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Strategies to facilitate shared decision-making in long-term care

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Abstract

Aim: The aim of this study was to explore shared decision-making among residents, their families and staff to determine relevant strategies to support shared decision-making in long-term care (LTC).

Background: Meaningful engagement of long-term care home (LTCH) residents and their families in care decisions is key in the provision of quality of care. Shared decision-making is an interprofessional approach to increasing resident and family engagement in care decisions which can lead to higher quality decisions, more relevant care interventions and greater resident, family, and staff satisfaction. Despite these advantages, shared decision-making has not been widely implemented in practice in LTC.

Methods: The study took place in one LTCH in Toronto, Ontario, Canada. A qualitative descriptive design was used to explore how residents, family members and staff described how they collaborate when making decisions concerning resident care, and their perceptions of facilitators and challenges to a collaborative approach to decision-making. Individual interviews were conducted with nine participants: residents, families and staff. Data were analysed using content and thematic analysis.

Findings: Four main themes that described resident, family and staff perspectives of shared decision-making were as follows: (a) oral communication pathways for information sharing; (b) supporting resident decision-making autonomy; (c) relational aspects of care facilitate shared decision-making; and (d) lack of effective communication creates barriers to shared decision-making.

Conclusion: As the demand for LTC continues to increase, it is crucial that healthcare providers engage in collaborative, relational practices that foster high-quality resident care. While a relational approach to care can facilitate shared decision-making, there are opportunities to further cultivate shared decision-making in LTCHs through more effective communication and collaboration.

Implications for practice: Understanding how information is shared and decisions are made can facilitate shared decision-making in LTCHs. The strategies identified from this study could be further co-developed and implemented in LTCHs.

KEYWORDS
interviews, long-term care, nursing homes, qualitative research, shared decision-making

1 | BACKGROUND

The need to improve the quality of long-term care (LTC) for older adults has never been greater. The world's older population is growing at a historic rate (He, Goodkind, & Kowal, 2016). Between 2025 and 2050, the older population is projected to almost double globally; this increasing longevity has a direct impact on LTC needs (He et al., 2016). In Canada, demographic projections indicate the overall demand for LTC will almost double by 2035 (Gibbard, 2017). This sustained rise in demand for LTC and increase in complex care needs has direct implications for the LTC workforce and the quality of care (Ontario Long-Term Care Association, 2015). In LTC homes (LTCHs), the healthcare team comprises personal support workers (PSWs) who are unregulated staff (also referred to as nurse aides/nursing assistants, healthcare aides) who provide the majority of direct resident care (Chamberlain et al., 2019), nurses: baccalaureate degree-prepared Registered Nurses [RNs] and diploma-prepared Registered Nurses/Licensed Practical Nurses [RPNs/LPNs], allied healthcare professionals (e.g. physiotherapist, dietician), physicians and, in some LTCHs, a nurse practitioner (currently only 3.8% of nurse practitioners in Canada work in LTCHs) (Canadian Nurses Association, 2019). New models of care are being developed that aim to de-institutionalise care settings and maximise opportunities for older people and all members of the healthcare team to participate in decision-making (McCormack, Roberts, Meyer, Morgan, & Boscart, 2012). Interprofessional collaborative models of healthcare delivery are critical for improving access to person-centred care (Canadian Nurses Association, 2011), yet studies have shown a lack of collaboration between regulated professional staff and the unregulated staff (Afzal, Stolee, Heckman, Boscart, & Sanyal, 2018; Caspar, Ratner, Phinney, & MacKinnon, 2016; Kontos, Miller, & Mitchell, 2010).

Shared decision-making is an interprofessional approach that fosters a collaborative approach to care. Key elements of shared decision-making are as follows: it is an iterative process that is patient-centric (e.g. patient involvement and consideration of values/preferences); it involves collaboration and information exchange between the interdisciplinary healthcare team, the patient and family (broadly defined to include caregivers or significant others) throughout the health decision-making process; and it involves the team's awareness of underlying emotional and environmental factors that can influence the process (e.g. social norms, organisational routines) (Légaré et al., 2010, 2011). Shared decision-making is an approach to increasing resident and family engagement in care decisions which can lead to higher quality decisions, more relevant care interventions and greater resident, family and staff satisfaction (Légaré et al., 2018). Despite these advantages, shared decision-making has not been widely implemented in practice in LTC (Légaré et al., 2018).

Encouraging resident and family involvement in healthcare team decision-making is critical because their participation may lead to higher quality decisions and greater resident, family and staff satisfaction (Légaré et al., 2018). Meaningful engagement of LTCH residents and their family in care decisions is a key priority

What does this research add to existing knowledge in gerontology?

- Shared decision-making is a promising model for long-term care.
- There are opportunities to facilitate a shared decision-making approach through more effective information sharing and communication between staff, residents and their family members.

What are the implications of this new knowledge for nursing care with older people?

- Meaningful engagement of residents and their families in care decisions could further support residents' decision autonomy.
- Inclusion of personal support workers in resident care decisions is an opportunity for shared decision-making and individualised, person-centred care.

How could the findings be used to influence policy or practice or research or education?

- Strategies are suggested that could be further co-developed with residents, their families, staff and other key stakeholders, tested and implemented to facilitate shared decision-making.
- Further research is needed to explore how leadership and nursing staff could facilitate personal support workers' involvement in team decision-making.
- Future research should explore ways to meaningfully engage residents and families in care planning and decisions.

in the provision of high-quality care (Alzheimer Society of Canada, 2015). Meaningful engagement is a person- and relationship-centred approach to care that encourages people to actively participate in their environment, but its implementation remains a challenge (Alzheimer Society of Canada, 2015). People with dementia have the right to receive support to participate as fully as possible in decisions that affect their care (Alzheimer Society of Canada, 2019), yet residents of LTCHs are vulnerable to being excluded from healthcare decisions due to factors such as frailty, advanced age and prevalence of dementia (Shawler, Rowles, & High, 2001). While family member participation in decision-making is part of the standard of care, their level of involvement is also inconsistent and variable, and they are often unclear about their role and expectations (Petriwskyj, Gibson, et al., 2014; Petriwskyj, Parker, et al., 2014). Inadequate staffing and workload also create barriers to establishing meaningful relationships with residents and their family members (McGilton & Boscart, 2007). For example, care conferences are where care plans and goals are discussed with the interdisciplinary team and are one avenue where shared decision-making can occur. In Ontario, care conferences are required within six weeks of a resident's admission to the LTCH and at least yearly thereafter (Ontario Ministry of Health and Long-Term Care, 2007). While this is the best practice, it is not clear how often persons with dementia and their family members attend. Studies have shown barriers to shared decision-making during care conferences such as limited input from PSWs due to their lack of time to attend (Caspar et al., 2016), residents may be unaware that they can attend or their preferences for engagement may be unknown by staff (Scales et al., 2019), and family perspectives may not always be solicited (Puurveen et al., 2019).

We sought to explore shared decision-making in LTC as an initial step to inform the development of an intervention that would actively involve the target population—residents, family members and staff in a collaborative approach to decision-making. The aim of this study was to explore shared decision-making among residents, families and staff to identify relevant strategies to support shared decision-making in LTC.

2 | METHODS

2.1 | Design

We used a qualitative descriptive design (Sandelowski, 2000) to explore how residents, family members and staff experienced collaboration when making decisions concerning resident care, and their perceptions of facilitators and challenges to a collaborative approach to decision-making. Qualitative description is useful to describe participants' experiences and descriptions of events (Sandelowski, 2000). Our goal was to stay close to the data (low-inference) to describe experiences using participants' own language and details, using quotes to enhance the credibility and confirmability of study findings (Lincoln & Guba, 1985).

2.2 | Setting and Sample

We sought to recruit staff from one medium-sized (130–175 bed range) LTCH in Toronto, Ontario, Canada. We invited staff (RNs, RPNs, PSWs) to participate in the study who worked for at least 3 months full- or part-time in the LTCH. Our inclusion criteria were to ensure that staff had time to learn the policies and procedures of the LTCH and could comment on resident and family involvement in team decision-making processes. We invited staff during a staff meeting and by approaching them on the care units to explain the study. This resulted in a total of 13 staff that were invited, 9 of whom had expressed interest in participating. Potential eligible residents were identified by the Resident Assessment Instrument-Minimum Data Set 2.0 (RAI-MDS 2.0) coordinator at the LTCH and the Director of Care (DOC). Eligible residents were those who were 70 years of age or older, had mild-to-moderate cognitive impairment (Cognitive Performance Scale Score ≤3) and were able to communicate and speak in English. Eligible family members were those who visited their relative in the LTCH at least monthly and who were the substitute (legally authorised) decision-makers for their relatives. Eligible residents were approached by the DOC to determine their interest in participating. However, not all eligible residents were approached, ours was a convenience sample of those who agreed to be interviewed. Approximately 45 residents were eligible. The DOC initially approached 4 residents, and they had expressed interest, and the DOC offered to continue recruitment if needed. The DOC indicated to the residents that their participation was voluntary, and if interested, the research team would come in person to explain the study and to obtain their consent for the interview. The DOC contacted eligible family members (of residents who were interested in participating) using a standardised script provided by the research team to introduce the study and ask if they were interested in participating. A research team member contacted interested family members to provide more information about the study and to schedule an interview.

2.3 | Data collection and analysis

Ethics approval was obtained from the University of Toronto Health Sciences Research Ethics Board (#32880), and operational approval was received from the study LTCH. Written informed consent was obtained from all participants by the study lead investigator (LC). For two resident participants, proxy consent forms were signed by their substitute decision-maker on their behalf and verbal assent was obtained from these residents. This was done to ensure that consent was given to participate in the interview for research purposes. While these residents stated that they understood the information in the consent form and they agreed to be interviewed, it was less clear whether they fully understood that the interview was part of a research study. Individual semi-structured interviews were conducted by the study investigator (LC).

Interviews were scheduled during the day shift (with the exception of one staff interview which was rescheduled to the evening shift), and all interviews were conducted separately. Family members were interviewed first, which enabled probing for further details during the interviews with residents, which followed immediately after. Families were interviewed in a quiet location in the LTCH, while residents preferred to be interviewed in their room. Residents and family members were asked about their involvement with the healthcare team in making care decisions, and how information was shared with staff. Staff were interviewed in a quiet room not in use during the interview (e.g. family room and library). Staff were asked how they worked as a team to make resident care decisions, how the residents and families were involved in healthcare decisions, and how information was shared and communicated to inform care decisions. Interviews were audio-recorded, transcribed verbatim and checked for accuracy by research staff. Written field notes were maintained to document any additional information about the interviews (e.g. context), to reflect on the interview process and to enhance dependability of the study findings (Lincoln & Guba, 1985). To describe the study sample and to enable comparisons during data analysis, demographic data were collected from staff and family members at the end of each interview, and residents' demographic data were provided by the DOC with residents' consent or proxy consent (as part of the consent process).

We used content and thematic analysis; data were initially coded and then categorised into themes (Miles, Huberman, & Saldana, 2015; Sandelowski, 2000). Research team members (LC, MH, TK, MH) first identified codes independently through line-by-line analysis beginning with the first interview transcript prior to conducting the second interview. An initial coding scheme was developed from the data to facilitate development and descriptions of themes. Themes were discussed with the larger research team for agreement and consensus to enhance credibility of study findings (Lincoln & Guba, 1985). We also compared the views of families about their involvement in care decisions with the perceptions of staff about family involvement in care decisions. Data saturation was confirmed when no further themes emerged from the analysis (Morse, 2015).

3 | FINDINGS

The study took place in a 140-bed non-for-profit LTCH in Toronto, Ontario, Canada. There were a total of nine participants, including 3 staff (1 RPN, 2 PSWs), 3 residents and 3 family members (1 child and 2 spouses of the residents). Overall, there were 5 female and 4 male participants. Staff age ranged from 37–45 years, and years' experience in their current role ranged from 4–18 years. Two staff worked full-time and one part-time, and highest level of completed education ranged from a postsecondary school certificate to an undergraduate degree. Family members usually visited their relative at least weekly. Residents' ages ranged from 72–88 years, and their length of time living at the LTCH ranged from 1–3 years. Residents' highest level of completed education ranged from high school to an undergraduate degree. Interview duration ranged from 15 to 40 min, with resident interviews being the shortest in length.

We identified four main themes (and their sub-themes) that described resident, family and staff perspectives of shared decision-making: (a) oral communication pathways for information sharing (informal, indirect and formal communication pathways); (b) supporting resident decision-making autonomy (types of decisions made); (c) relational aspects of care facilitate shared decision-making (building trust and team collaboration); and (d) lack of effective communication creates barriers to shared decision-making (differing perspectives and reactive communication).

3.1 | Theme 1: Oral communication pathways for information sharing

3.1.1 | Informal communication pathways

Staff and family members described how information about the resident or care plan was typically shared informally, such as the nurse updating the family when they visited or when family called the nurse for any updates. A change in the health status of the resident was a common example of a situation where information was first communicated with the nurse in charge for further action. PSWs described how in their role, they were positioned to often be the first to report any observed changes in a resident's behaviour or health condition to the nurse. The nurse would then notify the family of any changes in a resident's health status (typically a phone call), and whether any actions needed to be discussed with the healthcare team. The information shared with the family would then be documented in the resident's chart. Another example provided by staff and family about how information was shared was when family had a concern. Staff described that if family raised a concern, staff would notify management (DOC) who would then talk with the family. Similarly, family members described how they alerted the staff; however, they also shared how they felt comfortable talking directly with the DOC or manager with a concern.

3.1.2 | Indirect communication pathways

While there was some mention by PSWs of communicating with families about their relative, overall, there was a general lack of direct communication between family and PSWs. Indirect communication pathways existed where PSWs communicated with families via nurses or management. As one PSW indicated: "I will tell the nurse to say to the family that their mom needs something…" Another PSW stated: "But, even if they [family] come, I am not the one. I'm the healthcare aide. They usually have communication with the nurse on the floor or the Director of Care." A family member also illustrated a lack of communication with PSWs: "I do rely on the head nurse, typically, more than I do, the personal care workers."

Residents described how they would (or would not) notify staff about their preferences for care or activities of daily living (ADLs). For example, one resident described how he would tell staff if he did not like something (e.g. the food): "If I didn't like it I would say it." However, another resident indicated: "I just eat what's there. And don't eat what I don't want." With bath or shower routines, this resident further described how she would accept the shower even if she preferred to wait because she did not want to interrupt the routine:

> *Oh, I do it. I often…I think, oh, I can't be bothered. But I accept it because it keeps me healthy. And bless them. I have a shower. It's a lot easier than a bath.*

3.1.3 | Formal communication pathways

There were two types of formal meetings for sharing information described by staff and family. There were care conferences with management, the healthcare team and the family, which were scheduled upon admission to the LTCH, annually and as needed. Family indicated that the care conferences were good for sharing information and collaborative decision-making, though they were infrequent. There were also family council meetings held monthly at the LTCH; however, the family members interviewed indicated that they did not usually attend these meetings because the agenda was broad and not resident-specific. They preferred a more individualised, resident-centred approach for support and information sharing.

3.2 | Theme 2: Supporting resident decision-making autonomy

Our findings provided preliminary insight into how residents and family members are involved in decision-making and the extent to which they want to be involved.

3.2.1 | Types of decisions

Families and staff described two main types of decisions made concerning resident care: minor (or day-to-day) decisions and major (more complex) decisions. Some examples given of minor decisions around resident care were ADLs, diet and other resident personal preferences. Complex decisions involved care aspects such as medications and treatment options, level of care or code status decisions, and transfers to the hospital. Both staff and family members indicated that resident involvement in decision-making depended on the resident's cognitive capacity, functioning and ability. Staff indicated that if the resident is capable, they should participate in decision-making to express their care needs and preferences. Both families and staff supported the residents' decision-making autonomy. As one PSW indicated:

> *Some [residents] are more alert…they are more involved. You know, sometimes when you go to them for care, you are the ones they talk to. They tell you how they want to be cared for. And, you respect what it is they want.*

Staff and family members identified that when a resident is not capable of making more complex care decisions, the resident's substitute decision-maker would make decisions or consent to treatment on behalf of the resident. Staff described how care is tailored based on the residents' ability or willingness to be involved in care planning and to make choices; for example, residents may be able to choose what to eat, but not able to consent to a hospital admission. However, it was not clear how staff assessed a resident's cognitive capacity to make decisions. For non-verbal residents, staff described how residents remained involved in their care through facial expressions, which staff learned to interpret. Residents interviewed indicated that they were satisfied with their level of involvement in their care and explained how they were generally content accepting the decisions that their trusted family members and staff made on their behalf.

Family members expressed satisfaction with their level of involvement and the care their relative's received, and they perceived their participation in healthcare decision-making as an ongoing process to support their relative's decision-making autonomy. Staff described how they worked to support family involvement in care and decisions. For example, the nurse would call to ask family if they could come and sit with their relative if they were upset or exhibiting dementia-related behaviours.

3.3 | Theme 3: Relational aspects of care facilitate shared decision-making

A main facilitator of shared decision-making was relational aspects of care—the trust and rapport that families had with the healthcare team and the DOC.

3.3.1 | Building trust and team collaboration

Residents were impacted by the relational dynamics between themselves and staff (PSWs and nurses), while family were most impacted by their relationship with staff and the DOC. Family described having a good relationship and rapport with the nursing staff and the DOC in particular. Residents described having a good relationship with staff, and they were very appreciative of the care provided. One resident indicated:

> *I'm just so grateful that they take care of me…I wouldn't change anything…they do a darn good job.*

Another resident stated:

> *…I wouldn't even call it, well I guess they say that it is a nursing home. But, yeah, the staff are pretty good you know. Yeah, I mean if I were going to stay at a place for… [pause]…this would be an ideal location.*

Family members also indicated that their trust in the healthcare team and management played a significant role in their ability to participate in decision-making and their level of involvement. One family member stated:

> *If I didn't feel like [the resident] was getting very good care…I would certainly be more involved. But I think, [the resident] is well cared for, here. So, half of the, whether I want to get involved or not, is whether I have a sense that she is being well cared for. I'm very comfortable with the care that's given, and the caregivers on her floor…I trust they're making the right decisions for her…the more comfortable the family feels about how their parents are being treated, the better the whole system works.*

Family further described how during care conferences, the healthcare team would make recommendations to the family and discuss treatment options for the best course of action, which they found helpful. Staff also described how families might notice subtle changes in residents, and staff trusted their observations:

> *Sometimes when we see them every day, we're like, 'Oh, there's nothing wrong with them.' "They're the same colour. They haven't lost weight. Maybe, I mean, we could check the weights and we could compare. But if the family member is, 'Oh, she doesn't look so well. She looks pale.' Or, 'She looks like she lost weight.' Then we'll be like, 'Okay, maybe it's time to assess them further,' because it's an additional eye.*

One staff member described how decision-making takes practice and team collaboration can facilitate making good decisions:

> *…decision-making, it takes practice, know how, and a lot of common sense, as well, right, because sometimes your decision is the wrong decision. Sometimes the decision that you make, you think is correct, logically, it makes all kinds of sense, but, everybody else thinks…the rest of the team thinks that it could be…if you did it this way, its better.*

3.4 | Theme 4: Lack of effective communication creates barriers to shared decision-making

Family members' overreliance on the nurse in charge for information sharing, the indirect communication channels between PSWs and families, and difficulties with communicating effectively created barriers to a collaborative approach to decision-making. PSWs described how it was difficult for staff to communicate with families, and they noted that families too may have difficulty communicating with staff. As one PSW noted:

> *It's hard sometimes to talk with the family. Because they're the only ones, always…it's so, hard to…so, that's why we don't- maybe they can't explain properly. Maybe we don't explain properly to them.*

3.4.1 | Differing perspectives and reactive communication

Staff described how families may not agree with what the PSWs want to do concerning resident care such as ADLs. Staff and family may also have differing perceptions about end-of-life care. Both staff and family members discussed the challenges that some family members faced when making more complex decisions on behalf of the resident. Staff described how family members may not be prepared to make decisions around end-of-life care or "sometimes they're still in denial." Family members expressed the difficulty they experienced with being responsible for the care of their loved one and the importance of having supports in place. Family suggested that it would be helpful to have more emotional support at the LTCH when making difficult decisions. While discussions at the LTCH did take place between staff, management and the family concerning what the family's wishes are, and what is reasonable and in the best interests of the resident, these discussions were often a reactive response to a particular situation or concern.

While PSWs at this LTCH attended care conferences when time permitted, they expressed how they wanted their own platform to allow them to have more regular input into resident care and decisions. PSWs discussed how they wanted an opportunity to share their ideas and suggestions for care improvement with the healthcare team and with the families. One PSW stated:

> *We should be given an opportunity or a platform to really…to make suggestions, because we are directly involved with the resident. Because we know them. Sometimes we will know them more than their family members because we are here all the time.*

4 | DISCUSSION

Study findings highlighted the potential for shared decision-making in LTC as an interprofessional collaborative approach to providing high-quality resident care. While residents and families were satisfied with their level of involvement in care decisions, there were opportunities to improve communication between staff and residents, strengthen relationships between staff and families,

and increase PSWs' involvement in resident care decisions. It is essential for staff to develop their skills to more effectively communicate with residents to recognise and understand their needs. Residents, particularly those with dementia, may lack the ability to verbally or non-verbally communicate their needs which may cause them agitation (McGilton et al., 2017). There may be missed opportunities for staff to enhance social interactions with residents and engage in person-centred communication (Savundranayagam, 2014; Savundranayagam, Sibalija, & Scotchmer, 2016). Involving residents in their care and decision-making can foster a person-centred approach to care, yet it was not clear from our study how staff determined the residents' capacity for making decisions. For residents who have the ability to share their views, it is imperative to provide opportunities for them to engage in decision-making on a regular basis with support from their family and the healthcare team. Training staff to tailor their communication strategies to address a resident's individual abilities has demonstrated a positive effect on residents' quality of life (McGilton et al., 2017).

Participants' perceived challenges to shared decision-making could be leveraged as opportunities to facilitate a shared decision-making approach to resident care. We found that family and staff may experience difficulty communicating with one another, and family expressed wanting more emotional support in their decision-making as it can be stressful and challenging, particularly around end-of-life care. Staff and family further described the indirect communication that occurred between PSWs and families when sharing information about residents. PSW–family relationships could be strengthened by facilitating direct PSW–family communication pathways. These direct pathways support person-centred care because PSWs provide the majority of direct care to residents; thus, they require access to the individualised information about the residents' needs and preferences that family members possess (Caspar, 2014). Studies have highlighted the importance of having good communication, information exchange and relationships between staff and family to facilitate shared decision-making (Mariani, Vernooij-Dassen, Koopmans, Engels, & Chattat, 2017; Petriwskyj, Gibson, et al., 2014). Interventions aimed at improving communication and collaboration between staff, and family members can promote positive and constructive relationships and interpersonal connections (Barken & Lowndes, 2018; Haesler, Bauer, & Nay, 2010), and can foster a relational approach to care—characterised by open communication, mutual understanding and trust (Barken & Lowndes, 2018). In a recent study examining the effect of a staff communication skills training programme in the implementation of shared decision-making with residents and families in the care planning process, the authors reported an improvement in residents' care plans (Mariani et al., 2018).

Family involvement in decision-making is important as not all residents can share their views, although studies have shown that family members' preferred level of involvement and roles to support their relative vary considerably (e.g. impacted by contextual, cultural and sociopolitical factors) (Petriwskyj, Gibson, et al., 2014; Puurveen, Baumbusch, & Gandhi, 2018). We found that families who are involved and visit their relative regularly can observe early subtle changes in their relative's health. This finding is consistent with the study by Powell et al. (2017), who found that families can assist LTCH staff in the timely detection of changes in their relative's health status because of their intimate and biographical knowledge of their relative. However, family members who prefer to be more involved in their relative's care need to be more effectively supported, and their involvement more formalised through structures that foster collaborative approaches to care decisions (Petriwskyj, Parker, et al., 2014).

An engaged and effective management team was described by family member participants as a facilitator to shared decision-making, because they trusted them and felt comfortable approaching management to discuss any concerns. Barkens and Lowndes (2018) contend that leadership support is essential to ensure time and resources are available for family and staff to interact and discuss care planning. Research has demonstrated the positive impact of effective supervisory support on PSWs' job satisfaction (Bethell, Commisso, et al., 2018), and ability to provide person-centred care (Caspar, Le, & McGilton, 2019).

Our findings highlighted that PSWs need to be more actively engaged in team decision-making. This finding is consistent with previous studies that reported a need for PSWs to be active participants in interprofessional team collaborations (Caspar et al., 2016; Kontos et al., 2010; Wagner et al., 2014). While PSWs have been described as having specialised knowledge of residents (Kontos et al., 2010), they have also been depicted in the literature as invisible workers (Hewko et al., 2015), and untapped resources for knowledge (Chamberlain et al., 2019). Yet PSWs provide 80% of the direct care to residents and their roles continue to evolve as residents require increasingly complex care (Afzal et al., 2018; Bethell, Chu, et al., 2018). There is an increasing emphasis on providing decision support to PSWs and training to work within a team-based collaborative model of care delivery (Kontos et al., 2010) (Bethell, Chu, et al., 2018; Wagner et al., 2014). However, in Caspar et al. (2016) study which explored information exchanges in LTCHs, they reported that PSWs lacked practical access to written documentation and they lacked influence over organisational decisions concerning care provision. In LTCHs where oral exchanges were not formalised processes, they found that the oral sharing of information was dependent on the quality of staff relationships (Caspar et al., 2016). PSWs need to be formally integrated into team sharing of information and decision-making processes to afford them opportunities to provide input to inform resident care decisions. Previous research has shown that PSWs are willing to be involved in care planning and quality improvement initiatives (Norton, Cranley, Cummings, & Estabrooks, 2013), and their active involvement in such activities has the potential to improve outcomes known to impact this workforce such as, burnout and quality of work life (Chamberlain et al., 2019). With leadership and nurses' support in quality improvement activities, PSWs can be empowered to make change and their contributions can improve the quality of resident care (Norton et al., 2013; Slaughter et al., 2015). Giving more voice

to PSWs may not only empower them on the team, but could also elevate the voice of residents to support shared decision-making.

Based on our study findings, we identified five key strategies that are essential to facilitate shared decision-making in LTC:

1. Train staff to communicate effectively with residents and family;
2. Strengthen PSW–family relationships by facilitating direct PSW–family communication pathways;
3. Facilitate open, proactive communication among residents, family and staff;
4. Involve the management team to support shared decision-making; and
5. Actively involve PSWs in shared decision-making and seek their input and ideas.

These strategies could be further co-designed with residents, their families, staff, leadership and other key stakeholders, tested and implemented to support shared decision-making in LTCHs. Including the target population in the development of interventions can increase the relevance of interventions prior to their development and testing (Esmail, Moore, & Rein, 2015; Sidani & Braden, 2011). Future research should explore ways to meaningfully engage residents and families in care planning and decisions.

There are study limitations to note. This study provides a preliminary understanding of shared decision-making in LTC based on a small sample of participants from each of the three groups interviewed in one LTCH. As such, the transferability of the findings is limited. Any analytic comparisons between staff and family perspectives are tentative and should be interpreted with caution. The interviews with residents were short in length. It may be beneficial to interview the same resident on two different occasions, or offer residents a choice of an individual interview or to be interviewed as a dyad with their caregiver (Bethell, Commisso, et al., 2018), and offer a choice of time of day for the interview (Beuscher & Grando, 2009). We recruited family members who visited their relative regularly, and they may have been more willing to participate in the study and may have known the staff better (and may have had stronger relationships) than those visiting their relative less frequently. Recruiting a larger, more diverse sample of residents (e.g. those with no cognitive impairment), staff and family members as well as, including observational data, may have led to additional insights into shared decision-making. We were unable to recruit RNs to interview; therefore, their perspectives are not represented. Nonetheless, these findings provide a foundation for further research to explore how shared decision-making could be implemented in LTCHs.

5 | CONCLUSION

As the demand for LTC continues to increase, it is crucial that we develop and test strategies that are relevant and support collaborative practices that foster high-quality resident care. Study findings identified that while a relational approach to care can facilitate shared decision-making, there are opportunities to further cultivate shared decision-making in LTCHs through more effective communication and collaboration.

Implications for practice

- Understanding how information is shared and decisions are made can facilitate shared decisionmaking in LTCHs.
- Strategies identified from this study could be further co-developed and implemented in LTCHs.
- Inclusion of personal support workers in resident care decisions is an opportunity for shared decisionmaking practices in LTCHs.

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AUTHOR CONTRIBUTIONS

LC designed the study and collected the data; LC, MH, TK, MH analysed the data; LC drafted the manuscript; KM, SS, SC provided overall guidance for the study and made critical revisions to the manuscript.

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