RESEARCH BRIEFING

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Communication training for care home workers: outcomes for older people, staff, families and friends

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Key messages

- Training can improve the way that staff working in care homes communicate with older people.
- 'Refresher' sessions and regular feedback are needed to maintain these improvements. Training works best when it is part of a wider commitment to quality improvement.
- Staff think that communications training helps improve their knowledge and understanding of the issues faced by older people and their family carers.
- Where communications training leads to improvements in the quality of social interactions between staff and older people, this can in turn lead to improvements in older people's quality of life and well-being.
- Our current knowledge is limited by the quality and type of research that has been done on training. More studies looking at the effects of training in the long term and more drawing on the perspectives of older people and carers are needed.

Introduction

Good communication skills are the starting point for all the other skills that social care workers need. Without them, it would be impossible to establish effective and respectful relationships with people who use services.[1] Contrary to some popular misconceptions, these skills are not just something that we either have, or do not have, but are learned.[2–4] Without training, we would find it much harder to listen effectively to someone talking about a sensitive topic or difficult experience, break bad news as sensitively as possible, or communicate with a person who has communication difficulties, such as those arising from conditions like dementia, Parkinson's disease, or following a stroke.

It is especially important that staff working in care homes have good communication skills. This is because a high proportion of people living in care homes have problems that can cause difficulty with communication.

This briefing draws on a range of UK and internationally published research to look at training to improve nursing and residential care workers' communication skills. This research asks:

- What sort of topics does 'training in communication skills' cover?

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- What teaching and learning methods can be used to deliver training?
- Does training lead to improvements in knowledge?
- Does training improve the way that staff in nursing and care homes communicate with older people, their family carers and friends?
- Do residents and family carers think that training has resulted in improvements to the quality of care that they receive?
- What incentives and reinforcements can be used to help staff continue to apply what they have learned during training?

The material used in this briefing was retrieved using a methodology developed by SCIE[5] so that, although it is not a systematic review, the briefing is based on research that was identified systematically and in a reproducible way.

The briefing is based on research into training for staff working in care homes where communication was the only, or major, focus of the study. It is not about other types of communication, such as learning to write reports, discuss care plans with colleagues or language fluency. In addition, it does not cover aids to enhance communication, such as communication boards or Talking Mats.[6,7] These are important, but separate, issues.

What is the issue?

For many people living in care homes, especially those who do not see family members and friends regularly, interactions with staff are their main source of communication.[8,9] However, studies have consistently shown that such opportunities are very limited.[10] For example, an Alzheimer's Society survey of 12 care homes using the observational tool Dementia Care Mapping[11] found that the typical person living in a care home spent only two minutes interacting with staff or other residents over a six-hour period of observation, excluding time spent on care tasks, such as being helped to get dressed or eat.[12]

Even during care tasks, opportunities for interaction may be limited. Observations of practice[13,14] show that some staff will undertake these activities without even greeting the person, explaining what they are going to do and obtaining their permission before proceeding. They may also use patronising styles of speech that feature exaggerated tones, inappropriate personal pronouns, such as 'we' and 'our' instead of 'you' and 'your' and unsuitable endearments such as 'dear'. This way of talking is sometimes described as 'elderspeak'.[9,15]

Other examples of poor communication include making critical comments about residents within their hearing or carrying on conversations from which residents are excluded.[16,17] This may stem from a mistaken belief that if residents' verbal communication skills have been affected, then they will not understand what is being said about them. Even where residents' understanding is limited, they are likely to realise that something negative is being said by picking up on non-verbal signs such as facial expression.[18]

Other factors, such as the organisational culture of the home, peer pressure from other staff and difficulties in staffing, such as staff shortages or high turnover, can create an environment in which completing practical tasks as swiftly as possible becomes more important than spending time communicating with residents.[19,20]

Although there has been considerable investment in training for staff in care homes in the past 10 years,[21,22] little attention has been paid to its *quality*. It has even been suggested that poor quality training is counterproductive. For example, where trainers identify inadequacies in care provision but do not provide examples of alternative strategies, this may leave staff feeling demoralised and deskilled.[23,24] This briefing aims to identify some of the approaches that research has shown to be effective and can lead to improvements in staff performance and outcomes for people living in care homes.

The importance of improving training in communication skills

The implications of reduced opportunities for older people living in care homes to engage in positive social interactions are serious. They have been shown to impact negatively on residents' quality of life[16,17] and are thought to increase the frequency of behaviours such as signs of agitation and distress.[25–27]

Without steps to improve older people's access to positive social interactions, this situation is likely to worsen. Surveys of people admitted to care homes[28–31] have shown that a high proportion of people have long-term conditions such as Parkinson's disease, stroke and dementia which can affect their ability to communicate. For instance, depending on the type of home (care home, care home with nursing and whether it is registered for people with dementia), estimates of the number of residents with dementia range from 50–80 per cent.[32] However, concerns have been expressed that rises in the number of people with dementia in care homes have not been matched by increases in access to specialist training, including training in communication skills, so that staff are better able to support residents with dementia.[12,33,34]

What does the research show?

Focus of training

Only a minority of studies have adopted a broader approach to communication aimed at improving quality of life or wellbeing.[16,17,35] Instead, most have chosen to focus on a specific aspect of 'communication', such as teaching staff communication skills to use while bathing residents[36,37] or during 'morning care'(a collective term to describe support given to residents while they get up, wash, dress and eat).[38,39] In studies such as these, the aim of communication training is to help residents become more independent[14,38,40–42] and exercise greater choice.[43]

Other examples of specific communication skills training include identifying cues about what might trigger physically aggressive responses from residents[44,45] and preventing agitation[46] and abuse.[47]

With a few exceptions[48,49] these sorts of approach tend to focus more on practical ends than on increasing workers' abilities to help people who use services express their feelings. For example a person who has difficulties finding the right word, perhaps because of a stroke or dementia, requires extra time to answer questions and staff need to know how to respond effectively if they become frustrated by their difficulties.[49]

Given the high proportions of people with dementia mentioned earlier, it is unsurprising that so much research has focused on communication between staff and residents with dementia.[10,25–27,41,44,49–52] By contrast, even though depression is widespread among residents in care homes,[53,54] with a few exceptions[18,55,56] comparatively little research on communication has looked at improving staff's ability to recognise signs of depression and engage in social interactions aimed to alleviate its effects.

Training for care workers in knowing how to talk about difficult or sensitive topics[57–59] appears to be an equally neglected issue, even though the overwhelming majority of older people living in care homes have recent experiences of loss.

Another surprising gap is the apparent lack of attention paid to cross-cultural communication.[60] This might include the appropriate use of non-verbal forms of communication such as eye contact and use of touch, as well as language use.

Format and content of training

The amount of detail that researchers provide on the level of training provided, what it covered and how it was delivered is variable. While some of this can be attributed to the differing reporting requirements of different journals, it makes it difficult to compare results across different studies.

While the amount of time spent training can vary from a single session lasting one or two

hours[37,38,47,59] to day-long sessions completed over a period of months,[58] most interventions are based upon comparatively small amounts of training, amounting to the equivalent of one or two working days. Repeating sessions at different times of day[37,47,59] increases the number of staff across different shifts able to attend.

Sessions usually consist of a presentation introducing the subject and explaining ways in which communication can be affected by certain conditions, followed by more participatory teaching methods such as group discussions or role play, and practising problem-solving techniques.[9,38,40,47] DVDs or videos can be incorporated into the sessions.[37,61]

Using lay language is thought to be important in enabling staff to engage in the training sessions (e.g. talking about 'slurred or slow speech' rather than the technical term 'dysarthria').[48]

Handouts or course handbooks[10,56,57,59,62] or DVDs/videos may be provided for participants to take away.[63] These are aimed at reinforcing the material that has been presented in the training sessions and also mean that staff have a permanent record of what was covered in the training.

Example: intervention aimed at involving staff in finding solutions and in reinforcing learning
In an effort to reduce the use of 'elderspeak' in nursing homes, recordings of interactions were made with the agreement of residents and care workers.[9,15] During the training sessions, care workers listened to snippets of recordings and made suggestions about how the workers could have communicated more effectively. They were also given recordings of their own interactions to listen to privately. When the researchers repeated their observations, they found that workers' use of 'elderspeak' had reduced.

One difference that emerges when comparing studies is whether the training has been designed for specific groups of staff such as nurses[43,58,64] or care workers[14,25–27] or whether it has been aimed at all those working in the care home.[35,49,56,57]

However, it is not clear whether one approach is more effective than the other in ensuring that training leads to a change in the culture of a care home. A neglected issue is whether ancillary staff such as cooks, cleaners and gardeners should attend training, given that they are likely to need to communicate with residents on a daily basis.

Studies of training interventions rarely involve giving staff the opportunity to apply what they have learned in training under supervision. However, in one Dutch study nurses were able to observe video-recordings of their interactions with other trainees and a supervisor[65] and in a US study[27] the researcher observed a care worker provide care to a resident and then gave feedback on their performance. This exercise was repeated until the expected standard was reached. In both these studies, positive effects of training were observed at follow-up.

Who should do the training?

Reviews[60] have suggested that training is best delivered by an experienced external facilitator, but care workers themselves report that they prefer 'learning by doing' through observing a more experienced peer.[12] In some studies researchers have combined the role of trainers and observers.[10,27,66] Where communication training involves specialist knowledge, such as knowledge of speech and communication disorders[48,49] or end-of-life care[58] and the application of specific techniques such as snoezelen,[67] then it is likely that care homes will need outside experts to deliver the training.

Where should training take place?

On-site training[13,14,40,47,62] tends to be favoured over off-site delivery because it is easier to organise in terms of fitting in with staff's regular working hours. However, one study which tried both methods[62] commented that care workers attending workshops held in a university felt more valued members of the workforce. In addition, their managers' ratings of their performance showed greater improvements than workers who had attended the on-site training, even though the materials used and the trainer were identical in both instances.

Do incentives help uptake of training?

Few studies have looked at incentives to improve uptake of training and maintain learning.[26] Cash payments or vouchers[9,18] may act as incentives in the early stages but it may prove difficult to maintain staff enthusiasm once they are withdrawn.[27] In one study where a range of incentives were offered,[25] the most popular options among staff were an additional payment, 'goodie bags' of items such as inexpensive toiletries and an opportunity to leave work earlier. In another, thanking staff at the end of the shift was a non-financial incentive that seemed to help retention.[61] A US study[25] used public acknowledgements along the lines of 'employee of the month' but when a similar method was tried in England the results were mixed and led to unproductive rivalries.[61] In some circumstances, completion of training may result in permanent pay rises[68] but it is not known if this would be a more effective incentive in the long term compared with one-off incentives.

Outcomes of training

Outcomes of training for care workers have been measured through self-report and/or by observation. The most frequent benefits of training reported by workers are greater confidence in providing care and greater understanding of the issues faced by the older person.[12,35,49,55,57,62,69]

Questionnaires completed before and after training[16,27,45,48,49,70] show that training results in staff acquiring new knowledge. However, other ways of measuring change may be needed among staff with limited literacy in English or who have had negative experiences of education while at school.

Reported effects on staff wellbeing and morale have been mixed, with some suggesting that training leads to improvements in staff morale[18,68] but others concluding that, while participants are pleased to have undertaken training, it does not make their jobs easier or less stressful.[40,52]

Structured observations using written coding systems[10,20,25,27] or video recording[66,67] before and after training are generally thought to be more reliable than self-report or knowledge tests because they are based on 'real life' situations.

Observations of care staff's interactions with residents suggest that after training workers adopt more effective communication strategies, such as giving clearer and more detailed explanations about what they are going to do, and encouraging independence by using verbal and visual prompts when undertaking care tasks so that the older person can perform the activity themselves.[10,20,27,38,40,65,71] In one study, improvements were seen in staff members who had not been directly involved in training,[27] presumably because workers who had been trained acted as role models.

Equally importantly, staff have been observed to show greater signs of empathy, indicated by increased use of touch and eye contact[14] and are rated as being warmer, less authoritarian and more concerned with increasing choices for residents.[43,65] Increases in the frequency of positive interactions, such as greeting residents individually, and reductions in negative interactions such as ignoring residents' requests or restricting someone's activities unnecessarily, have also been reported.[20]

Example: the importance of supervision in reinforcing the effects of training
The largest published randomised control trial of training in communication to date[26] took place in the US. A group of residents with behavioural problems and care workers who received a four-week behaviour management course were randomly divided into two groups, one of which consisted of care workers who received formal supervisory management (FSM), which included written and verbal feedback on their performance, and those who received conventional staff management (CSM). After training, all the care workers improved in five out of seven communication skills and became better at promoting residents' independence during care routines, with the result that agitation among residents was reduced. However, six months later, care workers who received FSM were better at maintaining their skills than those who received CSM.

Outcomes of training for older people

Fewer studies have sought to measure the outcomes of training on residents, for example by looking at their wellbeing or quality of life.

Among these, a large-scale US study[72] found that people with dementia living in care homes and extra care housing which had staff trained in specialist dementia care rated their quality of life more highly than those whose accommodation was staffed by people without specialist training. Staff values, especially where they indicated more hope and optimism in terms of attitudes to dementia, were also linked to better quality of life among residents. Residents in two small-scale Canadian[69] and Finnish[64] studies reported that after staff had received training they felt more satisfied with their care and had more opportunities to make day-to-day decisions, such as what time they got up and bathed, and what clothes they chose to wear. The Finnish study also measured residents' wellbeing but did not find a statistically significant link between training and wellbeing.[64]

Example: training staff in recognising depression and improving social interaction
A UK study aimed at reducing depression among care home residents[55,73] gave staff training in recognising depression and awareness of approaches to alleviating it. A number of workers were allocated to an intervention group in which they each set up a new forum for communication by working with two or three residents, to produce an agreed care plan aimed at helping them undertake activities, such as resuming former hobbies or re-establishing contact with friends and family. Based on a comparison of residents' scores on a depression scale before and after the intervention, older people in the intervention group had a statistically significant reduction (that is, improvement) in their depression scores unrelated to changes in their medication. These reductions were even greater when residents were reassessed some 12 weeks later.

Lintern and colleagues[16,17] also suggest that it may take time for training to produce measurable changes in residents' lives. In their action research project, staff received training before and after residents wellbeing was measured using Dementia Care Mapping.[11] It was only at the final stage, which involved the development of action plans following feedback from the Dementia Care Mapping that statistically significant improvements in older people's wellbeing became apparent.

A US study aimed at helping workers improve their understanding of non-verbal emotional signals among residents[18] used a range of methods to measure impact, including observations of facial expression. Positive improvements in residents' mood occurred but the effect was short-lived.

Other observations of residents' interactions after staff have received training suggest that residents speak more often.[10] One study which examined whether conversation improved residents' verbal communication suggested that the decline of the number of words they used as a result of their Alzheimer disease appeared to be delayed.[51]

As well as positive improvements in wellbeing and mood, several studies have reported reductions in behaviours such as anxiety and agitation.[26,37,40,63] However, in some instances these behaviours may be too severe to be improved by training alone.[74]

Outcomes of training for family carers

In comparison with the number of studies looking at communication between older people and workers, far fewer have looked at communication with family carers, even though many family carers continue to be actively involved in caring for relatives after their admission to a care home.

Results from these studies indicate that training staff in communication with family carers can improve workers' understanding of family carers' needs and family dynamics,[58,75] reduce

Example: 'Caring and Learning Together': a shared approach to training
The Geropsychiatric Education Program (GPEP) has been operating in Canada since 1995. A project to establish more person-centred care in three care homes developed an approach in which staff and family carers met for two sessions, followed by a further separate session for each group. This was followed up by joint care reviews in which participants tried to identify more creative care strategies, such as allowing a resident who was a former baker to assist in the kitchen. Staff and families felt their relationships were improved and that they worked together more as a team.[69]

conflicts and improve family members' satisfaction with care.[69,76–79]

Can the effects of training be maintained?

One of the most important messages from research looking at the impact of training is that improvements are not maintained when training interventions have been limited in scope and not reinforced by 'refresher' sessions and individualised feedback.[9,13,18,37,38]

The studies with the longest-lasting positive results are based on tailored training supplemented by supervision in practice.[16,17,20,26,27,65] The need for support in retaining what they have learned has also been identified by workers themselves.[14,56] However, it is important to recognise that 'training is not enough to change practice'[16] and organisational and management commitment to change is also needed.

Limitations of existing published research

The majority of research into communication in care homes has been undertaken in North America, with a smaller European literature mainly undertaken in the UK, the Netherlands and Sweden. Within this, there is a variety in the methodological approaches adopted by researchers, each with their advantages and disadvantages.

Key point: there is a shortage of high-quality research
A major problem limiting our understanding of the effects of training has been the shortage of high-quality studies telling us 'what works and why'. Four systematic reviews[8,60,70,74] of the effectiveness of communication interventions with residents in care settings identified several hundred potential studies but very few met their quality criteria for inclusion. The only systematic review of communication with family carers[79] identified for this briefing also concluded that research into the topic was of poor methodological quality.

Small-scale studies that only involve collecting data at one point in time – for instance, on the day that training has taken place – can be comparatively cheap but do not enable conclusions to be drawn about whether training has resulted in changes in practice. However, even when studies do include a follow-up, it can still be difficult to decide whether training has resulted in changes. This is because between 25 and 50 per cent[13,25,38,40,47] of those who have received training are unable (for instance if they have left their post) or unwilling to take part in the second stage of the research. It is also not always clear how many workers may have chosen not to take part in training in the first place.

Outside the UK, randomised controlled trials[10,25–27,40,42,65,67,80] have been a popular way of evaluating the effect of communications training, mainly because they make it easier to compare the effects of interventions. However, these approaches are not without their limitations. For example, researchers sometimes deliver the training themselves and it is not clear if the trainers are then involved in observing staff or if the observers are blind to which workers, or which

care settings, have received training and which have not. These variations mean that caution may be needed when interpreting results.[70]

Action research projects[16,17,35,61] seek to achieve greater involvement among managers and staff in the research process. These designs are better able to offer a more personalised approach to what training is offered and how it is delivered. However, critics argue that it is time-consuming to conduct and does not allow for generalisations.

While undoubtedly many older people living in care homes would have some difficulties in expressing their views about staff performance, the absence of their perspectives on outcomes is striking. So far, no published studies have examined whether greater user and carer involvement would make training more relevant and effective.

Ethnicity is rarely reported except in terms of the ethnic profile of staff, and other issues that may affect the quality of interactions between staff and older people – such as gender, age and sexuality – do not seem to be discussed, perhaps because it is assumed that women will be caring for women.

When training is usually provided as part of a research project, researchers and care homes are part of an exchange in which the costs of training and training materials are provided in return for access to workers and residents. However, costs may be a major factor in managers' decisions about which type of training to purchase. There is an urgent need for economic evaluations of training which assist in this process.

Finally, it will also be clear from the briefing that there is a certain poverty of aspiration about what communication is intended to provide. Most people would have higher expectations about their own opportunities for social interactions beyond being spoken to while getting dressed. However, only a few published studies[16,17,20,35,72] look at communication in terms of how it affects residents' broader levels of wellbeing and quality of life.

Implications from the research

Despite the limitations outlined above, clear messages emerge that training can result in changes to the way that workers communicate with older people and their families. This can lead to improvements in older people's quality of life and wellbeing but these improvements are only likely to occur where training is sustained and reinforced by individualised supervision and feedback.

Implications for organisations

Organisations providing care homes and care homes with nursing are finding that an increasing number of their residents have communication difficulties. Staff will need access to specialised training that will enable them to meet the needs of these residents effectively.

Positive results have been found from comparatively small interventions in terms of the time needed for staff to attend training, and the costs of trainers and training materials. Such interventions can lead to improvements in residents' quality of life and wellbeing and can help staff to support older people in retaining their independence.

Managers may not have time and, depending on their background, the experience to deliver training. Developing new roles, either from within existing staff or by new appointments, may be one way of ensuring that knowledge gained in training is retained in practice. Examples from the literature include nurse practitioners, who provide hands-on training, act as a role model, as well as facilitating induction/NVQ training;[16] and 'dementia champions' who can provide peer training to care workers.[61] Although this has not, to our knowledge, been researched, opportunities to link training to career progression may help improve staff retention and morale.

When choosing care facilities, older people and their family members are beginning to look beyond the physical care environment towards considering the opportunities for social interaction and social activities that will be

available to them. Homes that pay attention to this issue may be more successful in attracting new business.

Implications for the policy community

Studies[28,31,32] have suggested that there has been an increase in the number of people with conditions likely to result in communication difficulties in care homes, and that this trend is likely to increase. This raises challenges for commissioners and policy-makers at a time of financial constraints.

Commissioners and policy-makers need to consider ways of coordinating and integrating the vast number of training materials, courses and trainers so that they can be incorporated into existing skills and qualifications frameworks.

Commissioners, policy-makers and regulators need to consider how strategies to improve opportunities for communication for older people can be incorporated into contracts to purchase care and regulatory requirements. In particular, systems for inspection need to build on existing work[81] which looks at residents' quality of life and wellbeing. This is particularly important in terms of meeting the objectives of the National Dementia Strategy.[82] At the same time, policy-makers, commissioners and regulators also need to be aware of the communication needs of people in care homes who do *not* have dementia, such as people with depression.

Implications for practitioners

Evidence from research highlights the benefits that practitioners' positive communications can make to the lives of older people. Greeting people individually, explaining what is going to happen, giving instructions in single steps and using verbal prompts and gestures instead of doing something for a person are small changes that, taken together, can make positive improvements to older people's control over their own lives and overall wellbeing.

Implications for people who use services and their carers

People who use services and their carers are a neglected resource in developing and evaluating training interventions to improve communication. For example, where older people are no longer able to provide detailed information on their likes and dislikes, family carers provide a valuable resource that can be used to add details on personal preferences to care plans. Staff can work with people who use services and carers to develop 'cooperative communication interventions',[69,77] and provide new opportunities for more creative approaches to supporting people living in care homes, such as increased opportunities for engaging in social activities.[20,55]

Implications for research

There is a clear need to develop a more rigorous methodology for designing, undertaking and reporting on research into communications training. More inclusive methodologies that involve people using services, family carers and workers themselves need to be developed. There is an urgent need for economic evaluations of training which could help care homes reach decisions about which types of training they should invest in.

Useful links

Training resources from the Alzheimer's Society:
http://alzheimers.org.uk/site/scripts/home_info.php?homepageID=61

Information on Dementia Care Mapping:
www.brad.ac.uk/health/dementia/DementiaCareMapping/

Short article outlining why effective communication is important and tips for making communication more effective:
Miller, L. (2002) 'Effective communication with older people', *Nursing Standard*, vol 17, no 9, pp 45–50.

Information on training and resources from the Dementia Services Development Centre:
www.dementia.stir.ac.uk/pdffolder/DementiaNow-Vol6-Part3-March09-Training.pdf

Resources for employers:
www.skillsforcare.org.uk/qualifications_and_training/qualifications_and_training.aspx

www.traintogain.gov.uk/

Related SCIE publications

Care Skills Base:
www.scie-careskillsbase.org.uk/

Open dementia e-learning programme:
www.scie.org.uk/publications/elearning/dementia/dementia07/index.asp

Communication skills e-learning resources:
www.scie.org.uk/publications/elearning/cs/index.asp

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Lead author is a topic expert. The briefing was peer reviewed internally for methodology, and externally by an independent topic expert.

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