC nursing staff (RNs, LPNs, and UAPs) about their communication with one another to improve resident quality of care and positive outcomes in this LTC facility. The investigators used a descriptive survey design to explore communication habits, communication topics, and communication tools used by nursing staff at a large LTC facility.

Research identifies ineffective healthcare communication as a critical reason for sentinel or adverse events, high staffing turnover, and negative healthcare outcomes (Cortes et al. 2004; Larson n.d.; Siegel & Young 2010; Udod & Lobschuk 2017). It also supports the use of evidence-based practice communication tools to build a transparent work culture where everyone feels valued along with a collaborative nursing team focused on improving resident and facility outcomes (Gooch 2016; Griffin et al. 2016; Nancarrow et al. 2013).

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Competing Interests

The authors have no competing interests to declare.

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