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Caregivers' Desired Patterns of Communication with Nursing Home Staff---Just TALKKK!

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Abstract

Individuals with cognitive impairment often represent a significant percentage of the residents in a nursing home nurse's care. With years of experience caring for their placed family members, caregivers of these residents are often experts in knowing the resident's needs, habits, behaviors, and moods. Caregivers often wish to convey this insider knowledge to nursing home staff. Furthermore, communication with caregivers promotes trust that personalized, safe, and effective care occurs when they are not there. Based on an interpretive study of the experiences of caregivers who place a family member with Alzheimer's disease in the nursing home, six preferred patterns of communication are presented in this article. The six patterns are represented by the acronym TALKKK (tell them; ask them; listen to them; know their family member by relating and communicating; be knowledgeable about dementia, its progression, dementia-specific care, and commonly used medications; and share that knowledge with them).

With more than 5.3 million individuals affected by Alzheimer's disease (AD) in the U.S., knowledge about dementia and the care needs of the cognitively impaired patient is essential for every nurse (Alzheimer's Association, 2011). Cared for in most every healthcare setting, individuals with cognitive impairment may represent a significant percentage of a nurse's caseload. For example, 37% of patients receiving home care services, 50% of those in adult day care, over 45% of those residing in assisted living, and 68% of those in the nursing home (NH) setting have cognitive impairment (Alzheimer's Association, 2011).

When the cognitive impairment is progressive, such as with AD, informal caregivers, often family members, become the voice of the cognitively impaired individual, and many caregivers eventually assume responsibility for the individual's care. Burdened with 24-hour care of someone with worsening dementia, personal illness and/or sleeplessness, or other bothersome factors, family caregivers may place the individual in a NH (Gaugler, Yu, Krichbaum, & Wyman, 2009; Schur & Whitlatch, 2003) where they may find themselves with limited or no input into the individual's care.

Caregivers who place an individual with dementia in the NH desire communication from the NH staff. Such communication promotes understanding of the placed individual's needs, behaviors, moods, and routines. This article describes and provides exemplars of six desired patterns of communication of family caregivers with NH staff, derived from an interpretive study of the experiences of family caregivers who placed individuals with dementia in the NH. The six patterns are represented by the acronym TALKKK: Tell the caregiver about the resident, ask for the caregiver's expert advice, listen to what the caregiver has to say, know

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the resident by relating and communicating, be knowledgeable about AD, and share that knowledge with the caregiver.

Please note that references to NH staff include nurse assistants (also referred to as aides and unlicensed assistive personnel [UAP]), medication technicians, licensed practical nurses (LPNs), RNs, nurse practitioners, and physicians. While NH staff are sometimes referred to as formal caregivers, when the term *caregiver* is used in this article, it is in reference to family caregivers. Finally, pseudonyms have been used where names are stated in the exemplars.

Background

Recognition of the challenges of communication between NH staff and family caregivers is not new (Haesler, Bauer, & Nay, 2006; Legault & Ducharme, 2009; Lopez, 2009; Marquis, Freegard, & Hoogland, 2004), and some of the important contributions to this area of research are dated. In a focus group study by Rantz et al. (1999), communication emerged as an important issue for consumers of care in NHs. Noted frustrations of family caregivers in the study were difficulties in communicating resident needs and preferences for care, an imperfect system for communication to promote follow-through by NH staff, and limited communication with family members. Hertzberg and Ekman (2000) found that family caregivers desired to hear about more than major events and changes, were hesitant to criticize or confront, and wanted to converse about the placed individual and the care the person received. Both family caregivers and staff members were hesitant to reach out to the other to avoid interrupting their work or time with the resident.

Majerovitz, Mollott, and Rudder (2009) reported on two studies of factors that hindered or promoted communication of family caregivers and NH staff. Numerous factors were identified as hindering communication, including insensitive comments by staff and family caregivers, staffing problems, and a lack of attempts to communicate. Family caregivers desired information about the status of the placed resident. Communication by family caregivers was hindered by care that did not meet expectations. Similarly, some staff voiced concern that family caregivers did not seem to know what to expect and had unrealistic expectations for care. Although they provided much of the direct care, nurse assistants felt excluded from important communications by the NH staff and family caregivers (Majerovitz, et al., 2009).

In a study of factors that promoted family involvement, notable findings included having welcoming staff who recognized the visiting family members' plight; respected family members and the residents; demonstrated commitment, care, and knowledge; involved family members as partners in care; kept family members informed; and gave family members private space to be with the placed individual (Marquis et al., 2004). Legault and Ducharme (2009) followed the advocacy role of adult daughters who admitted a parent with dementia to the NH. Daughters in their study experienced varying levels of trust of the nursing staff. Trust had to be earned, could be lost, and most likely was never complete. Even when trust was established, the daughters continued to monitor the quality of the care provided. They tried to use collaboration and diplomacy to integrate themselves into the institution. The daughters wanted the NH staff to listen to them, and they carefully chose when, how, and to whom to communicate (Legault & Ducharme, 2009). Support for increased communication between NH staff and family caregivers also comes from a study by Garity (2006). Positive interactions with the resident with dementia, other residents, family and friends, NH staff, and members of the NH support group helped family caregivers cope after placement of their family member in a NH. Negative interactions with any of these individuals were not supportive (Garity, 2006). Family caregivers' desire for

communication from NH staff about the placed individuals was a common finding in all of these studies.

Despite these findings, there is limited current research on communication patterns between staff and family caregivers, and research on interventions that promote communication between NH staff and caregivers is even more limited and dated. In a classic study, Pillemer, Hegeman, Albright, & Henderson (1998) conducted an intervention consisting of parallel workshops focused on communication techniques and conflict resolution. One series of workshops was with NH staff and the other with family members. The final workshop session was a joint meeting of both groups. Both staff and family members reported that they could relate the information they received to their situation. Two months after the intervention 81% of staff and 55% of family members believed that communication between the two groups had improved (Pillemer, et al.). Fortunately, research examining communication patterns and related interventions between staff and residents (Buron, 2010; Heliker & Nguyen, 2010; Phillips, Reid-Arndt, & Pak, 2010), nurses and UAPs (Siegel & Young, 2010), nurses and physicians (Tjia et al., 2009), administrators and staff (Vogelsmeier & Scott-Cawiezell, 2011), and staff and family at the end of life (Zheng & Temkin-Greener, 2010) is ongoing.

Caregiver communication needs begin with admission of the person with dementia to the NH. After providing care 24 hours per day, 7 days per week for years, caregivers may suddenly find themselves disregarded and ill informed about the resident's care needs, the involvement of other providers in their care, and decisions about the resident's care. Communication fosters trust between the NH staff and caregivers in knowing that care needs are met and the placed resident is safe when the caregiver is away.

Methods

The method of inquiry for this research was Heideggerian hermeneutic (interpretive) phenomenology. Using this method, the researcher approaches a phenomenon of study with a pre-understanding (or forestructure) based on his or her background of experiences and way of being in the world. This pre-understanding guides the direction of inquiry as "it is by virtue of our world that we, as researchers, have the questions we have, and that we see the possibilities we see" (Leonard, 1994, pp. 56–57). The phenomenologist organizes and interprets the phenomena of study to increase understanding of the meanings of involvement, habits, skills, and everyday practices (Dreyfus, 1991; Heidegger, 1962).

Since involvement in everyday practices occurs in an unreflective way, it is not readily accessible to researchers (Benner, Tanner, & Chesla, 1996; Dreyfus, 1991). For example, individuals typically go about preparing for work without thinking through the steps of preparation. Often, it is only when breakdown occurs (e.g., if an individual breaks an arm) that one realizes the process of bathing, dressing, and driving to work and is able to communicate it to others (Dreyfus, 1991). The phenomenologist is looking for the meanings that may be hidden within the everyday practices (Moran, 2000). By explicit questioning and an interpretive process of reading, coding, and rereading, and modifying findings in a circular fashion, the aim of this work was to uncover and disclose the patterns, gaps, concerns, dilemmas, conflicts, emotions, and contradictions that had been overlooked in the everyday embodied practices of caregivers surrounding the time of and after NH placement of their family member with AD.

Sample

Fifteen participants who had placed their family member with dementia in a NH setting within the previous 12 months participated in this study, which received Institutional

Review Board approval. Six participants were adult daughters (mean age = 56.7 years, SD=1.27 years) and 9 were spouses (4 husbands, 5 wives; mean age = 70.8, SD = 7.55 years). The study participants have been described in detail in Palmer, 2009.

Data Collection

All study participants, except for a daughter whose mother expired during the course of the study, completed three interview sessions. The interview sessions were scheduled 30 days ($\pm$ 10 days) apart. Each interview session lasted 90 to 135 minutes, and all but one took place in the caregivers' homes. The exception was one adult daughter who chose to do the interviews in a private space at her father's NH. The interviews were digitally recorded and transcribed by a professional transcriptionist. Interview data were supplemented with field notes typed immediately after the interview sessions.

Rigor

Rigor for this study and the findings were promoted in several ways. In addition to careful transcription of interview data and field notes, the researcher maintained a reflexive journal where she recorded her insights and changes in perspective. In addition, the researcher shared data with an interpretive group who reviewed transcripts, discussed their interpretations, and responded to the researcher's queries about data she found confusing or conflicting.

Findings

During the interviews, participants were asked to speak about their experiences as caregivers who placed an individual with AD in the nursing home. Six themes related to communication emerged from their narratives, representing six desired patterns of communication. Participants wanted NH staff to tell them about the resident; ask them for their expert advice; listen to what they had to say; know their family member and other residents; be knowledgeable about AD, cognitive loss, the needs of the resident with dementia, and commonly used medications; and share that knowledge with them. These desired patterns of communication are represented by the acronym TALKKK and illustrated with exemplars that follow.

Tell

The caregivers in this study desired to be told information about their placed family member. With their family member not being able to communicate foods they had eaten and activities they had participated in, the caregivers were left wondering what if anything had happened when they were away. One caregiver said:

I don't know really what she's been doing...I always ask her "What did you do today? Did you do any crafts?" And she doesn't know. I'll ask her how the food is. She always says the food is good. "Well what did you eat?" "I can't remember" is usually her response.

The need to be told even basic information about the placed person's day is demonstrated in the following exemplars:

I talk mainly to the nurse assistants. I ask them, "How did he do today? Has he had his meds today? Did he do good?"

There's an LPN there, and he's really, really good and he really likes my husband. He reports to me a lot when I come in. He'll stop and tell me what's been going on and he'll say to me. He [your husband] was walking around with his fists clenched and his teeth clenched. I knew he was upset.

This caregiver was reassured that the LPN was attuned to her husband's needs and knowledgeable about effective ways of caring for him. In contrast, the spouse in the following example was uncertain what happened with his wife when he was not present at the NH. When he questioned the staff, they did not seem to know his wife or know what she had been doing that day. The caregiver stated:

I really wish I knew [what she did when I am not there]. I can't identify that, unless you just spend time out there every minute. I'm sure she has activities that I don't know about...so that is very frustrating...you have no way to find out what she's doing.

Ask

The caregivers were experts in knowing the needs, desires, habits, routines, and behaviors of their placed family members. Often they knew what to do to calm and reassure their family members. They recognized change and symptoms of problems, and they desired to be asked to share their knowledge and know-how.

After attempting to communicate about her husband's needs with all of the nurses and nursing aides caring for her husband at a new NH, one caregiver described her anger when:

I go in there and he's the only one in the dining room and he's got his plate of food in his lap because he's trying to feed himself, chicken, gravy, the whole mess. So I went ballistic and cleaned him all up, got him fed, sat there....got him back to his room and then the aides came and I told them what happened. They apologized and said they didn't know he couldn't feed himself.

If the staff had asked her about his self-feeding ability, she could have informed them.

There were examples of when the caregivers had expert knowledge about their family member but were not asked and/ or seemed not to feel empowered to tell. For instance:

There was another episode where the nurse that gives Beth medication didn't know her at all...and the nurse was going to force Beth to take this medication. I happened to be in the room when she was going to force her. Beth said, "I don't want the pills." The nurse thought Beth was like her other people that she gives medications to. She forces them... So it got physical and the nurse had to have somebody come in and hold Beth. So she waited until Beth completely calmed down. Beth finally took the medication, but it was way later. So the nurse discovered that you don't force anything on Beth, you have to be happy-go-lucky, and not try to force anything on her and she'll do just fine.

Furthermore, the caregivers believed they had knowledge that could be informing to the NH physician or nurse practitioner who wrote orders for their family member; yet, only a couple of the study participants had met these healthcare providers. This left the rest wondering how the healthcare providers could know the history of their placed family member; the context within which to interpret assessment findings; and the basis for which medication changes, particularly those related to behaviors, could be made. One caregiver related:

I think she [the physician] probably sees him for 10 minutes once a month and I don't think she really knows his history nor do I think she really asks. I just don't have a lot of confidence in her.

One caregiver could never catch up with the NH physician so she made an appointment to see him at his office:

I went to see him because I did want him to know G's history....I want him to know that G's PSA had been up. He did not know that because he didn't have those records and G wouldn't have said anything.

Listen

Caregivers verbalized frustration when NH staff did not seem to listen to their concerns and knowledge or heed their warnings. They had served as the voice and advocate of the resident, but found the institutional environment could silence them. They experienced confusion in knowing with whom to discuss their concerns and observations. When concerns were not responded to, some assumed it was because they had communicated their worries to the wrong person. Even when they were asked for information, they were not always certain that they were heard. Follow-up was key to building their trust. As one caregiver said:

I told the nursing staff, she's got to have some better care. The staff wouldn't do anything about it. I said she's got to have some help on this. She couldn't hardly breathe. I called the doctor and [he said], "We'll take care of it. We'll take care of it." But nothing happened.

Getting no response to his pleas for attention to his wife's needs, this spouse moved his wife to another NH.

In contrast, one spouse told of a time when a new nurse listened to his concerns and his insight into his wife's behavior changes:

This last time we had the time change...and we had a new nurse.... Sheila [wife] started doing her sundowners because of the time change. It got dark. When it gets dark, normally she's fine because they give her medication early. I went out to the nurse and I said, "You know, I've been with Sheila for a long time". I said, "Whenever there's a time change you have to give her medication early and work your way into the time change because her body still thinks it's that certain time". I said, "She's doing sundowners right now, doing very unusual things because you haven't given her her medication. And she said, "Oh, I never thought of that". So the nurse gave her [Sheila] her medication and after that she was fine.

Know

It was expected that NH staff would get to know the needs, desires, habits, routines, and behaviors of the residents. Caregivers watched for emotional connections and relationships between their placed family members and the staff. Respect for the personhood of the residents was important to them. They watched to see if staff recognized and responded to the moods and behaviors of their increasingly silent family members. One daughter shared her observations.

There's a med tech. I don't know that I've ever even seen her smile. She kind of comes in, gives them their meds, and that's about it. She gives some of them [the residents] meds in pudding. Well I wouldn't want it shoved into my mouth like that. I mean can you even say, "Hi, how are you feeling? How are you today? I've got your medicine".

The daughter continued:

I can tell you right now who I feel more relaxed when I know they're on duty than those people that I don't. When Bev [an aide] is there, I know she keeps an eye on mom. She comes in and makes sure that mom goes to the bathroom and doesn't sit [alone for long periods].

Similarly, another caregiver told of a couple of aides who developed a relationship with her and her husband. The aides not only became familiar with her admitted husband's needs, habits and desires but also with hers. She said:

I know it's their job but they go that extra mile with him, the extra mile. They'll laugh with him... They'll call, "He's not hurt but we just wanted to let you know" ... Or they'll give me a little note when I come there like this one day, "He didn't eat this but we gave a little extra of that...."

Being Knowledgeable and Sharing that Knowledge

There was the belief among participants that staff should know how to care for persons with dementia, know the medications commonly prescribed (or not) for older adults with confusion, and be able to communicate with them regarding disease progression. One caregiver stated:

The doctor has got to say, "I will look this up and figure out what other alternatives there are." Nobody did that up there. I was the one that was doing that: "Let's try this" and "No, let's not give him [a specific psychotropic medication]." I'm not a medical person. One of my major frustrations is who's the doctor here?

In contrast, the following caregiver met with her husband's new physician. The physician spent time listening to her, taking her husband's medical history, and reviewing the progression of her husband's cognitive loss. She said:

He was the first doctor who really seemed to understand the disease and why Scott is in the home and I felt like he was affirming me with this illness that it is okay for Scott to be there. He's a gerontologist, so he just seemed to understand.

One daughter described a time when she was visiting her mother and her mother was becoming increasingly agitated. A nurse and med tech were sitting within a couple of feet of her but were not proactive in telling the daughter what to do or in helping her to calm her mother. She said:

I'm relying on them to be the experts in how to handle this. They did not budge.... I was like, "Help me out. I do not know what to do and you're standing there."

In summary, the caregivers who were interviewed expressed a need for communication.

They wanted the NH staff to tell them about their family member; ask them for their expert advice in knowing their family member's behaviors and needs; listen to what they had to say; know their family member and other residents by relating and communicating; be knowledgeable about AD including how it progresses, the needs of the resident with dementia, and commonly used medications; and also to share that knowledge with them.

Discussion

The primary goal of nursing care, regardless of setting, is optimal and safe care of the patient. Caregivers are often experts in knowing the resident, particularly those newly admitted. As described in this article, caregivers participating in an interpretive study of their experiences surrounding the time of NH admission of their family member with dementia highlighted the need for basic communication between them and the NH staff.

With basic communication, messages are sent and received. Communicating to caregivers the basic day-to-day care, listening to caregivers who are the experts in knowing the resident, and confirming that effective communication has occurred between the sender (nurse) and receiver (caregiver) promotes optimal resident care.

One limitation of this study is that the findings were based on a sample of adult daughters and spouses who were involved in the NH care of their family members with AD. The study findings may not represent the views of those potential caregivers who are uninvolved in the care of family members with AD in the NH. In addition, although sons and individuals representing minority populations were invited to participate, no sons and only one caregiver from a minority group participated. Therefore, the study findings may not be representative of their experiences.

Also, the experiences of all involved parties were not collected. For example, the stories of NH staff, the residents with dementia, and other family and friends were not included. Moreover, interviews with additional parties could have provided greater understanding of the experiences of those who were interviewed. However, basic communication with residents and caregivers is something that nurses and nursing staff should strive for in all settings.

Research Implications

An implication for research is to build on the classic descriptive and theoretical work on family involvement in the NH by Gaugler (Gaugler, 2005; Gaugler, Anderson, Zarit, & Pearlin, 2004) and the Family Involvement in Care intervention by Maas et al. (2004). Maas et al. (2004) found that some caregivers benefited when they were oriented to the NH, were educated about ways they could be involved in care, formally negotiated a partnership agreement with NH staff, and then were assisted to evaluate and renegotiate the partnership agreement. Increased communication using the TALKKK model as an intervention framework may foster family involvement in care.

Other implications of this research are to determine the most effective way to promote communication between NH staff and caregivers, as well as to evaluate whether improved communication, based on the six desired patterns of communication, promotes caregiver satisfaction, well-being, and involvement; enhances staff satisfaction and retention; and improves communication with caregivers as partners in care, ultimately fostering safer, more effective resident care. Although the cognitively impaired resident's satisfaction with care may be difficult to measure, it is possible that improved communication between caregivers and staff will improve communication with residents, too.

Clinical Implications

This study highlights that communication between the NH staff (including UAPs, nurses, and physicians) and family caregivers needs to occur more often than it currently does. Greeting and welcoming caregivers is important. Telling them about the resident's care, medical needs, and the simple occurrences of the day; asking for their advice; listening to what they have to say; and conveying ways the staff know the admitted family member and are knowledgeable about dementia and care of residents with dementia are all desired patterns of communication.

Staff training about the importance of communication with family caregivers, techniques for effective communication, and preferred patterns of communication is essential. Role-playing can be a convincing, fun, and inexpensive inservice tool that is easily incorporated into educational programs.

By role modeling frequent and effective communication to family members and residents, NH administrators and nurse leaders can create a culture of open communication. In this study, the study participants positively viewed those administrators who regularly talked with the family caregivers and their family members. One caregiver noted, "I'm really

impressed with the administrator.... She knows everybody's names...which is very comforting." Moving beyond speaking about how to better communicate and actually demonstrating how to do it helps learners improve their communication skills and demonstrates the value of communication to others.

Conclusion

By knowing and implementing the preferred patterns of communication, nurses and NH staff convey essential information to caregivers and optimize time spent with them. Acknowledging caregivers as partners in care, respecting them as experts in knowing the resident, and communicating with them accordingly promotes trust that safe and effective nursing care will be provided in their absence. Bidirectional communication and respect for the expertise each party possesses unites the family caregiver and the NH staff to better meet the resident's needs. While more research is needed about how to best implement a TALKKK intervention and measure its effectiveness, implementing basic communication instruction is now warranted, practical, and cost-effective. This is because all staff members have the potential to address communication needs of family caregivers in the NH.

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References

- Alzheimer's Association. 2011 Alzheimer's disease facts and figures. Chicago, IL: Alzheimer's Association; 2011. Retrieved from http://www.alz.org/downloads/Facts_Figures_2011.pdf
- Benner, P.; Tanner, CA.; Chesla, CA. Expertise in nursing practice: Caring, clinical judgment, and ethics. New York: Springer; 1996. Appendix A: Background and method; p. 351-372.
- Buron B. Life history collages: Effects on nursing home staff caring for residents with dementia. *Journal of Gerontological Nursing*. 2010; 36(12):38–48.10.3928/00989134-20100602-01 [PubMed: 21197697]
- Dreyfus, HL. Being-in-the-world. A commentary on Heidegger's Being and Time, Division 1. Cambridge, MA: The MIT Press; 1991.
- Gaugler JE. Family involvement in residential long-term care: A synthesis and critical review. *Aging & Mental Health*. 2005; 9:105–118. [PubMed: 15804627]
- Gaugler JE, Anderson KA, Zarit SH, Pearlin LI. Family involvement in nursing homes: Effects on stress and well-being. *Aging & Mental Health*. 2004; 8:65–75. [PubMed: 14690870]
- Gaugler JE, Yu F, Krichbaum K, Wyman JF. Predictors of nursing home admission for persons with dementia. *Medical Care*. 2009; 47:191–198. [PubMed: 19169120]
- Garity J. Caring for a family member with Alzheimer's disease: Coping with caregiver burden post-nursing home placement. *Journal of Gerontological Nursing*. 2006; 32 (6):39–48. [PubMed: 16773862]
- Haesler E, Bauer M, Nay R. Factors associated with constructive staff–family relationships in the care of older adults in the institutional setting. *International Journal of Evidence Based Healthcare* 2006. 2006; 4:288–336.
- Heidegger, M. Being and Time. In: Zeit, German Sein und, translator. A translation of SEIN UND ZEIT by John Macquarrie and Edward Robinson. 7. New York: Harper & Row, Publishers, Incorporated; Neomarius Verlag; Tubingen: 1962.
- Heliker D, Nguyen HT. Story sharing: Enhancing nurse aide-resident relationships in long-term care. *Research in Gerontological Nursing*. 2010; 3:240–251. [PubMed: 20429492]

- Hertzberg A, Ekman SL. 'We, not them and us?' Views on the relationships and interactions between staff and relatives of older people permanently living in nursing homes. *Journal of Advanced Nursing*. 2000; 31:614–622. [PubMed: 10718881]
- Legault A, Ducharme F. Advocating for a parent with dementia in a long-term care facility: The process experienced by daughters. *Journal of Family Nursing*. 2009; 15:198–219. [PubMed: 19307314]
- Leonard, VW. A Heideggerian phenomenologic perspective on the concept of the person. In: Benner, P., editor. *Interpretive phenomenology: Embodiment, caring, and ethics in health and illness*. Thousand Oaks, CA: SAGE Publications; 1994. p. 43-64.
- Lopez RP. Decision-making for acutely ill nursing home residents: Nurses in the middle. *Journal of Advanced Nursing*. 2009; 65:1001–1009. [PubMed: 19291186]
- Maas ML, Reed D, Park M, Specht JP, Schutte D, Kelley LS, Buckwalter KC. Outcomes of family involvement in care intervention for caregivers of individuals with dementia. *Nursing Research*. 2004; 53:76–86. [PubMed: 15084992]
- Majerovitz SD, Mollott RJ, Rudder C. We're on the same side: Improving communication between nursing home and family. *Health Communication*. 2009; 24:12–20. [PubMed: 19204854]
- Marquis R, Freegard H, Hoogland L. Influences on positive family involvement in aged care: An ethnographic view. *Contemporary Nurse*. 2004; 16:178–186. [PubMed: 15125100]
- Palmer, JL. Doctoral dissertation, Saint Louis University. 2009. Caregivers' experiences before and during the first year of nursing home placement of a family member with Alzheimer's disease. Available from ProQuest Dissertations and Theses database (UMI No. 3383309)
- Phillips LJ, Reid-Arndt SA, Pak Y. Effects of a creative expression intervention on emotions, communication, and quality of life in persons with dementia. *Nursing Research*. 2010; 59:417–425. [PubMed: 21048483]
- Pillemer K, Hegeman CR, Albright B, Henderson C. Building bridges between families and nursing home staff: The partners in caregiving program. *The Gerontologist*. 1998; 38:499–503. [PubMed: 9726137]
- Rantz MJ, Zwygart-Stauffacher M, Popejoy L, Grando VT, Mehr DR, Hicks LL, et al. Nursing home care quality: A multidimensional theoretical model integrating the views of consumers and providers. *Journal of Nursing Care Quality*. 1999; 14:16–37. [PubMed: 10575828]
- Schur D, Whitlatch CJ. Circumstances leading to placement. A difficult caregiving decision. *Lippincott's Case Management*. 2003; 8:187–197.
- Siegel EO, Young HM. Communication between nurses and unlicensed assistive personnel in nursing homes: Explicit expectations. *Journal of Gerontological Nursing*. 2010; 36(12):32–37. [PubMed: 20669856]
- Tjia J, Mazor KM, Field T, Meterko V, Spenard A, Gurwitz JH. Nurse-physician communication in the long-term care setting: Perceived barriers and impact on patient safety. *Journal of Patient Safety*. 2009; 5:145–152. [PubMed: 19927047]
- Vogelsmeier A, Scott-Cawiezell J. Achieving quality improvement in the nursing home: Influence of nursing leadership on communication and teamwork. *Journal of Nursing Care Quality*. 2011; 26:236–242. [PubMed: 21278595]
- Zheng NT, Temkin-Greener H. End-of-life care in nursing homes: The importance of CNA staff communication. *Journal of the American Medical Directors Association*. 2010; 11:494–499. [PubMed: 20816337]