Supporting Professional Caregivers Working In Nursing Homes: A Literature Review

Bachelor of Social Services and Health Care

Geronom (YH)

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Degree Thesis

Human Ageing And Elderly Service

2013

DEGREE THESIS	
Arcada	
Degree Programme:	Human Ageing and Elderly Service
Identification number:	12872
Author:	Doris Babeh Ebai
Title:	Supporting Professional Caregivers Working in Nursing Homes: A Literature review
Supervisor (Arcada):	Sundell Solveig and Birgitta Dahl
Commissioned by:	Kustaankartanon Monipuolinen Palvelukeskus- Ward C3

Abstract:

The aim of this thesis is to explore communication patterns to support professional caregivers to enhance the well-being of older adults living in nursing homes. Two research objectives were formed to meet this aim: what are the different types of communication interactions used by professional caregivers in nursing homes for older adults; and how these communication interactions affect the well-being of older adults. This work has two target groups: professional caregivers (primary) and older adults (secondary). The theoretical framework was based on Kitwood's theory of "personhood". Ten (10) scientific peer reviewed articles were analysed through the deductive content analysis process to get the results. The findings for the most part concurred with previous studies and the theoretical framework used. It revealed four types of communication interactions: negative, task-oriented, relationship-oriented and lastly person-centred communication interactions. The findings also revealed that communication interactions have a positive (social and emotional; psychological and physical) and negative impact on older persons' well-being. The main issue in the discussion was that, confirmation is the breaking-point between a negative and positive communication interactions; it determines the face of a communication interaction. Furthermore, it was discussed that factors such as: the caregiver's work-load; job satisfaction; education; work experience; personal attitudes toward older people; and organisation cultures under which care is provided greatly shapes the communication patterns that caregivers are likely to initiate with older persons under their care. It was concluded that "personhood" is maintained through person-centred communication which has a positive effect on the older adults' well-being. More so, it has a positive impact on the staffs' well-being as it reduces the incidence of resistance to care which causes burn-out and stress for caregivers. The author recommends further studies on how organisation providing care can improved on work culture that support professional caregivers to carry out person-centred communication interactions.

Keywords:	Communication, Interactions, Needs, Well-being, Person-centred Care , Caregivers, Older People, Nursing homes
Number of pages:	59
Language:	English
Date of acceptance:	28.10.2013

EXAMENSARBETE	
Arcada	
Utbildningsprogram:	Human Ageing and Elderly Service
Identifikationsnummer:	12872
Författare:	Doris Babeh Ebai
Arbetets namn:	Att stöda närvårdare på vårdhem: En litteraturstudie
Handledare (Arcada):	Sundell Solveig och Birgitta Dahl
Uppdragsgivare:	Gustavsgårds Mångsidiga Servicecenter - Avdelning C3

Sammandrag:
Syftet med denna avhandling är att undersöka kommunikationsmönster som stöder närvårdare att förbättra välbefinnandet hos de äldre på vårdhem. Två målsättningar skapades för att nå ändamålet: vilka är de olika kommunikationssätten närvårdare använder inom långtidsvården för äldre, och hur påverkar dessa kommunikationssätt de äldres välbefinnande? Detta arbete har två målgrupper: närvårdare (primärt) och äldre (sekundärt). Den teoretiska strukturen baserade sig på Kitwood:s teori om ”personhood”. För att nå ett resultat analyserades tio (10) vetenskapliga granskade artiklar enligt den deduktiva innehållsanalytiska metoden. Fynden sammanföll mestadels med tidigare undersökningar och den teoretiska referensramen. Det avslöjades fyra olika kommunikationssätt: negativt, uppgiftsorienterat, förhållandeorienterat och personcentrerat kommunikationssätt. Det avslöjades även att kommunikationssätten har positiva (sociala och emotionella; psykologiska och fysiska) och negativa verkan på de äldres välbefinnande. Huvudfrågan gällde bekräftelse, den är brytpunkten mellan negativ och positiv kommunikation; bekräftelse bestämmer naturen av kommunikations samspelet. Vidare diskuterades faktorer relaterade till närvårdaren; de äldre och organisationskulturen där vården ges, de påverkar kommunikationssättet som närvårdaren väljer att initiera. Slutsatsen blev att ”personhood” upprätthålls genom personcetrerad kommunikation, vilket har en positiv inverkan på den äldres välbefinnande. Dessutom har det en positiv inverkan på närvårdarens välbefinnande genom att reducera förekomsten av nervkollaps och stress. Skribenten rekommenderar fortsatta studier om hur man kan stöda organisationer som erbjuder vård att förbättra arbetskulturen så att.

Nyckelord:	Kommunikation, Interaktion, Behov, Välbefinnande, Personcentrerad vård, Närvårdare, Äldre, Vårdhem
Sidantal:	59
Språk:	Engelska
Datum för godkännande:	28.10.2013

OPINNÄYTE	
Arcada	
Koulutusohjelma:	Human Ageing And Elderly Service
Tunnistenumero:	12872
Tekijä:	Doris Babeh Ebai
Työn nimi:	Vanhustentalossa Työskentelevien Omaishoitajien Tukeminen: Kirjallisuuskatsaus
Työn ohjaaja (Arcada):	Sundell Solveig ja Birgitta Dahl
Toimeksiantaja:	Kustaankartanon Monipuolinen Palvelukeskus- Osasto C3

Tiivistelmä:

Tämän työn tarkoitus on tukea omaishoitajia parantamaan vanhusten hyvinvointia hoitolaitoksissa tutkimalla kommunikointikaavoja. Kaksi tutkimustavoitetta muotoutui: mitä eri kommunikointikaavoja käytetään vanhusten pitkäaikaishoitoyksiköissä; sekä miten nämä kommunikointikaavat vaikuttavat vanhusten hyvinvointiin? Tällä tutkimuksella on kaksi kohderyhmää: hoitajat (ensisijaisesti) ja vanhukset (toissijaisesti). Teoreettinen viitekehys perustui Kitwoodin ”personhood” -teoriaan. Tuloksen saavuttamiseksi analysoitiin kymmenen (10) tieteellistä kirjoitusta deduktiivisen sisältöanalyysin mukaisesti. Suurin osa tuloksista oli samankaltaisia kuin edeltävät tutkimukset. Paljastui neljä eri kommunikointitapaa: kielteinen, tehtäväpainoitteinen, ihmissuhdepainoitteinen sekä henkilökeskeinen kommunikointitapa. Tulokset paljastivat myös että kommunikoinnilla on sekä positiivinen (sosiaalinen ja emotionaalinen; psykologinen ja fyysinen) että negatiivinen vaikutus vanhuksen hyvinvointiin. Pohdinnan pääkysymys käsitteli vahvistamisen merkitystä myönteisen ja kielteisen kommunikoinnin muodostumisessa; vahvistaminen määrittää kommunikoinnin luonteen. Lisäksi keskusteltiin siitä että hoitajaan liittyvät tekijät, kuten vanhukset ja hoitoympäristössä vallitseva kulttuuri, vaikuttaa kommunikointiin. Päästiin siihen johtopäätökseen että ”personhood”ia ylläpidetään henkilökeskeisen kommunikoinnin avulla ja sillä on myönteinen vaikutus vanhuksen hyvinvointiin. Lisäksi sillä on myönteinen vaikutus omaishoitajaan pienentämällä omaishoitajan loppuunpalamisen ja stressin vähentymiseen. Kirjoittaja suosittelee lisätutkimuksia siitä kuinka hoidon tarjoaja voi parantaa työympäristöä sellaiseksi että se tukee omaishoitajia toteuttamaan henkilökeskeistä kommunikointitapaa.

Avainsanat:	Kommunikointi, Vuorovaikutus, Tarpeet, Hyvinvointi, Henkilökeskeinen hoito, Omaishoitajat, Vanhukset, Vanhustentalo
Sivumäärä:	59
Kieli:	Englantia
Hyväksymispäivämäärä:	28.10. 2013

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FOREWORD

I would like to express my gratitude to Arcada for granting me the opportunity to study this course and to Kustaankartano ward C3 for commissioning this thesis project. Special thanks to all my lecturers, I am a better person because of what you taught me during my studies.

My gratitude to Christel G, for all the help she gave to me throughout my studies. Thanks to Gun-Britt L. and Miia G. for helping me at the beginning of my thesis. Special thanks to my supervisors Solveig S. and Birgitta D. for guiding me through this project. Solveig, your gentleness and motherly concern throughout my studies has been very refreshing, thank you for everything.

My classmates made this experience a formidable one. Richard S., I am very happy that I had the opportunity to meet you. To my friends Pia W., Anni V., Svenja S. and Dede P, words cannot express how grateful I am to you for to reading my work; I deeply appreciate your help.

Thanks to all my colleagues for their moral support especially to Miia K. and Sari S. A million thanks to my family and friends for all their support in one way or the other especially to my dear friend and sister Mira N. and to Nabil E. for your relentless efforts to support me.

To my mother Madam Victorine Ebagge and sister Paskamuli, I say thank you for your unconditional love and endless support. Thank you sweet Jesus for your strength, I couldn't have done this without you!

This work is dedicated to my lovely niece, sister and mother.

I love you all very much.

Helsinki, October 2013 Doris Babeh Ebai

1 INTRODUCTION

Moving to Finland and adapting a new language have been quite challenging. From personal experiences, it is obvious to the author that sufficient linguistics skills are tremendously important when working with older adults. However, during second practical training placement, the author came to realize that, good verbal communication skills are essential but not enough to effectively communicate with clients on physical, psychological, social and spiritual levels. The authors' quest to explore, study and incorporate effective communication (verbal and non-verbal) skills into personal working style with older adults is one of the reasons for choosing this topic.

It is common knowledge that caring for people with cognitive impairments can be very emotionally draining and physically difficult for the caregivers. In dementia care, sometimes it is hard to tell what is the right thing to do and what is wrong especially when the disease takes a toll on the communication abilities of the people suffering from it and makes interpretation of implicit and explicit actions tricky. The author has a huge interest to broaden knowledge on how to effectively and affectively build healthy relationships with clients of varying personality types, cognitive abilities, cultural background and life experiences.

1.1 Motivation

This work is in accordance with Finland's National Framework for High-Quality Service for Older People relating to one of the strategic guidelines for personnel and management team working with older people. It states that: "Staff competence should be ensured by targeting supplementary training to meet the estimated future skills need and by following the supplementary training provisions and frameworks for social and health care" (MSAH 2008 p. 32). This guideline clearly acknowledges the need for caregivers working with older persons to receive support (from training and refresher courses) to enable them in their care giving roles.

In addition, this work is based on the most recent update of the above mentioned framework outlining the main ethical principles ensuring old age with dignity in Finland

(MSAH 2008 p. 12). They are: self-determination; individuality; resource orientation; equality; participation; and security. Self-determination entails the right to informed choices and to be able to obtain information and other help that older people need to make decisions. Equality implies preventing discrimination and accepting differences in people (MSAH 2008 p. 12 f.). Participation entails providing opportunities for older people to have social involvement and make contributions to their various communities. Individuality considers the importance of seeing older persons as unique individuals capable of making their own decisions and taking responsibility over their own lives. Security entails, providing and enhancing the feeling of physical; mental; and social safety for older people (MSAH 2008 p. 13).

As a prospective professional in elderly care, the authors' reason for choosing this topic arises from the need to advocate the rights of older persons especially those with cognitive impairment living in nursing homes. It is quite tough that some older people in need of care have to leave their homes and move into a strange environment. And even worst if the caregivers in their new homes cannot understand and communicate with them in ways that promote their quality of life. Blackhall *et al* (2011 p. 35) wrote that: "care for older people including those who have a diagnosis of dementia, has received high-profile criticisms in recent years[…], basic principle of compassion is too often missing from care of vulnerable older adults". Thus, this topic is very essential in the field of Elderly Care.

1.2 Relevance of the topic

There is a great need for people working with older persons to be aware of good communication techniques that may improve their effective communication skills with clients. Communication is an essential element in care settings for older adults with memory disabilities. Clients with memory disorders are sometimes unable to express their needs verbally. Consequently, it is the caregivers' responsibility to be vigilant and use communication patterns that best enhances the unexpressed needs of older people (Small *et al.* 2003, Fleischer *et al.* 2008, Souder *et al.* 2004 p. 24, Jootun & McGhee 2011, Wilson *et al.* 2012 pp. 328 ff.).

Blackhall *et al.* (2011 p. 35) stated that: "caring for people with dementia is a complicated and highly specialised area and therefore beyond the capacity of the average care worker" (cp. Alzheimer's Society 2009, DH 2009, NICE 2010.).There is a need for high quality professionals capable of meeting the needs of older persons under their care. Communication being a medium through which needs are met (Souder *et al.* 2004 p.22).

Until today, caregivers are not receiving sufficient support in order to practice effective and affective communication to ensure a good quality of life for their clients. This is a rising problem which needs to be addressed due to the fact that communication is a key element in nursing care (Shattell 2004 p. 717). Some studies indicated that professional caregivers receive very little support from the organization about what are the recommended communication patterns to be used with older people (Shattell 2004 p. 717). Others also indicated that there is a high risk for burn-out when professional caregivers lack effective communication skills and the clients are vulnerable to receive a low quality of care (Small *et al.* 2003, Jootun & McGhee 2011.). Thus, this study comes as a means to address these issues.

This work seeks to address the need of support for professional caregivers on communication patterns that are beneficial to enhance well-being of older people living in nursing homes. The background shall consist of previous research relating to the topic, the research aim and questions, scope of the topic, and theoretical framework. The main concepts as raised by the objectives shall be described. The next part shall focus on the methods of data collection and methods of data analysis, whilst the last part shall focus on the results, implementation, discussion, and conclusion. This work shall also include a critical examination of the limitations and strengths of the results and recommendations for future studies.

2 BACKGROUND

The background of this work shall consist of a brief examination of previous researches relating to this topic, the research aim and questions; the scope of this work, and description of key concepts in the objectives (communication vs. interaction, well-being and nursing homes).

2.1 Earlier studies

Backhaus (2012) stated that despite the fact that communication is a critical aspect of life in all age cohorts; "Yet, the particular challenges of communication between caregiver and usually much older care recipient have rarely been studied, let alone addressed in care courses". There exist a host of previous researches relating to this topic but very few are on supporting professional caregivers through their communication with older people. As background knowledge for this work, five areas of studies that are related to this work shall be briefly examined. These include topics such as: positive approaches in dementia care; strategies for working with older people; the nurse-patient communication interactions; interventions to evaluate nurse-patient interactions; and factors related to nurse communication with elderly people.

The first previous study from which this thesis draws its inspiration is the work of Shattell (2004) entitled "nurse-patient interaction: a review of literature". The aim of this article was in threefold: "review a theoretical basis for nursing knowledge development for nurse-patient interaction, review the literature on nurse-patient interaction, and discuss arrears for further research". It was indicated that the nurses' power over the older people is seen in the "sick role" attributed to the clients (Shattell 2004 p. 716). Communication was rated as by the older people as helpful, hurtful, confirmatory or exclusionary. The following types of communication styles were indicated in this article namely: dominant; open; attentive; friendly; relaxed; precise; dramatic; contentious; and animated communication styles (Shattell 2004 p. 719).

The second earlier study used as previous study for this thesis was by Kaakinen *et al.* (2011) entitled "Strategies for Working with Elderly Clients: Qualitative Analysis". It

focused on analysing the communication between elderly clients and nurse practitioners (NPs) or health care practitioner (HCPs). Three models of communication were stated: elderly clients' satisfaction and HCP communication; nurse practitioner-client communication; and communication models (Kaakinen *et al.* 2011 p. 325).

The first model indicated that, the degree of mutual participation in communication between older people and HCP during the caring process determines the older person's level of satisfaction. It was indicated that, the more the HCP talked, the less satisfied was the client (Kaakinen *et al.* 2011 p. 325). The second model indicated that the NPs took into consideration the social circumstances of their clients during communication (Kaakinen et al. 2011 p. 325 f.). The last model acknowledged the importance of HCP knowing the clients' life history and background (Kaakinen *et al.* 2011 p. 326).

The third previous study inspiring this thesis was by Hoe & Thompson (2010) entitled: "promoting positive approaches to dementia care in nursing". The aim of this article was to provide an overview of relevant issues that nurses should considered when working with people with dementia. The well-being of a person is reflected in their interactions with others and engagement with the environment. Well-being is an important aspect of quality of life. This article indicated that the VIPS model of care is useful in providing individualized person-centred care (Hoe & Thompson 2010 p. 50), (cp. Brooker 2007). Therapeutic communication strategies such as: cognitive stimulation therapy; validation therapy, reality; orientation therapy; resolution therapy; reminiscence therapy; and a few others were recommended for their positive impact on well-being and quality of life of the older person with cognitive impairment (Hoe & Thompson 2010 p. 52 f.).

The fourth earlier studies as background for this work was carried out by McGilton *et al. (*2012) entitled: "Patient-centred communication interventions study to evaluate nurse-patient interactions in complex continuing care". It was stipulated in this study that person-centred care is the underlying principle for the provision of quality care in nursing homes and that when quality of care is undermined well-being is not optimized (McGilton *et al.* 2012 p. 2). Person-centred care according to this article encompasses the ability of the caregivers to communicate effectively to understand the needs of the clients. It is only when clients' needs are met that they can have a positive experience of well-being (McGilton *et al.* 2012 p. 5). The article concluded that improving

communication in complex care settings has the effect of reducing the clients' agitation and making interactions less stressful for the caregivers (McGilton *et al.* 2012 p. 8).

The fifth earlier study for this work was by Caris-Verhallen *et al.* (1999) entitled: "Factors related to nurse communication with elderly people". It stated that there are three main factors affecting the quality and the quantity of communication between caregivers and older persons. These factors were related to the characteristics of the caregivers, the older people; and the organisation providing care. It was stated that attitude towards elderly, job satisfaction, education and training, as well as the length of work experiences of the caregivers affects their quality and quantity of communication they initiate or have with the clients.

It was indicated that gender, age, and health situation of the older person influences the frequency and nature of communication interaction initiated by the caregivers with them (Caris-Verhallen *et al.* 1999 p. 1107). With regards to factor relating to the organisation, it was emphasized that work pressure does not influence communication negatively. Studies carried across six nursing homes revealed that best communication occurred in very busy care units. Care units with special activity programmes on their schedules promoted more positive communication between caregivers and the clients (Caris-Verhallen *et al.* 1999 p. 1107 ff.).

After reading all of these researches, the author felt that even though they insinuated that caregivers are not receiving enough support in communication with their clients they however did not provide enough information on how to support caregivers' communication. Consequently, the author had clarity about what direction this work was going to take, hence, inspiring the formulation of the research aim and setting the questions for this work.

2.2 Research aim and questions

Communication is an essential element in nursing care for older adults and previous studies have shown that good and effective communication is paramount in the caring process. Caregivers need sufficient skills to be able to engage with their clients and

promote healthy relationships (Jootun & McGhee 2011 p. 40 f.). Hence, this research aims to explore communication patterns that may support professional caregivers to enhance well-being of older adults living in nursing homes. To fulfil this aim, two questions were raised:

- What are the different types of communication interactions used by professional caregivers in nursing homes for older adults?
- How do these communication interactions affect the well-being of older adults?

These two questions satisfy the aim of this research as they provide useful information about working styles which professional caregivers may incorporate to improve their competences as caregivers.

2.3 Scope of the work

The commissioning partner for this work advised strongly against over broadening the scope and that the author should focus on issues that their staffs can easily understand and incorporate into their working lives. It is extremely important to mention at this point that communication in this work shall be strictly limited to communication interactions in nursing care as described in the subsequent headings. Communication in this work shall exclude all aspects of communication technology.

Also, as a limitation of the scope of this work, communication interactions shall be limited only to those initiated by professional caregivers between themselves and older people residing in nursing homes. All communication interactions initiated by the clients to the caregivers are not primary to this work. The primary target group for this work are the professional caregivers and the secondary targets are the older people residing in nursing homes. After examining previous researches relating to this work and stating the aim and research questions, the next part of this work shall consist of the theoretical framework. The theoretical framework is chosen by the author for the purpose of testing the questions that are going to be investigated later.

2.4 Theoretical Framework

The theoretical framework of this thesis is based on Tom Kitwood's theory of 'Personhood'. The term personhood according to Kitwood can be used in three main discourses: transcendence, ethics and lastly social psychology (Kitwood 1997 p. 7 f.). For this work, the last discourse of personhood (social psychology) is more relevant to the aim of this research and is better related to the research questions.

Within the social psychology the term 'personhood' is mainly associated with the place of an individual in a social group, their integrity, continuity, stability of the sense of self as well their self-esteem and their role in the society (Kitwood 1997 pg. 8). Kitwood (1997 p.8) (cp. Kitwood 1993) defined personhood as:

> a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being. It implies recognition, respect and trust. Both the according of personhood, and failure to do so, have consequences that are empirically testable.

Kitwood (1997 p. 45 ff.) stated that a situation common in nursing homes is that older persons with dementia are often seen as people with no personhood or subjectivity. Kitwood (1997 p.7) emphasized that: "our frame of reference should no longer be person- with- DEMENTIA, but PERSON-with-dementia". Kitwood argued that dementia is within a person and not the person within dementia. This implies dementia is a subset of a person and not a person a subset of dementia. This approach was termed by Kitwood as the 'person-centred approach' (Kitwood 1997 p.7 ff).

Kitwood went further to state that people with dementia should not lose their personhood because of the disease but rather their personhood must be maintained within the content of their relationship: communication being the medium through which personhood can be maintain (Kitwood 1997 p.55 ff.) , (cp. Kitwood 1993). Kitwood (1997 p. 55) quoting from the landmark document entitled 'Living Well into Old Age', stated that: "people with dementia have the same values, same needs and same rights as everyone else" (cp. King's Fund 1986).

The theory of Personhood further on stated that there are a number of psychological and social needs that enhances and maintain well-being of people with dementia. The person's life history and their level of cognitive impairment determine the patterns of their needs as well as the intensity of their needs respectively (Kitwood 1997 p. 81). Accord-

ing to Kitwood (1997 p. 80 ff.) the main psychological needs of person with dementia are comfort; inclusion; attachment; identity; and occupation.

Kitwood mentioned that during his early days of working with people with dementia, he noticed that there was a high tendency of 'DE personality' in dementia care as many process of work in nursing homes in a way undermines personhood of people with dementia. He used different examples to proof this point. Kitwood (1997 p. 45 f.) stated four examples of work processes or depersonalisation traditions in elderly care homes namely: Bestialization, the contribution of moral deficits, warehousing, and the unnecessary use of a medical model. Kitwood came up with two situations: the malignant social psychology and the positive person-work. The former undermines personhood whilst the later meets the needs of people with dementia and maintain their personhood hence enhancing their feelings of well-being (Kitwood 1997 p. 46 f.).

2.4.1 Malignant social psychology

Malignant social psychology was defined as: "the care environment that is deeply damaging to personhood, possibly even undermining physical well-being" (Kitwood 1997 p. 46). However, malignant social psychology does not include the evil intentions of the caregivers, Kitwood (1997 p. 46) stated that: "most of the work is done with kindness and good intent. The malignancy is a part of our cultural inheritance".

Kitwood came up with twelve malignant interactions that may undermine personhood namely: treachery, disempowerment, infantilization, intimidation, stigmatization, outpacing, invalidation, banishment, objectification, ignoring, imposition, withholding, accusation, disruption, mockery, and disparagement (Kitwood 1997 p. 46 ff.).

2.4.2 Positive Person- Work (PPW)

The positive person-work refers to good dementia care; it is about person-centred care. Kitwood (1997 p. 89 ff.) mentioned that: "the positive person-work in dementia is essentially that of interactions, according to each individual's needs, personalities and abilities. This work requires a level of 'free attention' on the part of caregivers". The caregivers' interaction is important in maintaining personhood of older people in care units (Kitwood 1997 p. 119 ff.).

There are ten (10) different types of interactions or communication patterns under PPW that can maintain well-being of people with dementia. These include: recognition, negotiation, collaboration, play, stimulation, celebration, relaxation, validation, holding, and facilitation (Kitwood 1997 p. 119 f.). It was stated by Kitwood (1997 p. 89) that: "Each one enhances personhood in different ways: strengthening a positive feeling, nurturing ability, or helping to heal some psychic wound. The quality of interaction is warmer, more rich in feeling […]."

The reason for choosing this theory as the framework for this thesis is to develop an understanding of different communication interactions patterns and strategies used by staffs within the care environment as well as their effects on the clients' well-being. Although this theory was more about personhood for people with dementia, it is however applicable to this work. This is because personhood is for everyone regardless of their ages and cognitive status. In Alzheimer Europe (2012) it was stated that: "in an ethical sense, personhood is attributed even to the newborn infant. In an empirical sense, personhood emerges in a social context." (cp. Kitwood & Bredin 1992 p.275). Thus, it is correct to say that this theory forms a good framework for this thesis.

3 DESCRIPTION OF CONCEPTS

A few key concepts of this work will be described in the subsequent pages and detail information about these key terms can be further on search through the links provided in the reference list. The following key concepts shall be described under this heading: communication vs. interaction; nursing homes; and well-being.

3.1 *Communication vs. Interaction in Nursing Care*

The description and relationship between communication and interaction has not been clearly stated in nursing care today. The two terms have been used in literatures interchangeably or synonymously (Fleischer *et al.* 2008 p. 339 f.). The main intention of communication and interaction in health care is to influence the patient's health status and hence the state of well-being (Fleischer *et al.* 2008 p. 339 f.). The first step towards achieving this is by understanding the person (cp. Sarvimäki 1988). The process of in-

teraction and communication in elderly care depends on three main factors: the clients' cognitive status; the type of communication styles of the caregivers; and the settings under which care is given (Fleischer *et al.* 2008 p. 347).

3.1.1 Interaction in Nursing Care

It has never been defined independent of communication; in many literatures the differentiation of these two is only implicit. The theoretical framework of symbolic interactionism is often used to describe the process of interaction. Interaction has a higher position with regards to communication and it is a larger concept over communication. Communication is a sub-set of interaction (Fleischer *et al.* 2008 p. 340).
Interaction was described by Fleischer *et al.* (2008 p. 341 f.) as: "the observable behaviour during communication implying a different perspective" (cp. Oliver & Redfern 1991). It was also described as: "a mutual process of interpretation and construction of meaning […] intersubjective understanding of a situation or an object is a possible result of interaction" (Fleischer *et al.* 2008 p. 340 f.). Fleischer *et al.* (2008 p. 342) indicated that the mutuality of the interaction process includes actions of participants which can be physical, interplay or a contact or a bond of verbal or nonverbal communication (cp. Dornheim 2003).

3.1.2 Communication in Nursing Care

Fleischer *et al.* (2008 p. 342) described communication as: "a dynamic, complex, and mutual context-related ongoing multivariate process in which the experiences of participants are shared". Jootun & McGhee (2011 p. 40) considered communication as: "a reciprocal process in which messages are sent and received between two or more people" (cp. Balzer Riley 2004). De Vries (2013 p. 30) referred to communication as the: "exchanges between people when engaging in social and formal interactions".

Jootun & McGhee (2011 p. 41) stated that communication has four properties. These properties represent fundamental assumptions upon which human communication theories draw their inspirations. They are: communication is a process; communication is a

transaction; communication is over-changing and context-specific; and lastly communication is multidimensional (cp. Northouse & Northouse 1998).

Fleischer *et al.* (2008 p. 342) stated that communication between people depends strongly on their cultures, social status and most importantly on their relationship with the other participant(s) in the communication process. The goal of communication determines the extent or nature of communication. The nature of communication is generally affective, instrumental or a mixture of both. There are two main types of communication: the verbal and non-verbal (Fleischer *et al.* 2008, Jootun & McGhee 2011.).

The verbal communication was described as all expression with language as a key component in the delivery of information or messages (Jootun & McGhee 2011 p. 42, Fleischer *et al.* 2008 p. 342 f.). Non-verbal communication on the other hand includes all behaviours except spoken words used for communication. Non-verbal communication (for example body language, touch, eye contact, silence….) has a vital role in human communication (Fleischer *et al.* 2008 p. 343, Caris-Verhallen *et al.* 1999 p. 809). Jootun & McGhee (2011 p. 42) indicated that majority of human communication is done more non-verbally (93%) than verbally (7%) (cp. Argyle 1988).

3.2 Well-being

The concept of well-being is very broad; it has several definitions depending on the domain in which it is used (Rissanen 2013 p. 22, CDC 2013). For this reason, Rissanen (2013 p. 22 f.) stated that:

> the definition of wellbeing is usually assumed, or is lacking in clarity, and range of similar terms, such as happiness and life satisfaction, are used interchangeably; second, wellbeing has been measured in research using various scales, which may not capture the complexity of the concept [...].

Within this work, the concept of well-being described relates to the well-being of older people living in nursing homes. CDC (2012) stated the following aspects of well-being namely: Physical well-being; Economic well-being; Social well-being; Development and activity; Emotional well-being; Psychological well-being; Life satisfaction; Domain specific satisfaction; and Engaging activities and work. Rissanen (2013 p. 24), (cp. WHO 2012 p.12) described well-being as:

> the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age. Active ageing applies to both individuals and groups. It allows people to realise their potential for physical, social and mental wellbeing throughout their lives and to participate in society according to their needs, desires and capacities, while providing them with adequate protection, security and care when they require assistance.

Lundin *et al.* (2013 p. 2 ff.) defined well-being as: "an emotional experience which does not require intact cognition". Thus, affirming the fact that older people with cognitive impairments are in great need of well-being supported care because they can still feel emotions notwithstanding the presence of the disease (cp. Ericsson 2012 p. 3).

A Swedish study on well-being indicated that " social relations, functional ability and activities may influence the quality of life of elderly people as much as health status". The physical and social environments are connected to well-being (Rissanen 2013 p. 24ff). Relating to the physical environment, Rissanen (2013 p. 28) explained that:

> the natural surroundings of the accommodation and aesthetic experiences are important partsof wellbeing […]garden had positive effects on residents' quality of life, particularly in terms of meaningful daily activities, enjoyment of daily life, resident relationships, and functional competency.

Relating to the social environment, well-being of older people living in nursing homes is seen in their opportunities to make choices, engage in activities, and the caregivers approaches to care (Rissanen 2013 p. 28).

3.2.1 Subjective and Objective well-being

Subjective well-being and objective well-being have different approaches (Rissanen 2013 p.23, King 2007 p.8f.). Well-being has been examined in literature through two approaches. King (2007 p.8 f) states two approaches of well-being: hedonic and eudaimonic approach. The former refers to well-being as happiness and experience of pleasure. The later approach contrasting the former and argues that: "wellbeing and subjective happiness should not be equated because the pleasure producing outcomes that underlie subjective happiness do not necessarily promote wellness and wellbeing" (cp.Ryan & Deci 2001). Diener *et al.* (2003 p.404) describes subjective well-being as:

> the field of subjective well-being (SWB) comprises the scientific analysis of how people evaluate their lives—both at the moment and for longer periods such as for the past year. These evaluations include people's emotional reactions to events, their moods, and judgments they form about their life satisfaction, fulfillment, and satisfaction with domains such as marriage and work.

Subjective well-being relates to personal view; an individual's life satisfaction; and happiness (Rissanen 2013 p.23, Lundin *et al.* 2013 p. 2 ff.). In Böckerman *et al.* (2012 p. 1183), fifteen dimensions of subjective well-being were stated, namely: 'mobility, vision, hearing, breathing, sleeping, eating, speech, elimination, usual activities, mental function, discomfort and symptoms, depression, distress, vitality and sexual activity' (cp. Sinotonen 1994,1995,2001).

Objective well-being on the other hand relates to standard of living or a list of resources necessary for a rational plan of life (Rissanen 2013 p.23 ff). It is not discuss in detail in this work because well- being of older adults resulting from communication interaction is more related to subjective well-being.

3.2.2 Aspects of subjective well-being

In Rissanen (2013 p. 22 f) it was indicated that the term well-being has always been divided into: physical (meeting physical needs); social (social activities); and mental well-being (psychological and spiritual). The holistic approach of well-being comprises all these three aspects.

Psychological well-being has six measuring dimensions namely: autonomy; positive relations, self-acceptance; environmental mastery; purpose in life; and personal growth (King 2007 p. 13) (cp. Ryff 1989). The emotional component of subjective well-being is measured by the feeling of joy and contentment in life whilst the cognitive component is more about assessing life satisfaction in various areas of life like relationships, leisure and work (Diener *et al.* 2003 p.405). Five elements of emotional well-being are: social connections; comfort and basic needs; resilience and coping; productive contribution; and sensory enrichment (Victorian Government Health Information 2011).

Social well-being was described in Keyes (1998 p.122) as: "the appraisal of one's circumstances and functioning in the society. The five dimensions of social well-being are: social acceptance (societal acceptance of one's character and qualities); social actualization (belief in others); social integration (quality of one's relationships), social coher-

ence (meaningful life), and lastly social contribution (social value of a person) (Keyes (1998 p.121 ff.).

In Chow (2005) spiritual well-being was described as "the affirmation of life in a relationship with God, self, community, and environment that nurtures and celebrates wholeness" (cp.Thorson & Cook 1980). Spiritual dimension is unique to every person and through it people can derive inner peace, harmony and contentment in life. Spiritual well-being is a means by which people can add meaning, value and purpose of their lives (Chow 2005). The term spirituality has been associated with spiritual well-being. Chow (2005) however indicated that: "it should reflect the human traits of compassion, honesty, love, wisdom, and for many, the existence of a guiding spirit or transcendence". The notion is that spirituality increases with ageing (Chow 2005).

3.3 Nursing homes

Finland's population estimate of July 2012 was at 5,262,930 people, of which 18.5% were 65 years and over (Indexmundi 2013). Places where older people in need of care live apart from their homes have a very unclear definition because the name varies between culture and countries. The following names have been used in literature: residential age care homes, assisted living facilities, care homes, LTC facilities, care housing, nursing homes, and care institutions amongst others.. The reason given for such diverse number of names is basically political as it has been said that the name institutional care conveys a kind of negative image towards older people (Rissanen 2013 p. 25 f.).

That is why over the years, many names have been given to such facilities. Most Nordic countries use the term "care homes" or "nursing home". It is referred to as: "units where older people with various care needs are living with 24hours care staffs available" (Rissanen 2013 p. 25 f.). OECD (2011) refers to Long-term care (LTC) facilities as:

> nursing and residential care facilities which provide accommodation and long-term care as a package. Beds in adapted living arrangements for persons who require help while guaranteeing a high degree of autonomy and self-control are not included.

Long-term care units consist of mainly two types: nursing homes and the residential care. LTC institutions are both public (funded by public funds and private (both profit

and non-profit) (OECD 2011). Finne-Sover *et al.* (2010 p. 8) stated that: "Long-term care for older people in Finland is delivered either at home, in sheltered housing, residential care homes (nursing homes), or within health centre inpatient wards (chronic care hospitals) (Böckerman *et al.* 2012, p.1179). Arrhenius & Kiviniemi (2010 p. 2) stated that: "Care in health centre hospitals and homes for older people, comprises institutional care, while intensive sheltered housing (with 24-hours assistance) includes overall outpatient care, non-institutional care"

The number of older people living in health centres and residential homes has reduced and the number of older people living in intensive sheltered housing has increased over the years (Arrhenius & Kiviniemi 2010 p. 2 f.). Since the institutional care reforms in 2000, the number of clients in institutional care has increased by 41% (National Institute for Health and Welfare 2012). For people suffering from moderate to severe dementia, it was estimated in Arrhenius & Kiviniemi (2010 p. 1) that about 40% are likely to need 24-hour assistance at sheltered housing or in their homes. The symptoms of dementia disease are the main factors that increase the need for residential or long-term care for older adults.

The Finnish government is trying to put in place adequate housing and assistance services to help older people continue to live at their homes for as long as possible. This is reflected in MSAH (2008 p. 29 ff.) that: "Adequate home care and sheltered housing with 24-hour assistance, together with new types of care service, will reduce the need for long-term institutional care". It was also stated in this publication that: " the national targets to be reached by 2012 are that, of all people over 75 years old;[…] 3% live in old people's homes or are in long-term care in health centre hospitals" (MSAH 2008 p. 28 ff.).

The national average of personnel per older person in care facilities in Finland has increased. It was stated in MSAH (2008 p. 36) that: "In 2005, the national average was 0.46–0.55 in sheltered housing with 24-hour assistance, 0.52 in residential homes, and 0.66 in health centre inpatient care". In 2008, it was increased to 0.5- 0.6 for 24-hours shelter housing and 0.6 - 0.7for long- term care in health centre hospital employees. However in reality, the good staffing ratio is 0.7 -0.8 for nursing homes (MSAH 2008 p. 36).

After examining previous researches relating to this work, aim and research questions and a description of the concepts that the research question raised, the next part of this work shall consist of descripting the materials and method used for this literature review.

4 MATERIALS AND METHOD

This part consists of a detail description of the method used for this work. All the processes and steps of data collection; data interpretation; data evaluation and ethical considerations shall be discussed. After reading thoroughly multiple materials on research methodologies, qualitative analysis was chosen as the research method. It was clear that qualitative analysis- precisely the 'Deductive Content Analysis' was the best method of data analysis for this work for the following reasons presented below.

4.1 Deductive Content Analysis

As earlier mentioned, the data materials for this literature review shall be analysed through the deductive content analysis method. But first, it is important to define qualitative content analysis under which deductive content analysis falls. Zhang & Wildemuth (2009 p. 1) described qualitative content analysis as: "a research method for the subjective interpretation of content of text data through the systematic classification process of coding and identifying themes or patterns" (cp. Hsieh & Shannon 2005 p.1278).

It is a method of data analysis which allows for theoretical reviews to be used to enhance the understanding of data through a deductive or an inductive procedure (Elo & Kyngäs 2008 p. 107 f.). Deductive content analysis is mostly used when the aim is to retest data in a new context (Elo & Kyngäs 2008 p. 111, Zhang & Wildemuth 2009 p. 1 ff.). Here, analytical reasoning is based on three things: existing theories, previous studies and the experience or expert knowledge on the subject to be research (Elo & Kyngäs 2008 p. 107, Zhang & Wildemuth 2009 p. 1 ff, White & Marsh 2006 p. 27.).

By virtue of these facts stated above, the author had clarity that this was the best method for this work as it constitutes all the above mentioned things. First, a theoretical framework is used (Kitwood's personhood theory). Secondly, the aim and research questions are inspired by previous studies. And thirdly, answers to the research questions will be provided by analysing the works of experts relating to the research topic (peer reviewed articles).

In addition, deductive content analysis is well-suited for this work by virtue of the fact that the approach moves from a general to a more specific idea, thereby narrowing down the work. The author first of all examined broad concepts of communication interactions and then narrowed it down to the effectiveness of each concept with regards to promoting well-being of older adults living in nursing homes. Hence, the structure unit of this work is a Funnel- model (broad top and narrow base).

Deductive content analysis processes involves formulating the research question; collecting the data (sample); analysing the data and interpreting the results by coding or categorizing text from the review articles (White & Marsh 2006, Elo & Kyngäs 2008 p. 112.). In the first phase of formulating the research question, the author used the research aim or theme as a guide for establishing the questions (White & Marsh 2006 p. 30). To this effect, two research questions were formulated (as stated above).

The deductive content analysis method requires that the researcher at the beginning of the research process determines whether to analyse the articles only from their manifest and/ or latent content. Manifest content refers to easily identifiable aspect of the text content (White & Marsh 2006 p. 23). Whilst latent content refers to hidden issues not expressly stated in writing but can be reasonably inferred (Elo & Kyngäs 2008 p. 109, Graneheim & Lundman 2003 p. 106.). Considering the aim of this research, the decision was made to analyse the articles by using both their manifest and latent content. The reason for this was that, data analysis will yield richer results, from which valuable conclusions would be made.

4.2 Data collection

The sample or data materials for this research work were selected based on the methods of deductive content analysis. This method requires that the data selected for analyses should provide answers to the research questions or hypothesis being investigated (Zhang & Wildemuth 2009 p. 3).

Search for material was basically through Nelli portal. The following databases were searched: Ebsco, Proquest, SAGE, Biomed central, CINAHL, Google scholar, Elite, Cochrane, Ebrary, PubMed, Academic Journals and Google. Also the author contacted the Arcada library and the Meilahti library in Helsinki to obtain materials for the analysis. Most of the sources had good materials but their availability was limited.

At the initial stage the following search terms were used as illustrated in *Appendix (1/6)*. These search terms were related to six (6) aspects relevant to this work namely: communication, well-being, older adults, memory disorders, care units and caregivers. These search terms produced several results. A very challenging task for gathering material for this work was using search terms that provided relevant articles. It was noticed that when search terms like caregiver and older people were used, the search results yielded considerably less relevant results as opposed to when search terms such as 'nurses' and 'elderly/elderly patient' were used. In this regard, the author feels that materials available in the databases indirectly influence how the search words were narrowed down.

The search terms producing the most relevant articles were selected. The following search terms yielded results that were used: Communication AND Dementia Care; Nurse Behaviour AND Dementia Care; Communication Interactions AND Nursing Homes; Communication Strategy AND Well-being; Well-being AND Needs; Communication AND Elderly Care; Communication AND Residential Care; Nurse- Elderly AND Intervention; Nurse- elderly Communication; Carers AND Dementia AND Nursing Home. The motivation for choosing these search terms was mainly that they were related to the main concepts of this work. *Appendix (2/6*) illustrates the final search words and the corresponding data materials as well as the data base from which they

were retrieved. A total of 16 articles were found but six were eliminated for the reasons stated below.

4.2.1 Inclusion and exclusion criteria

The prerequisite criterion for selecting an article for the data analysis was the relevance of the material to the topic. The author was keen that each article should have a different perspective on the topic. Two (2) articles were eliminated because their approaches to the topic were superficial. The fourteen (14) articles were later on evaluated against the following inclusion and exclusion criteria as presented in the Table (2) below. Ten (10) articles met the inclusion and exclusion criteria for the data analysis.

Table 2. Showing the Inclusion and Exclusion criteria for the data materials.

Inclusion Criteria	Exclusion Criteria
✓ Material relating to the topic (Qualitative and quantitative studies). ✓ High reliability scores (>0.9) or large sample size ✓ Articles written in English only ✓ Full text available ✓ Scholarly journals (of which no books) ✓ Scientifically written materials ✓ peer reviewed materials ✓ Published between 2000 – 2013 (exception of two articles published 1997 and 1998)	✓ Materials from trade journals, conference papers and proceedings, magazines, reports websites, and Blogs ✓ Materials relating to the topic but not written in English ✓ Materials outside the scope of this work ✓ Materials relating to topic but without a full text available ✓ Materials not scientifically written or not peer reviewed

4.2.2 Description of Materials

The ten (10) articles were found, some were qualitative and others quantitative researches. The articles were systematic reviews, literature reviews and pilot studies. For the qualitative and quantitative studies a majority were carried out in the Netherlands followed by Sweden. For the literature review article, literature analysed had an international background. Most of the studies were carried in nursing homes, majority of the

participants were older people living in nursing homes and their caregivers. Some articles answered only one of the research questions whilst others provided answers to the both questions. Description (author(s), year of publication, title, aim of research, method and results) of each data material used for this thesis is illustrated in *Appendix (3/6).*

4.3 Data Analysis

Before starting the data analysis process, the author numbered the ten articles in the following manner [1], [2], [3]… [10]. In-text referencing was according to these numbers. Each of the ten articles was read several times in order to make sense of the data and to understand their contents (Elo & Kyngäs 2008 p. 109). The analytic constructs or rules of inferences were used at this stage to analyse each one of the articles. The 'analytic constructs' or 'rules of inference' is the process of answering the research question by looking at the text of the review articles. White & Marsh (2006 p. 27) indicated that it helps the researcher to: "move from the text to the answers of the research question". All the aspects which answered the research questions within the manifest or latent content were highlighted. Data analysis entails interpreting the results by stating the theme, developing categories, subcategories, units, and sub units to describe the results (Elo & Kyngäs 2008 p. 112).

As earlier mentioned, the aim of this work is to explore communication patterns that may support professional caregivers to enhance well-being of older adults living in nursing homes. The research questions are: to find the different types of communication interaction manifested in nursing homes for older adults; and to examine their effects on the feeling of well-being for the older persons under care. The aim of this work was considered as the main theme and category one and category two were from question one and question two respectively.

In selecting the subcategories, units and subunits, the structured matrix analysis was used. The structured matrix of analysis allows for choosing from the data only aspects that fits the categorized frame (White & Marsh 2006, p.27). Using the theoretical framework and knowledge from earlier studies as the baseline, the different subcategories were formed. Ideas or information that was repeatedly mentioned in these articles

were grouped into sub-categories. From category one four subcategories emerged and three subcategories from category two.

It was noticed that under these sub-categories some elements were similar to each other, those were grouped to form the units. However, some elements were similar to two or more units. The deductive content analysis process requires that no element should be left out because of lack of a group (Elo & Kyngäs 2007 p. 111ff.). All decisions to add an element to a group was based on the information repeated in the data material; knowledge from the theoretical framework; and the earlier studies. In that light, the categories were internally homogenous to each other and as the subcategories developed further, they became more heterogeneous from each other (Zhang & Wildemuth 2009 p. 4). Because this is a very tactical process, the author will show how the subcategories and units were formed only on the result section.

4.4 Limitations of materials and Challenges of method Used

The limitations faced during this process were basically related to the collection of data materials. The availability of relevant materials was the most problematic throughout this work. Many good and relevant articles to the topic were not used because they were unavailable, therefore in a way limiting the material selected for this work. Two articles used as data were out of the publication date range (1997 and 1998), notwithstanding they were used because they provided very useful information for the results.

On the other hand, the challenges faced during this thesis project were related more to the coding process of the data. Selecting the theme, categories and subcategories for this work was more or less a very comprehensive and straight forward procedure. However, forming the subunits and grouping them into the various units and sub-categories was very difficult. Many units belonged to more than one sub-category; it became very difficult to decide which sub-category is most suitable for them. Thus, the author by critically examining this work and method of data analysis realised that there is a possibility of over narrowing or over broadening of the units. However, all necessary measures were

taken to ensure that all units were fitted under the appropriate subcategories and categories by rechecking with data materials, the theoretical framework and earlier studies.

4.5 Trustworthiness

The trustworthiness of this work shall be examined through the validity, reliability and credibility criteria. White & Marsh (2006 p. 31) defines validity as: "the extent to which a measuring procedure represents the intended, and only intended, concept". The validity of this work is evident in the fact that the research aim and questions are clearly defined. Validity of this work is seen in the objectiveness of the author during data interpretation. The results have no subjective views, rather they are a vivid reflection of the data material analysed.

Elo& Kyngäs (2007 p.112) stated that to: "to increase the reliability of the study, it is necessary to demonstrate a link between the results and the data". Reliability of this work is seen in the fact that the findings were described in detail and the information from the data was exhaustively presented in the results in authorial text and figures. The reliability of this work is also seen in the fact that authentic referencing was used throughout this work. The author has described systematically the process used in such a way that others can follow the procedure to get the same results.

Elo& Kyngäs (2007 p.112) indicated that "credibility of a research findings also deals with how well the categories cover the data". As seen in the results, category 1 and 2 were fully covered in the sense that they were conceptually and empirically grounded. All the materials under the two categories were empirically and theoretically based.

4.6 Ethical Considerations

According to the Arcada's guideline for thesis writing, the author read and reviewed all the necessary text on the 'Good scientific practice in studies at Arcada' and also confirmed adherence to these roles by signing the thesis agreement form. A short plan of

the thesis work was submitted to; and approved by the supervising lecturers. Later, it was presented to the commissioning partner (Kustaankartanon Monipuolinen Palvelukeskus - Ward C3), and the head nurse also gave her approval. Only scientific articles were analysed as data materials for this work. No interviews were conducted.

The author was completely objective when reviewing the selected scientific material for data analysis to get the results. Personal knowledge and views had no effect on the interpretation of the results as the author was fully aware of the fact that research results may sometimes present views that were not anticipated and are different from own opinions. All the findings were evidence-based. Given the fact that this was a literature review, the author considered strongly the reliability of the articles during data collection.

5 RESULTS

The results are presented in two categories. Category one explores the different types of communication interactions prevalent in nursing homes as posited by the data material. Category two on its part examines the effects of such communication interactions on the well-being of older adults living in nursing home.

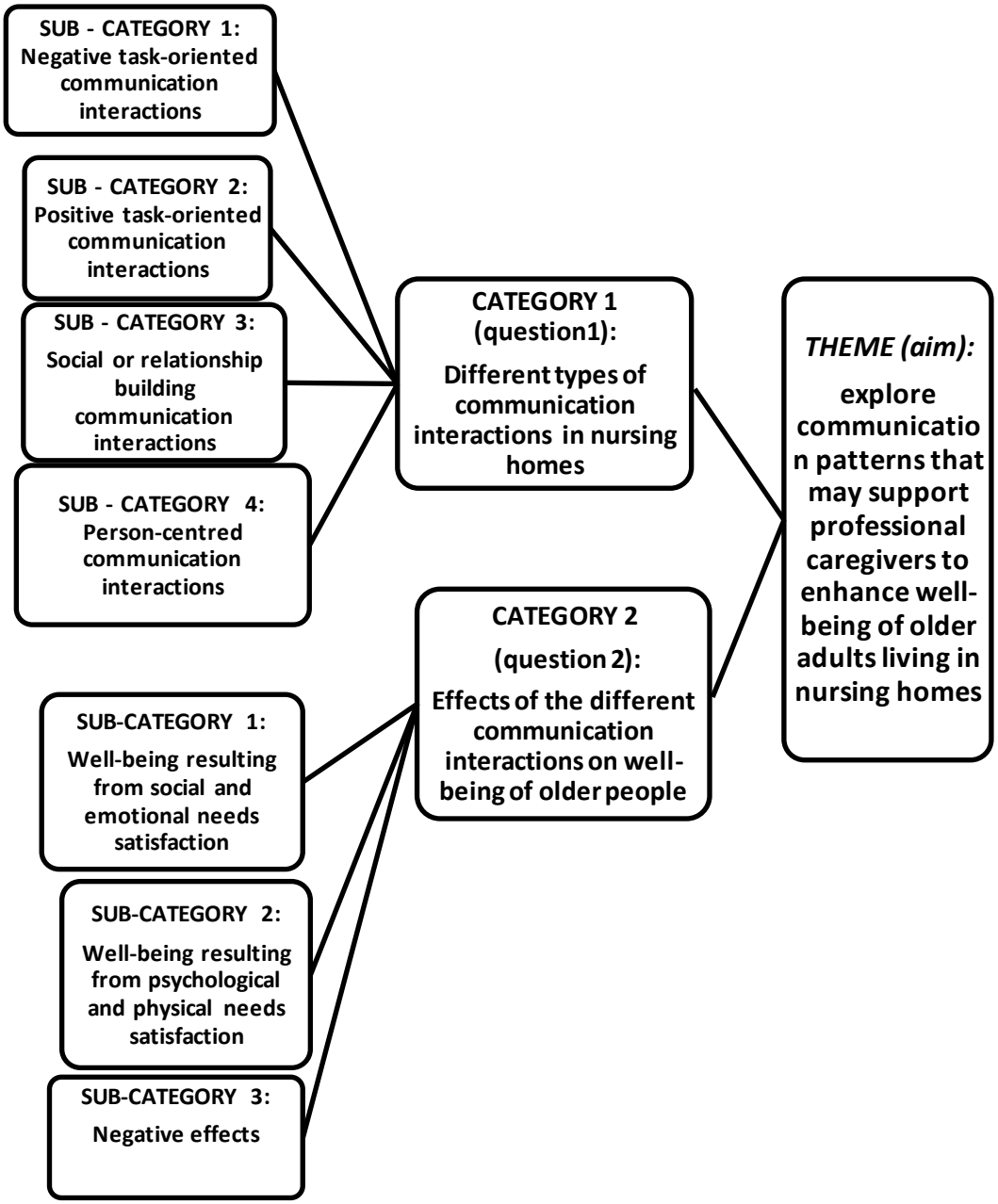

Figure 1. The Theme, Categories and Respective Sub-categories

5.1 Category One: Communication Interactions in Nursing Homes

Communication was defined as "the information component of interactions" [3]. Studies indicated that, communication is a fundamental aspect of nursing care and it is a prerequisite for the delivery of a good quality nursing care [4, 8, 3]. It was posited in [8] that:

in the nurse-patient relationship, communication involves more than the transmission of information; it also involves transmitting feelings, recognizing these feelings and letting the patients know that their feelings have been recognized and support their views.

Four main subcategories emerged as the types of communication interaction that are initiated by caregivers towards the older people living in nursing homes. There are namely: negative task, task-oriented, social/relationship-oriented, and person-oriented communication interactions. Findings for each of these sub-categories are presented as well as their units and subunits.

5.1.1 Negative task- oriented communication interactions

These are communication interactions which are focused on 'only getting the job done' [2, 3, 4, 5, 7]. This type of interaction was referred to as the 'I-It' relationship [5]. It is unfortunate that older people in some of the research articles reviewed attested more frequently to the fact that the nurses or professional caregivers are concerned about the task than talking to them [4]. For this sub-category the following units emerged: power –over [3]; prejudice [2, 5, 7]; disenabling [7]; and distance in negative point of view communication interaction.

A. Distance in point of view

In [5], it was stated that these interactions were not frequent but were obviously present before and after the interventions in this study. This type of interaction was characterized by a low confidence in the resident by the caregivers as they make no efforts in interpreting the clients' implicit and explicit communications [5]. Emotional tone [5], disagreement [3], misunderstanding [3], and accusation [7, 5] were subunits under this unit.

Emotional tone was described as a communication interaction wherein the carer used a tone of voice and emotions which are neutral and shows no commitment to the client thus distancing the Carers from their clients' concrete physical sense [5]. Carers' speech tone was least when residents complied or routine was accomplished. However they spoke more when the residents failed to comply with a task [5].

B. Power –over communication interactions

Studies revealed that caregivers sometimes exert power over communication or have tendency to take over care and 'act on behalf' of their clients [3]. Here the caregiver states the wishes of the client and sometimes dominate communication both verbally and non-verbally [5]. Three interactions where noted under this type of communication interaction: impositions [7, 5], verbal persuasions- coalition [2], Desistance [2] and enforcement [2].

Imposition represents all caregivers' behaviours that seem to portray the caregivers as be in control of decisions for their clients. This is evident when the caregiver states the clients' wishes. It also includes communications which has the aim of prompting a client to perform an action (for example using a hard tone of voice) [5].
Enforcement entails using authoritative commands with the clients or using physical presence to perform a task (for example keeping residence in position during provisions of care). It was also described as using commanding actions or physical presences for the purpose of summiting a client through a care process [2].
Verbal persuasion was common in all nursing homes investigated in [2]. Sometimes, it led to coalition when two or more nurses were called to join the persuasion [2].
Desistance according to finding [2] was less observed. It entails postponing a task [2].

C. Prejudice interactions

Prejudice [2, 5, 7] was described as discrimination on the bases of having dementia or being old [2]. Four communication interactions emerged from prejudice namely: labelling [2]; stigmatization [7]; infantilization [7, 2, 4] and objectification [7] communication interactions.

Labelling communications interactions initiated by caregivers was manifested in the notion of 'bad' or 'good' clients in nursing homes. This was evident in even the caregivers' language during the interviews. Labelling residents as 'demanding' and 'attention-seeking' revealed the caregivers perception of the rightfulness of a resident's needs and demands [2].

Infantilization [7, 2, 4] was referred to as 'secondary baby talk' [4] or 'institutional talk' or 'care speak' [2]. It was one of the most commonly used verbal communications by the staffs. It was defined in [4] as: " a set of accommodation including simplification and high and variable pitch, usually addressed to children, but also used in talking with elderly". Care speak was defined in [2] as a kind of institutional talk used by caregivers for older adults to manage their tasks.

D. Disenabling interactions

Disenabling interactions [7] emerged as one of the negative interactions manifested by caregivers during task activities. The following interactions were grouped under disenabling interactions namely: lack of communication [5, 8], fragmentation [5], out-pacing [5], ignoring [7], blocking [4], rebuke [5]; and testing knowledge [7]. The first three where defined in some of the article and the last just stated without any definitions given to them.

Fragmentation was defined in [5] as a communication interactions wherein the "carers changed the topic of conversation or they talked about more than one topic, there was information about something apart from the on-going activity or new activity started before the previous one had ended". Examples of fragmentation interaction are actions promoted without any logical reason, actions initiated without prior information and conflicting messages. It was stated that one out of five nurses interaction was characterized with fragmentation [5].

Lack of communication in interaction is an element of a negative task-oriented communication interaction. This occurs where; the caregiver initiates no communication with the client during a caring process or activity [4]. It was reported in a study that 2.3 averages of interactions were wholly silent in nature with no verbal communication from the caregivers to the clients [2].

Out-pacing was common in nursing homes as indicated by the research. The following statement attested to this fact: "[…] little choice in the timing and provision of care and the observed care episodes unfolded at a pace set by the staff" [2].

5.1.2 Positive Task – oriented communication interactions

The second sub-category for this objective is the task- oriented or instrumental communication interaction used by caregivers in nursing homes for older people. As evident in the name, task-centred interaction was defined in [4] as those interactions necessary in assessing and solving problems in the caring process. It was also described as interactions made by carers for the purpose of realizing a good care for residents [4]. This type of communication was initiated particularly during the performance or helping in the performance of a task.

It is task oriented but not necessarily a bad communication interaction [4]. Task-centred communication interactions may be verbal as well as nonverbal [4]. Under this subcategory three main groups emerges: instructive interactions [2,3,4,5,7]; interactions promoting competence/ independence [2,3, 5,7,] and decision making interactions [3,5,7].

A. **Instructive communication interactions**

These are communication interactions that are initiated to solve problems, give information and provide physical care [2] amongst other daily tasks of caregivers in nursing homes. In this type of communication interactions, the caregiver informs and instructs their clients continuously [5]. Under this unit the following interactions emerged: checking out [4], instrumental touch [1, 5, 4], asking and requesting information [4], making contact [7] (consisting of eye contact [4, 5] and facial expression [4]). Under this unit instrumental touch or task touch was very much explained in details in many of the articles whereas, the others were mainly stated throughout the articles.

Instrumental Touch was defined as a deliberate physical contact necessary to perform a task [4]. Touch is a very important type of non-verbal communication strategy used by professional caregivers. It is presumably practiced with respect of the client's privacy and integrity [5, 4, 1]. Instrumental touch is also referred to as necessary touch or task touch or guided touch or attention touch or comfort touch or physical touch. Other names used for this kind of touch was protective touch "that is touch which protects the person physically like wearing gloves" [4]. Instrumental touch was considered as a means of confirmation. Findings revealed that in reality, in institutional care for older people, nursing care touch is for the most part related to this kind of touch [4, 1].It was

emphasized that it is a very delicate means of communication interaction for caregivers as well as for the clients. The reason is that it may be perceived as a positive or negative communication [1]. Hence, it was stated in [5, 1] that it should be used with much caution.

B. Interactions promoting competence and independence

This type of communication interaction was stated in [5] as: "prominent after intervention, when the carers not only became better at noticing patients' capabilities but also started to trust them more". Under this unit, the following interactions emerged: enabling [7, 5], activity [5], distraction [5, 7], complimenting or praising [5], support [3] and facilitation [7].

Enabling communication interaction was described as a communication interaction wherein, during the performance of a task especially activities of daily living (ADLs), the caregiver gives the older person the opportunity to participate in the actions by allowing and helping them make their own decisions regarding their care [5].

Activity entails the carers noticing the resident capabilities and trusting them with task. It also involves engaging the residents as active participants in their own individual daily care routines [5].

Complimenting and praising actions constituted of giving feedbacks to resident and making them to feel confident. These were seen as interactions that promoted competence [5].

C. Promoting autonomy communication interactions

This relates to interactions which are task-oriented and also focus on the older person by providing the opportunity for the older person to direct his or her own care. The following emerged under this unit: collaboration [5, 7], co-operation [3, 5], negotiation [5], agreement [3], and approval [5].

Within *Co-operation* interactions, the caregivers make contact with the client and talk to the other like in a normal conversation. Here, the older person is very engaged in the conversation [5]. Using a positive tone is a way of achieving co-operation, words like 'we' and 'us' are examples of co-operative tone of carers. Creating an atmosphere of teamwork with the clients and allowing time for the client was indicated in [5] as a co-

operation communication interaction technique often initiated by the carers. Findings indicated that "negotiation was in a way of co-operation" [5].

5.1.3 Social / relationship-oriented communication interactions

Interactions in LTC are very frequent as stated in [3, 1, 4] but the amount of social communication is very low. Caregivers communicate to residents mostly during task performance [8]. Social/relationship communication interaction was described in [2] as all interactions initiated by the carers that are not motivated by the need to render care but for the sole purpose of forming a relationship with the client. They include aspects of caregivers' behaviour that sought to establish a good relationship with residents by showing respect, giving comfort and trust [4]. Some articles referred to it as affective (socio- emotional) behaviour of the caregivers [4].

In [8], it was stated that this type of communication interaction demonstrates emotional support, understanding and respect for the elderly residents as individuals. Here the relationship between the caregiver and the older person is an 'I-Thou' relationship [6, 7]. For this sub-categories the following units emerged: friendliness and play [8, 7]; giving comfort [4]; stimulation [7, 6].

A. Stimulation

Only few articles mentioned stimulation as a communication interaction, it is also known as multiple sensory stimuli. It was defined in [7] as: "the explicit use of visual, auditory, tactile, olfactory or gustatory stimuli to make contact with the resident and/or elicit a response from the resident. Here, the caregivers interact with the clients by the use of more than one sensory organ at the same time [7]. Stimulation can be conducted through music, aromatherapy or massage therapy [7].

Visual stimulation includes the "[…] explicit use of mirror, talking about colours or design of a resident's clothing or looking with the resident at something in the immediate environment, for example looking out of the window or at a photograph" [7]. An important point noted in [7] with regards to an example of olfactory sensory stimulation was that; telling to the resident how nice the soap smelt was not enough to constitute

olfactory stimulation. However, letting the person smell the soap, talking about the smell and most importantly waiting for the person to response to the smell of the soap is what constitute stimulation [7].

Multisensory stimulation communication [7] and Music therapeutic caregiving (MTC) [6] were two elements found in the articles to illustrate examples of stimulation communication interaction existing in care facilities for older adults. Multisensory stimulation communication was described as a type of multisensory stimulation that combines a person-centred approach of sensory stimulation in daily care of nursing home residents. In [7] it was referred to as 'snozelen'. Music therapeutic caregiving (MTC) on the other hand, is a method of communication used by caregivers during care situations. It consists for the most part singing about things other than getting dressed (for example dancing, love, God….) [6].

B. Friendly interactions

Findings indicated that many residents appreciated caregivers for being friendly, chatty and humorous in their relationship with them [8]. The use of humour has been well document as a client-centred communication approach in elderly care. Nurses used humour and friendliness as a superficial level of communication that creates a relaxed and sociable atmosphere. However, it was stated that a relaxed and sociable atmosphere is unsuitable for dealing with emotional or difficult issues of care [8]. From this unit the following subunits emerged: small talks [3], jokes/humour [8]/ laughter [3], play [7] and celebration [7].

C. Giving comfort

Two subunits emerged under giving comfort: express touch [1] and relaxation [7].

Express touch is most often spontaneous and affective in nature and is not initiated for the completion of any sort of task by the caregiver for the elderly receiving care [4]. It was also referred to as: emotional touch, therapeutic touch, non-necessary touch and touch for no purpose [1]. In addition, it was indicated in [1] that this type of touch "…was often used in connection with verbal communication such as giving instructions, walking up the client, explaining, making requests, reprimanding and pointing to things".

Many older people in nursing homes are deprived from this kind of touch [1]. In [1], it was stated that the need of express touch increases as a person gets older. However, all the studies in [4] indicated that touch in nursing homes for older adults are mostly instrumental touch rather than express touch. Most importantly, a study revealed that touch in nursing care has five main goals: "promoting physical comfort; promoting emotional comfort; promoting mind-body comfort; performing social role and sharing spirituality" [1].

By virtue of this fact it is possible that expressed touch can be social/ relationship communication interaction as well as task-oriented communication interaction. But given the fact that under deductive content analysis a unit cannot be under two subcategories; or neither can it be left out, the author decided it was better under giving comfort.

5.1.4 Person-centred communication interactions

These are interactions which have double motivation: the need to fulfil a task; and the need to make a relationship with the resident [2]. It was also referred to as Elderly- Oriented communication interactions. These are the types of communication interactions that invite and encourage the clients in care to participate and negotiate in decision-making regarding their own care [8]. They include aspects of caregivers' behaviours that seek to establish a good relationship with the older persons and also focus on them as individuals [4, 2]. Here the carers meet the residents as unique individuals and not as objects of care [5, 2].

During this type of communication interaction, the carers have a deep and sincere interest in understanding the clients' experience of the disease and possible treatment. Communication (verbal and non-verbal) between caregiver and resident is intensive and the carers provide emotional support to the client [4]. The relationship between the carer and the older person receiving care is an "All at once" relationship [5]. The meaning of 'All at once' was stated in [5] as "feeling close to the patients while distancing from them". It is the combination of I-It (task oriented) and I-Thou (social-relationship oriented) communication interactions [5]. For this sub-categories the following units

emerged: attending[8]; understanding (empathy and validation)[2, 3, 7,5] ; showing respect [7,5,4] and confirmation [5] communication interactions.

A. Showing respect

This was characterized by kindness, politeness and asking for the clients' approval as well as their opinion and point of view before and during the performance of an activity or task [5]. Showing respect [7, 5, 4] communication interaction was manifested and evident in studies where the carers' behaviour was in a way promoting the clients' dignity [4], respecting their privacy [5] as well as maintaining their integrity [5].

B. Confirmation

According to [5], confirmation behaviour is that which: "permits people to experience their own being and significance, as well as a sense of togetherness with others". It's about recognition [3, 4, 5], acknowledgment [5], and endorsement [5]. However it is important to know that these three elements of confirmation are not so clear cut in reality, hence the carers ability to confirm in the real world depends on their qualities and capabilities [5].

The act of confirmation in communication initiated by the carers is one of the most fundamental aspects which change the face of a communication interaction. It renders a communication interaction positive or negative [5]. The presence or absence of confirmation produces the 'I-It', 'I-Thou' and 'all at once' relationship. When the carer interacts with the client through confirming behaviour, the I-It relationship is not negative [5]. It was stated that all the parties (caregivers and the older person) need to be considered, accepted as equals and valued as individuals in a confirmation interaction [5].

C. Attending

Attending behaviours by the caregivers refers to "the physical demonstration of nurse's accessibility and readiness to listen to patients through the use of non-verbal communication" [8]. Research results revealed that attending communication interactions include mostly carers' behaviours such as: giving time to the clients and being there; having open and honest communication; and having a complete sense of genuineness in the affairs of the client [8].The following emerged under this unit: reassurance [3, 4]; encour-

agement [3, 4]; open and honest conversation [8], being present [1, 8], genuineness [8] and communion [4].

Giving time to the client and being present is a person-centred communication that was described in [1] as having to "time spent on non-task activity…." One study reviewed in [1] suggested that in dementia care this was non-existent in many nursing homes. Studies in [8] revealed that student nurses spent more time with the clients as opposed to senior nurses who have better self-esteem and knowledge about the importance of spending time with the client. The reason given for this observation was that the student nurses had fewer tasks to do, hence, less task-centred communication [8].

Genuineness was described in [8] as "beyond professionalism and phoniness". It can be communicated verbally or non-verbally. However in the study [8], the older people participating in the study considered non-verbal communication as an aspect of genuineness when it showed emotional support, understanding and respect for them as individuals.

Communion communication interaction was described in [5] as the nursing care situation wherein there is a deep relationship between caregiver and the older person characterised by empathy, positive feelings, calmness and peace. Communion interaction is seen as a true meeting between carers and older person wherein both parties are seen as two equals. It was also stated in [5] that: "when situations of communion were seen, it was possible for carers to turn protests from patients into consent in certain situations".

D. Understanding

Showing empathy [7, 8] and validation [5, 7] were the two interactions that emerged under this unit.

Empathetic communication interaction was described as an emotional engagement or responses by the caregivers to the clients. Findings revealed that sympathy is a first level of an empathetic response. Empathetic communication may be verbally or non-verbally expressed. One research article revealed that older people attested to positive experiences of empathetic communication by the nurses [8].

Validation is a communication interaction technique used by carers. It invites the caregiver to understand and sincerely share the client's world with all its experiences [7]. It

is a communion interaction wherein feelings are shared and an understanding between carers and patients is made without language.

Most nursing homes have shifted from an instrumental or task model of care to a person-centred approach [10]. By implementing the person-centred approach of communication, they seek to adopt and carry out personalized nursing care which is intended to enhance resident's autonomy, sense of choice, personal control, and independence. This method also seeks to create opportunities for healthy interactions between the caregivers and the older people [10]. The key aspect of person-centred care is the well-being and quality of life of an individual [10]. The Appendix (4/6) shows a summary of this category.

5.2 Category Two: Effects of Communication Interactions on well-being

The focus here is to examine the impact of communication interactions initiated by the caregivers on the well-being of the older people living in nursing homes. Caregivers depend on communication to meet the needs of their clients [3]. Communication interaction in nursing homes is crucial in determining the quality of care from the clients' point of view [5]. In care settings, the carers positively and negatively affect the residents through their communication actions and possibly how they felt and thought of the elderly [5].

This means that carers during their interaction with elderly residents are faced with enormous difficulties in interpreting the client's experiences, behaviours and satisfying their heterogeneous needs and wishes. Authors in [5] referred to this as: "keeping a balance as though one is walking on a tightrope". To give a clear demonstration of how communication interactions by caregivers affects well-being of older adults in nursing homes, the author used knowledge from materials reviewed which indicated the 'satisfaction of needs as the prerequisite of well-being' [9].

In [9], two theories were used to define what consist of needs of individuals. These theories were: SPF theory and the Maslow's hierarchy of needs. The former referred to 'needs of an individual' as: "a restricted set of basic physical and social needs that must be at least minimally fulfilled for a person to experience overall well-being". Whilst the later, contradicting the formers stipulated [9] that:

> individuals require only a certain minimum satisfaction of both physical and social needs. Beyond this minimum, substitution is possible and likely whenever the satisfaction of one need becomes more difficult than that of another need.

From this second perspective, it is evident that the needs of individuals are not the same; they are shaped by their personal goals and resources [9].

By virtue of these facts stated in [9], two groups of needs were formed for category two. There are namely: psychological and physical needs; and social and emotional needs (representing sub category 1 and 2 respectively). The satisfaction of these needs (emotional, social, physical and psychological needs) enhance positively the well-being of older people. Another sub-category (sub-category 3) which also emerged under this category was the negative effects of communication interactions on well-being. Thus, sub-categories 1 and 2 represented the positive effects, whilst sub-category 3 represents the negative effects of communication interactions on well-being older persons living in nursing homes.

5.2.1 Well-being from emotional and social needs satisfaction

The satisfaction of emotional and social needs may results in a good experience of social and emotional well-being for older adults as stated in [9]. In study [9], older people rated social relationship as the most important determinant of good or successful ageing. However, as people grow older their composition of their social network changes, so too their frequency in contacts decreases [9].

The findings also indicated three social needs of older people: affection, behavioural confirmation and status. The satisfaction of these needs relates positively to their experience of well-being [9]. However, it was stated that as people grow old, the affective needs are much difficult to maintain than the other social needs [9].

A. Affection needs

These are needs which are fulfilled by communication interactions or relationships [9] that:

> give you the feeling that you are liked, loved, trusted and accepted, understood, empathized with, know that your feelings are reciprocated, feel that others are willing to help without expecting something in return, feel that your well-being is intertwined with others, and feel that others like to be either emotionally or physically close to you (e.g., to hug). Affection thus refers to the love you get for being who you are, regardless of your assets (status) or actions (behavioral confirmation).

From this fact, it is evident that emotional touch enhances the satisfaction of affective needs, hence a positive impact on the well-being of the older person receiving the touch. The need for touch increases with age, authors in [1] (cp. Montague 1978), wrote:

> […] in old age […] the tactile hunger is more powerful than ever, for it is the only sensuous experience that remains to him. It is at this time, when he has again become so dependent upon others for human support, that he is in need of embraces, of an arm around his shoulder, of being taken by hand, caressed, and given the opportunity to respond.

Touch has a physical, psychological and spiritual effect on the older person experiencing the touch and many studies have been carried out on this. On the physical dimensions, it was stated that emotional or expressed touch combined with verbal communication increased residents' nutritional intake in nursing home. Thus, emotional touch has the effect of preventing malnutrition in older people living in nursing homes [1].

Older people perceive greater immediacy and affection from nurse's use of comforting touch [4]. Touch can enhance an older person's self-esteem, stimulate them, reassure and reduce anxiety [1, 4] .Touch provides an opportunity to promote the older person's adaptation to their environment and create a connection between the caregivers and the clients [1]. Finding showed that touch increased the duration of verbal responses in the clients during the time period when the touch was applied [4].

Even though touch is a non-verbal and not emotional communication strategy, it however may be used to transmit emotions. Through touch (especially expressed touch), emotions are formed and they have physical, psychological and spiritual effects on the person experiencing the touch [1]. Earlier studies in [1] revealed that the use of expressed touch by caregivers with clients suffering from dementia has a probability to improve their emotional well-being [1]. The most important findings relating to the effects of touch were stated in [1]. Here, it was stated that touch remains a lifeline for old-

er persons with dementia to retain some of their personhood. Notwithstanding its importance in the field of nursing care, it emphasized in this study that it should be used with care as it may be perceived as negative [1].

In the research carried out in [8], it was stated that when caregivers were sympathetic, older people felt that their feeling were justified, and that carers understood their situation and cared for them as persons and not objects of care. The fact that the caregivers communicated understanding and recognition of the older person's situation does not necessary fix and makes everything alright. However, it helps to reduce the residents feeling of uncertainty and anxiety [8]. Empathetic communications by the nurses towards the resident enable resident to trust the carers and results in the clients feeling secured and reassured [8].

Social and relationship communication interactions initiated by the caregivers to the clients give the clients the opportunity to step out of their 'sick-role' [8]. Video- tape observation from studies indicated that interactions were less frequently characterized by tenderness. Warmth from carers to residents was greatly appreciated by the older people but unfortunately they were brief. However, when they occurred, there clearly led to an improvement in the well-being of the clients [8].

B. Behavioural confirmation

On its part, it is satisfied by communication relationships [9] which:

> give you the feeling of doing the "right" thing in the eyes of relevant others and yourself; it includes doing good things, doing things well, being a good person, being useful, contributing to a common goal, and being part of a functional group.

Attending behaviours or interaction by the staff makes residents to feel that the staffs are regularly monitoring their physical condition and also their psychological and emotional well-being [8]. Open and honest communication interactions between nursing home staffs and resident helped the residents to deal positively with their illnesses [8]. Communication done by caregivers in a person-oriented manner empowered the clients because it created opportunities for them to be partners in making decisions regarding their own needs. This reduces the possibilities of caregivers making assumptions about their needs [8].

Humour improves residents' self-esteem when they could make others laugh and when they could laugh with the nurses. Nurses who incorporated humour in the communication with resident seem more approachable to their clients [8]. Humour helps to establish rapport and trust. It also relieves anxiety, tension, and conveys unspoken emotional messages. Findings showed that humour can help pass time and deflect from boring routines in nursing homes [8].

C. Status

Lastly, the need of status is satisfied by relationships [9] that:

> give you the feeling that you are being treated with respect, are being taken seriously, are independent or autonomous, achieve more than others, have influence, realize yourself, and are known for your achievements, skills, or assets.

Thus, from this definition communication interaction which enhances the satisfaction of such needs includes: showing respect which includes aspects of promoting dignity and integrity as well as respect of privacy [7, 5, 4] which are elements of person-centred care. One study confirmed the importance of person-centred care communications by stating that through it, caregivers improve their capacity to meet the individual needs of their clients with dignity and respect [10].

It was also mentioned that: "person-centred approaches improved the continuity of residents' care because they were more likely to be assigned to the same nursing staff and also led to increased social interaction between residents"[10].

5.2.2 Well-being from Psychological and physical needs satisfaction

On the psychological and physical dimensions, it was indicated that emotional touch endorses feelings of comfort, relaxation, and has cherishing effects on the older person [1]. It was also indicated that emotional touch helps to reduce dysfunctional behaviours in clients with dementia and provide comfort in distressing situations [1]. Research findings indicated that, when Music Therapeutic Caregiving (MTC) was incorporated in the caring process of people with dementia, behavioural and psychological symptoms of dementia (BPSD) were reduced and the relationship and co-operation between the caregivers and clients were fostered. Examples of BPSD include aggression, resistance to care, agitation, screaming….) [6].

One research article revealed that during MTC, "PWDs (Persons with dementia) responded with more vitality and expressed positive emotions and moods". It also revealed that in general during MTC, "PWD responded in composed manner to the caregiver's communication by being active and compliant as well as relaxed". Notwithstanding during MTC, resistance and disruptive behaviours were still present [6].

Results also indicated that MTC created a communication were the resident are treated like subjects (I-Thou) not objects (I-It) [6]. MTC creates an opportunity for the caregivers to do the task and also be there for the clients [6]. It increases communication and evokes co-operation [6]. During MTC, caregivers indicated higher level of sincere interests in their communication with the clients [6].
It was noticed that during MTC, people with severe dementia were able to sing along despite their inabilities to speak or construct sentences; in a way enhancing their communication with others [6]. In this study, it was stated that despite the positive effects of MTC on the older people, research limitation noted that: "theoretical mechanisms that might explain the effects are still unclear, especially the relationship between the change in nursing assistants' behaviours and the improvement in residents' well-being" [6].

Multisensory stimulation has the advantage of activating neurological pathways [7]. This is because of the fact that music composes of a variety of elements (melody, accent and rhythms) which jointly provides a greater opportunity of accessing different parts of the brain [7]. Findings indicated that multisensory stimulation has the effect of increasing Positive person–work (PPW) and reducing malignant social psychology (negative behaviour of the caregivers). This enhances the experience of a good well-being for older adults living in care facilities [7].

5.2.3 Negative effects of communication interactions on well-being

Most of the negative effect of interaction resulted from negative task –oriented communication interactions (communication without confirmation from the clients). In [8] it was indicated that nursing homes residents felt that, caregivers did not communicate with them because they made assumptions about their needs and concerns. It was also

stated in this study that the older people did not blame the staffs for having a task-centred approach of communication with them. However, they stated strongly how important it was for them for staffs to communicate with them [8].

Concerning the tone of communication, it was indicated in some studies that using baby talk with older persons may be perceived as patronizing. Patronizing tones insinuates feelings of decline in the older persons' physical and psychological capacities, thus decreasing the possibility of the experience of a positive well-being [3, 4].
Non-person centred type of communication can have a negative effect on the client's sense of well-being and security [8]. Non-empathetic communications from carers invoke for the clients feelings of frustration and being uncared for by the carers. If caregivers fail to empathize with the client, they are not able to help them to understand or cope effectively with their illnesses [8].

Lack of communication has a negative effect on the clients' well-being because the clients' needs and wishes are not communicated. Power-over communication interactions blocks rather than facilitate communication. Hence, restricting the participation of the person for whom the care is done (in this case the clients) [4]. Power over communication was one of the negative communication observed [3], it creates a situation wherein, the residents to have no say in the care process hence limiting their independence [3].

Communication failure in elderly care may results in a breach in socialisation process between the caregivers and their clients, which is a recipe for non-compliance and resistance to care. These elements to contribute the caregivers' work stress. Failure in communication most importantly may cause the needs of the clients to be left unmet [3]; which has a negative effect on the experience of a well-being. Negatives impacts of touch were not revealed but for the fact that it is was used as a means of persuasion and that some clients find it uncomfortable [1].The *Appendix (5/9*) below summarises category two; the effects of communication interactions patterns on the well-being of older people.

Application of theory to practice

In Rissanen (2013 p. 25) it was posited that research findings on care workers in Nordic countries revealed that: "caring for older people in Finland is felt to be more burdensome, and that feelings of inadequacy were more common and the threat of violence the highest among the Nordic Countries" (cp. Teppo Kröger's research group 2009).

The author is optimistic that the implementation of this work on the primary target group (caregivers) will reduce the burden of the caregivers; provide better job satisfaction; decrease work related stress and burn-outs; promote healthier relationships with their clients and most importantly increase their abilities to render person centred care which is an element of well-being. In Rissanen (2013 p.25) it was stated that an earlier study had shown that "person-centred care has a positive effect on a number of dimensions of caregivers' job satisfaction in care units". For the secondary target group (the older people living in nursing homes), implementation of the results will improve autonomy, increase social participation, and general maintaining of their personhood which is a very essential element in subjective well-being and quality of life.

In McGilton *et al.* (2006 p. 41 f.) it was emphasized that there is the need for best techniques to transfer new training to practice. The manager of a nursing home plays an important role in supporting caregivers to acquire and maintain new good approaches to elderly care (McGilton *et al.* 2006 p. 41, Vesterinen *et al.* 2013 p. 6.). In Vesterinen *et al.* (2013 p. 6) it was stated that the main challenges of nurses' managers in Finland today is that of incorporating research findings in practical working styles in their various units.

This work is useful to professional caregivers and can be applied through the evidence - based learning approach. Work environment should be supportive in developing person-centred communication skills. Caregivers can practice evidence based knowledge through role playing whereby co-workers can give feedback about communication styles to each other. The manager of nursing homes should create work environments that acknowledge that no one is perfect but "practice makes perfect".

6 DISCUSSION

As earlier mentioned this work is aimed at exploring communication patterns that may support professional caregivers to enhance the well-being of older adults living in long-term care facilities. The author strongly believes that the method used (deductive content analysis) was the most suitable as it gave the author the opportunity to use the analytical reasoning approach to make reasonable conclusion as well as testing the results against ideas presented in the earlier studies and theoretical framework.

As demonstrated, the results showed similar finding to the theoretical framework and previous studies. The author throughout the analysing process felt that Kitwood's theory of personhood was like 'an invisible hand' guiding the results. However, the findings shared more lights on the following four main types of communication interactions and also examined how there are motivated and the factors hindering their use by caregivers.

New to the author, the research findings stated vividly in [3, 1] that the goals of nursing care determines the type of communication interaction which will be initiated by the caregivers in the course of their duty. Two general goals were stated in the articles: task related goals; and emotion /social related goals. The former includes assessing the health problems of clients, giving and exchanging information, giving explanations [4, 3]. The later on the other hand includes meeting the needs of support, recognition and understanding of the clients- all of which requires affective communication [7]. In dementia care, the goal of effective communication is interpreting implicit messages that are not verbally expressed and respond in an appropriate manner [4].

The author acknowledges that this situation made the categorizations of the subcategories very tricky as sometimes more than one type of communication interactions were used in a care process because of the goals. However, it was also a good thing because the author during coding of the sub-category took into consideration the goal of the caregivers' action when deciding the subcategory under which a unit or element is best suited.

Another crucial fact revealed by the results was that "confirmation behaviour" of the caregivers is like a 'breaking point' between the negative and positive communication

interaction. And that it can change the face of an interaction. The first earlier studies examined under this work concurred to this result (see Shattell 2003 p.716 ff.). The author's subjective opinion is that no confirmation during a task-oriented communication is what renders a good intended action (for example a goal to groom a client- positive task) into a negative behaviour by the caregiver (use of persuasive communication interaction during the care process).

Results also indicated that patronizing communication like altered speech or baby talk even though was rated by the nursing students in the research as most patronizing, the older people rated it as respectful and non-dominant [4]. In Williams et al. (2009 p. 1 ff.), it was stated that in dementia care, aspects of elder speak may diminish personhood but also that it can be used to improve communication and cooperation with older people.

Communion, desistance, and fragmentation were new communication interactions that emerged from the results only; they were not mentioned by earlier studies or the theoretical framework and were new to the author as well. Treachery was not indicated in any of the research article even though the theoretical framework mentioned it. The result did not disclose anything about spiritual needs which is a very essential element for meeting subjective well-being of older people.

Findings indicated that communication interactions changed several times in different caring situations across the interventions [5]. Notwithstanding this fact, some articles established a different view. They indicated that communication interactions in nursing homes were very standardized despite the fact that residents in nursing homes usually have very different cognitive and communication capacities [2, 4]. These interactions were standardized through repetition in the care process. It was stated that interactions were in this routine: "out-of-bed – wash – dress – feed – toilet – back -to-bed" [2]. This standardized style of interactions was referred to in [2] as the: "mantra of dementia care".

Caregivers indicated in some of the articles that the reason why they do not communicate in a person-centred manner is because it takes up time. However, other articles contradicted this view by stating that person-centred communication interaction does not

take up more of the caregivers' time neither does it require any extra resources by the institutions providing care [5, 8]. The last earlier studies of this work confirms this fact by stating that staff shortages or being 'too busy' cannot be used as an excuse for poor nurse-patient communication. It is the quality not the length of the communication that matters (Caris-Verhallen 1999 p.1107). The author strongly feels that caregivers heavy work load greatly encourages task –centred communication, however it is no grounds for initiating a negative task-oriented communication interaction.

The results revealed similar knowledge established in the fifth earlier studies relating to factors hindering caregiver's ability to carry out person-centred care. Caregivers' education, their attitude towards older people, job satisfaction, level of work experience are very important variables inherent in the caregivers that can affect their communication with their clients [8, 5], (Shattell 2004 p. 717, Caris-Verhallen et al. 1999 p. 1106 ff.). The author strongly agrees to this fact. Subjectively, caregivers who are full with positive energy and good interpersonal skills have a lot to offer. It is logical that one cannot give what they don't have in themselves. The author believes that the more sociable, friendly, empathetic, loving, and honest the caregiver is; the higher the possibility of creating healthy relationships with the clients through person-centred communication interaction.

7 CONCLUSION

There is a strong relationship between communication interactions and the experience of well-being of older adults living in nursing homes. In nursing homes where the residents have power over their care and their interests are of primary importance to their caregivers, there is a higher possibility that such older persons will experience a better well-being than where their confirmation is not considered.

A positive relationship between the caregivers and the clients is the first step in providing a person-centred care which can only be achieved through person-centred communication. Person-centred communication interaction has the most beneficial effect on the well-being of older people. Hence, it is an essential approach to be incorporated by

caregivers because it will enhance their ability to interpret, understand, and satisfy the needs of older persons which is an important aspect of their general well-being.

Impaired communication is the primary cause of resistance to care in dementia nursing home care (Williams & Herman 2009 p. 2). However, when caregivers communicate in a person-centred manner especially with older adults with cognitive impairment, there is a possibility of decline to resistance to care behaviours- which are the most contributing factors to caregivers' burn-out (Hammar et al. 2011 p. 970). Communicating in a person-centred manner by the caregivers enhances the well-being of their clients as well as the caregivers' well-being.

The factors that hinder the caregivers' ability to enhance the clients' well-being through their interactions should not be minimised. Organizations providing care services should set up support mechanism for caregivers in order to help them promote well-being of older adults under their care by communicating with them in a person-centred manner. A good example will be reducing the work load of caregivers and setting time on their schedules for person-centred activities.

Caregivers should be willing and ready themselves to incorporate positive care communication approaches. They should be enthusiastic about person-centred communication. It is not enough for one to be trained in person-centred communication but incorporating these patterns into individual working style is what makes the difference. As indicated in Shattell (2004) and Williams & Herman (2009 p. 2) communication training either returned to baseline level or did not changed after training. Kelley *et al.* (2012 p. 2 ff.), indicated that the willingness and interest of the caregivers made the training intervention for communication skills possible and effective. Comments such as: "I didn't realize how uncomfortable certain communication roadblocks made me feel[…]now I understand how to navigate them effectively and skilfully" by caregivers, clearly indicated their eagerness to incorporate training into working styles (Kelley *et al.* 2012 p. 2 ff.).

This work is not intended to point fingers at caregiver's communication styles but rather an eye-opener to the positive communication techniques that can be used by caregivers to enhance their abilities to promote well-being of older people living in nursing homes.

In the final conclusion, the author recaps that for the most part, the results of this work did not come as a total surprise as the findings cluster around the same knowledge presented in the theoretical framework and previous studies. The focus of the theoretical framework was on maintaining 'Personhood' through Positive Person-Work. The analysis of previous studies revealed that Positive Person-Work is all about person-centred care, and person-centred care is achieved through needs satisfaction. The findings revealed that person-centred communication interaction is a medium through which needs are met. Satisfaction of the needs of an older person is a prerequisite for a positive experience of well-being for that person. These facts and their correlation to each other prove beyond reasonable doubt that the findings of this work are reflected in; and are supported by the previous studies and Kitwood's theory of 'Personhood'.

Strength and Weaknesses of the Results

The biggest strength of this work is that findings are well correlated to the theoretical framework and earlier studies, hence completely eliminating the 'red thread' phenomenon. The author feels that the framework and earlier studies throughout the analytical process were like a 'pulse' sustaining the heartbeat of the results. Although it was a good thing for the theory to be reflected in the results, the author feels that it gave out a lot and that not many new ideas emerged as anticipated. To this effect, the author is unsure if in the face of entirely new articles and/or theoretical framework, the same results would be obtained. However, this is positive in the sense that it sets a good ground for further research and hence, the continuity of this work.

Most of the articles reviewed used video-tape recording to observe communication interactions between the caregivers and the clients. It was stated that the researchers took appropriate measure to minimise the effects of the cameras. The Roter's Interaction Analysis System (RIAS) was also used to analyse the communication interactions between the caregivers- older persons in the studies. In addition, the articles reviewed had high reliability, continuity and credibility scores which permitted reasonable conclusions to be drawn from analysing them.

8 RECOMMENDATIONS

The author recommends that new studies should be conducted on how to support care-givers to transfer evidence –based knowledge to practical working styles. The author also suggest that literature materials that are used to educate caregivers on how to care for older people should refer to older people in words that does not convey thoughts and feelings of incapacity of older people to the minds of the carers. Words like patient or elderly patient should be revised in literature materials on elderly care.

The author suggests more studies should be done on how organisation can improve on work cultures that supports professional caregivers to carry out person-centred communication interactions. In Finland the work culture for care of older adults has already shifted from ‘quality of care’ to ‘person-centred care’ (MSAH 2008). The author suggests that professionals working with older people (doctors, nurses, auxiliary nurses, geriatric professionals, researcher, physiotherapist, occupational therapist….) should reconsider and examine constantly their personal communication styles with older people.

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APPENDICES

APPENDIX (1/6): *Table 1: Key Terms Initially Used for Material Search.*

Word related to communication	**Words related to well-being**	**Words related to older adults**	**Words related to memory disorders**	**Word related to care units**	**words or phrase relating to caregivers**
communication strategies, communication patterns, communication skills, communication interactions, effective communication, communication interventions, effectiveness of communication strategies, positive effects of communication, good communication, influence of communication, communication training,	general well-being, subjective well-being, objective well-being, spiritual well-being, physical well-being, emotional well-being, social well-being, needs, optimal care, quality of care, goals attainment, holistic care,	older people, older persons, elderly, elderly people, old people	Alzheimer, dementia, memory disabilities, persons with dementia, memory loss, memory diseases, dementia patient-centred care, resistance to care, aggressive behaviours, psychological aspects of dementia	residents, clients, long-term care, nursing homes, care homes, care institutions, care facilities, care homes for elderly, care homes for older people, activities of daily living, residential care, residential aged care homes	professional caregivers, health care providers, practitioners, geronom, nurses, nursing, staffs, nurse' aid ,

APPENDIX (2/6): *Table 2. Showing the key terms and sources of data materials.*

Search terms	**Data sources Used**	**Number of Hits**	**Search Fields**	**Date Range**	**Article Retrieved**	**Articles used**
Communication strategies AND Dementia Care	Ebsco	113	All fields	2000-2013	1	Article 1
Nurse Behaviour AND Dementia Care	Ebsco	47	All fields	2000-2013	2	Article 7
Communication Interactions AND Nursing Homes	PubMed And Google	3740	All fields	2000-2013	2	Article 10
Communication Strategy AND Well-being	Ebsco	1,437	All fields	2000-2013	1	Article 6
Well-being AND Needs	Google scholar	690,000	All fields	2005-2013	1	Article 9
Communication AND Elderly Care	Google scholar	456,000	All fields	1996-2013	1	Article4
Communication AND Residential Care	Ebsco	39	Title/All fields	2000-2013	2	Article 2
Nurse- elderly AND Intervention	Wiley online library	2216	Title/Title	2000-2013	2	Article 8
Nurse- elderly Communication	Google Scholar	239	All fields	non	3	Article 3
Carers AND Dementia AND Nursing Home	Wiley online Library	47	Title/title/all fields	2000-2013	1	Article 5
					Total = 16	

APPENDIX (3/6): *Table 4. Description of Articles Used in Data Analysis.*

Author and Date	Title	Aim	Methods used	Results
Article (1) Madeline Gleeson and Fiona Timmins, *(2004)*.	Touch: a fundamental aspect of communication with older people experiencing dementia.	Explored the used of touch by nurses in care homes for elderly experiencing dementia.	Literature review.	Studies indicated that the use of expressive touch with clients with dementia is likely to improve their emotional wellbeing.
Article (2) Ward, Richard and Vass, Antony A and Aggarwal, Neeru and Garfield, Cydonie and Cybyk, Beau, *(2008)*.	A different story : exploring patterns of Communication in residential dementia care.	The aim was to develop a more detailed understanding of what happens in dementia-care settings; what goes on when a care worker and a resident with dementia interact,	A range of qualitative methods was used. A 3years pilot study.	The project found that people with dementia are both capable of communication, and invest much effort in seeking to engage those around them, but are excluded from the monitoring, planning and provision of care in ways that we argue are discriminatory.
Article (3) Wilma M. C. M. Caris-Verhallen, Ada Kerkstra, Peter G. M. van der Heijdenb, Jozien M. Bensing, *(1998)*.	Nurse-elderly patient communication in home care and institutional care: an explorative study	The aim was to explore communication partners in two care setting-housing homes and institutions	Videotape observation by using an adapted version of Roter's Interaction Analysis System	It was found that the amount of socio-emotional interaction in both settings appeared to be higher than was reported in previous studies into nurse-patient communication.
Article (4) Wilma M. C. M. Caris-Verhallen, Ada Kerkstra, Peter G. M. van der Heijdenb, Jozien M. Bensing , *(1997)*.	The role of communication in nursing care for elderly people: a review of literature	The aim was to give an overview of research into nurse-patient communication	Literature review of research materials on the topic	Results revealed that communication behaviour of caregivers influences patients' outcome. But little research is on the outcome of effective nurse-patients communication

Author and Date	Title	Aim	Methods used	Results
Article (5) Görel Hansebo and Mona Kihlgren, *(2001)*.	Carers' interaction with patients suffering from severe dementia: a difficult balance to facilitate mutual togetherness	Study carers' interactions with patients suffering from severe dementia and to also see whether or not the interactions were influenced by the supervision in the intervention project.	Qualitative approach was used to analyse video recordings	The supervision intervention contributed to an improvement in caregivers'' skills in balancing in their interactions. In the caring process caregivers and patients shared experiences and, due to patients' disabilities, interactions depended mainly on the caregivers qualities and capabilities for confirming nursing care
Article (6) Lena Marmstål Hammar, Azita Emami, Gabriella Engström, Eva Götell, *(2011)*.	Communicating through caregiver singing during morning care situations in dementia care	The aim of this study was to describe how PWD and their caregivers express verbal and nonverbal communication during morning care situations without and with MTC.	Qualitative content analysis	Finding revealed that during the situation without MTC, the caregivers led the dressing procedure with verbal instructions and body movement and seldom invited the PWD to communicate or participate in getting dressed.
Article (7) van Weert JC, Janssen BM, van Dulmen AM, Spreeuwenberg PM, Bensing JM, Ribbe MW. *(2006)*	Nursing assistants' behaviour during morning care: effects of the implementation of snoezelen, integrated in 24-hour dementia care	The aim was to investigation the effects of the implementation of snoezelen, or multisensory stimulation, on the quality of nursing assistants' behaviour during morning care.	A quasi-experimental pre- and post-test design.	The results showed a statistically significant increase in 'Positive Person Work' and decrease in 'Malignant Social Psychology' (total scores) after the implementation of snoezelen.
Article (8) Catherine McCabe, *(2004)*.	Nurse-patient communication: an exploration of patients' experiences	The aim of the study was to explore and produce statements relating to patients' experiences of how nurses communicate	A qualitative perspective using a hermeneutic phenomenological approach was used.	Findings indicated that nurses can communicate well with patients when they use a patient-centred approach.

Author and Date	Title	Aim	Methods used	Results
Article (9) Nardi Steverink and Siegwart Lindenberg, *(2006)*.	Which Social Needs Are Important for Subjective Well-Being? What Happens to Them With Aging?	"investigated how satisfaction levels of affection, behavioural confirmation, and status, as three human social needs, relate to age, physical loss, and subjective well-being."	Systematic analysis of video recording of nursing staff interactions with residents with dementia	The findings revealed that "[...] three needs relate differentially to indicators of subjective well-being: affection and behavioral confirmation relate positively to life satisfaction; status and behavioral confirmation relate positively to positive affect and negatively to negative affect".
Article (10) Sonya Brownia and Susan Nancarrow, *(2013)*.	Effects of person-centered care on residents and staff in aged-care facilities: a systematic review	Evaluates the evidence for an impact of person-centered interventions on aged-care residents and nursing staff.	Systematic review.	Finding revealed that: "[...] person-centered interventions were found to impact nurses' sense of job satisfaction and their capacity to meet the individual needs of residents in a positive way."

APPENDIX (4/6):

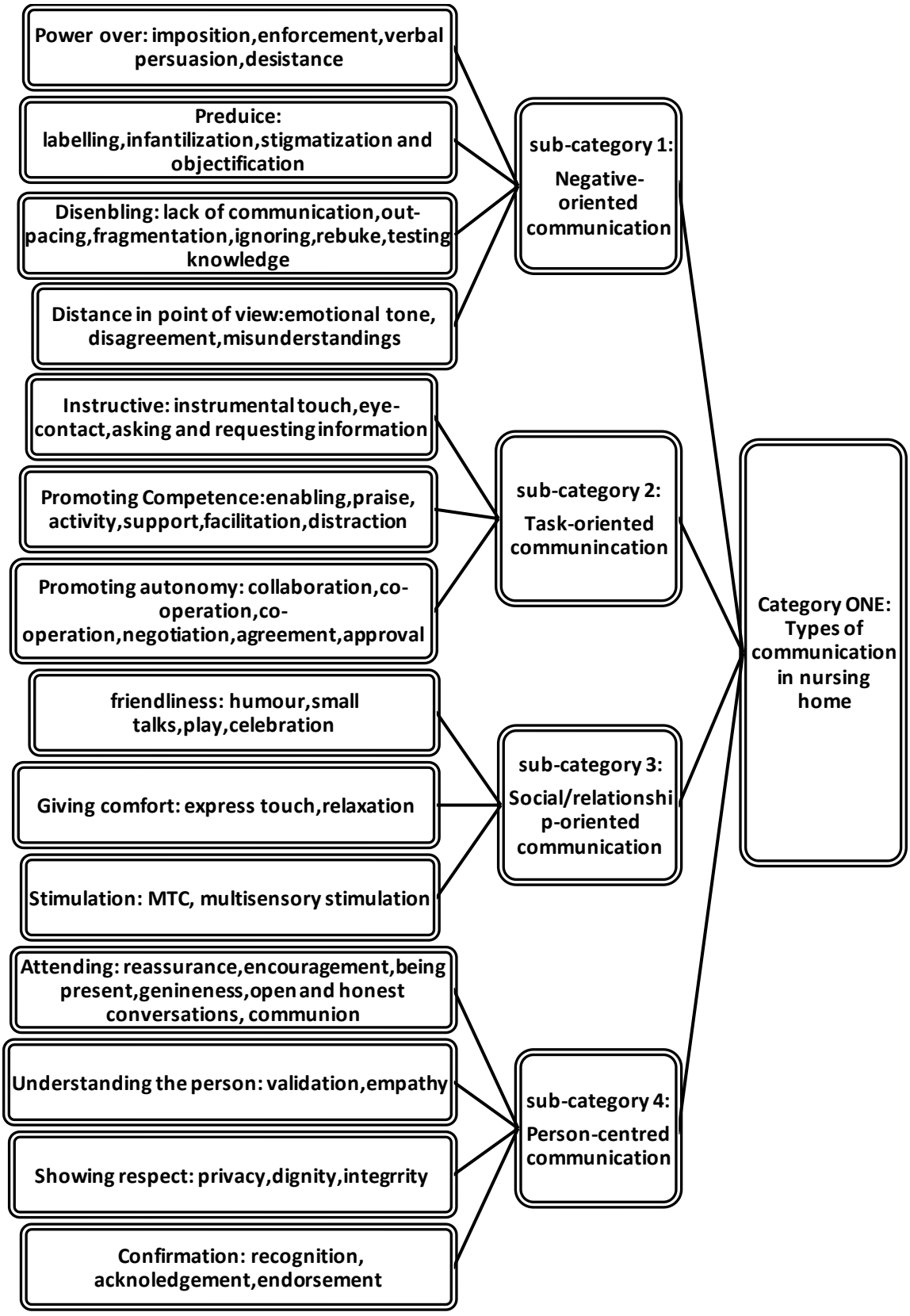

Figure 2. Summary of Category one, subcategories, units and sub-units

APPENDIX (5/6):

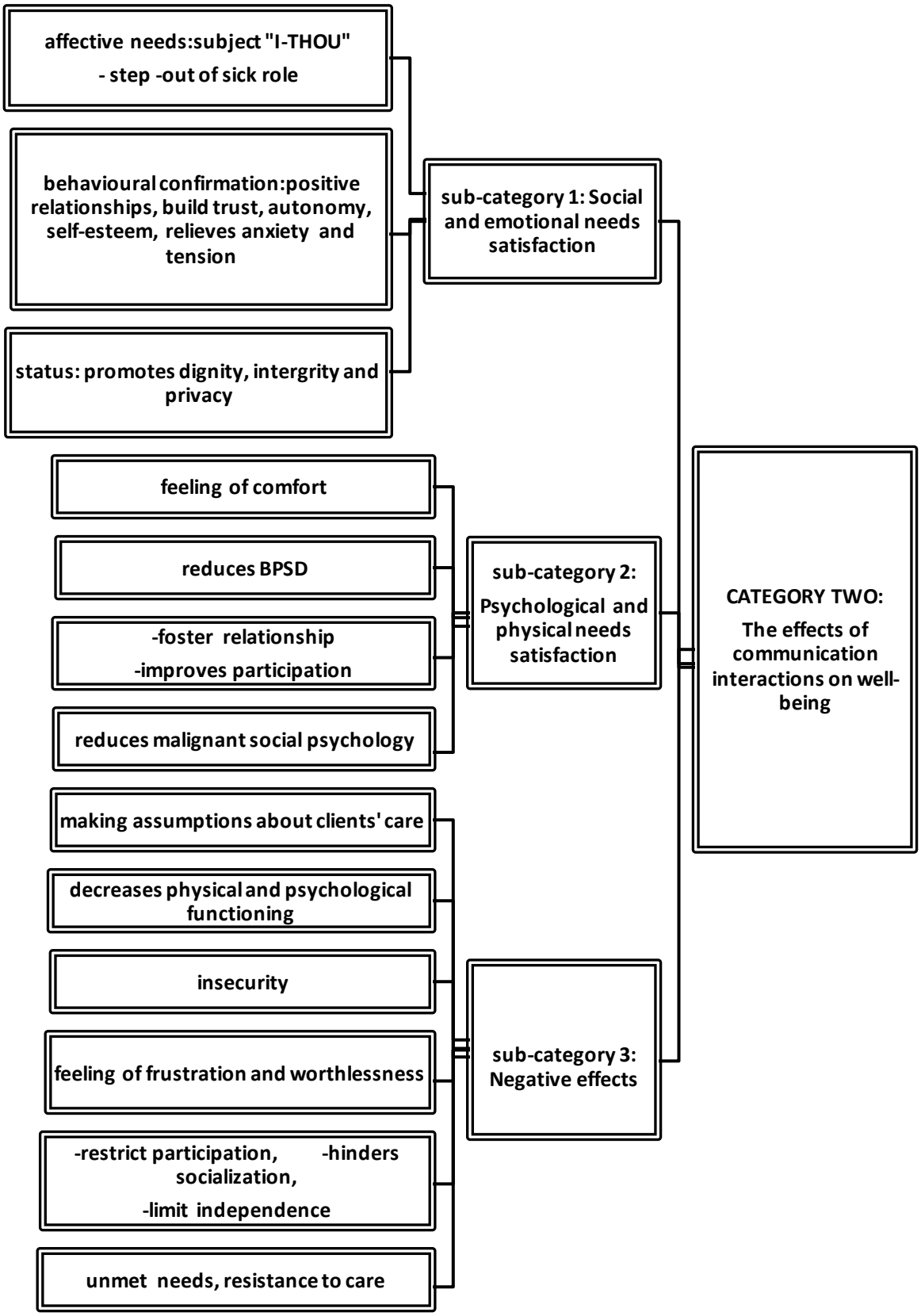

Figure 3. Summary of Category two, subcategories, units and sub-units

APPENDIX (6/6): Abbreviations

Abbreviations	**Full names**
• HCPs	HEALTH CARE PRATISIONERS
• LTC	LONG-TERM CARE
• MTC	MUSIC THERAPEUTIC CARE
• PPW,	POSITIVE PERSON WORK
• PCC,	PERSON CENTRED-CARE
• NPs	NURSE PRACTISIONERS
• PWD	PERSONS WITH DEMENTIA