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INTEGRATIVE REVIEW

Health communication and shared decision-making between nurses and older adults in community setting: An integrative review

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Abstract

Aim: To explore the role of health communication in Shared Decision-Making (SDM) between nursing staff and older people in the community setting.

Background: Society and healthcare services are marked by an exponentially ageing population, leading to a significant proportion of patients being older adults with highly demanding care needs. Scientific literature supports shared decision-making as a process that engages patients in their care. However, the increasing use of technology and the consequences of the COVID-19 pandemic have influenced how nurses communicate with older patients. Therefore, it is crucial to understand how to develop health communication to reach effective, shared decision-making processes.

Methods: Whittemore and Knafl's integrative review method, the literature search comprised five databases: PubMed, CINALH, Web of Science, Scopus and PsycINFO.

Results: The 12 included studies were synthesised into three study patterns: (1) nurse–older patient health communication relationship, (2) older patients' perspectives and (3) nontherapeutic communication in end-of-life care.

Conclusion: This review underscored the crucial role of effective health communication in shaping SDM dynamics between nursing staff and older people in the community setting. Key elements included transparent information exchange, establishing trust and maintaining communication channels with informal caregiving networks. SDM actions were aligned with preserving older people's autonomy, but communication challenges persisted, particularly in end-of-life situations. Advanced care planning was recommended to address these shortcomings and improve communication among older people, healthcare professionals and families.

Implications: Implementing educational measures based on verbal and nonverbal health communication in nursing training could be beneficial. Nursing research could continue to develop and refine specific communication strategies adapted to the

social determinants of health for diverse clinical situations regarding older adults in the community setting.

Reporting Method: The authors have adhered to relevant EQUATOR guidelines through the PRISMA 2020 checklist.

No Patient or Public Contribution.

KEYWORDS

clinical nursing, community setting, health communication, nurses, older people, shared decision-making

1 | BACKGROUND

The World Health Organization (2022) estimates that the number of individuals aged 60 and above will double by the year 2050, reaching 22% of the population compared to 12% in 2015. Among the most aged countries, the top positions are held by those with higher development and income levels. This is due to a decrease in birth rates, an increase in life expectancy due to new medical advancements, and a reduction in mortality rates, resulting in a population with a higher dependency ratio (Martín Gómez & Rivera Navarro, 2020). However, it is vital to broaden our understanding of ageing by incorporating a holistic approach that encompasses not only the physical but also the psychological and social dimensions of health, as these are equally important in shaping the well-being and quality of life of older adults (Montano et al., 2024).

In this broader context, the social and economic circumstances in which older adults live are critical to consider. The interconnectedness of these elements plays a significant role in their overall health, influencing preventive and curative healthcare strategies (Marmamula, 2022). It is also necessary to consider the social and economic context in which the older adult lives to establish preventive or curative measures in line with their situation (Lepe-Martínez et al., 2020). Regarding establishing criteria or adopting interventions related to the health of older adults, it is essential to involve them in the decision-making process.

Shared decision-making (SDM) is defined as a collaborative process in which a healthcare provider and a patient work together to make a healthcare decision that is best for the patient. The optimal decision considers evidence-based information about available options, the provider's knowledge and experience, and the patient's values and preferences (Agency for Healthcare Research and Quality, 2023). This approach underscores the importance of understanding the individual's values and preferences, which often extend beyond the physical domain and reflect their unique life experiences and beliefs (Davitt et al., 2016). To ensure that this transfer of information is carried out most efficiently, a nursing attitude based on therapeutic communication rooted in empathy and active listening should be embraced, along with an acceptance and respect for individual preferences (Prieto-Agüero, 2016). Therapeutic communication in this context goes beyond mere information exchange, involving a deeper understanding of the patient's holistic needs, including their emotional, social and psychological well-being (Rudnicka et al., 2020; Xue & Heffernan, 2021).

What does this paper contribute to the wider global clinical community?

- Poor shared decision-making situations are partly based on a communicative relationship hindered by the nursing staff's lack of verbal and nonverbal communication skills and structural limitations in health care policy.
- In healthcare situations, nurses' perceptions of older patients' communicative attitudes in the community may be influenced, potentially leading to biassed communication.
- Advance care planning is presented as a real solution to communication problems regarding end-of-life shared decision-making.

Both SDM and therapeutic communication occur in clinical encounters that could be defined as communicative interactions set within a healthcare institutional context, characterised by the social attributes of the participants and their communicative patterns. Through discourse, the purpose of these encounters is to perform a series of finite activities influenced by sociohealth norms and codes within a specific physical space and timeframe (Cicourel, 1987).

In this context, nursing staff must proactively seek potential causes that may have led to the health issue and identify alterations in the biopsychosocial sphere in all clinical encounters with older adults. Similarly, older people often present comorbidities or fragility associated with functional dependency and potential disability, necessitating more effective attention and communication (Aguirre Raya et al., 2020; Carrazco-Peña et al., 2019). Furthermore, it may not only be difficult to maintain communicative clinical encounters with older people regarding SDM but also involving the patient's family and close environment in this process becomes as necessary as it is challenging (Palacios et al., 2020).

In numerous situations, maintained over time, health communication becomes crucial for upholding SDM even when health

circumstances are complicated, such as developing advance care planning. This can facilitate the preservation of the older patient's preferences regarding end-of-life care while alleviating the significant psychological and emotional burden experienced by families and the immediate environment during those times (Dias et al., 2022).

It is essential to consider that the way healthcare staff communicate with older patients is changing due to technological advancements and sociosanitary events such as the COVID-19 pandemic, with increased information technologies that allow continuous monitoring and more streamlined tracking of the clinical situation (Bermúdez, 2020). However, this implementation can create barriers between nurses and older people due to difficulties in understanding or accessing these technologies, a lower inclination to use them, and a lack of awareness or experience in comprehending their use and handling (Loaiza-Lima & Velásquez-Benavides, 2020).

Nevertheless, whether through traditional means or technology, effective communication remains vital between healthcare staff and older adults who desire to maintain their independence within their capabilities. Regardless of its form, this communication plays a practical role in fostering positive outcomes by enabling older adults to feel integrated into society and facilitating the SDM process (Latorre et al., 2020). Despite its challenges, technology integration in healthcare communication must be navigated carefully to ensure it complements rather than complicates the holistic approach to older care. The aim is to enhance the efficacy of SDM by leveraging these technological tools while remaining sensitive to the unique needs and preferences of older adults (Kim et al., 2021).

SDM has demonstrated its benefits in clinical situations and patient management, as supported by numerous instances in scientific literature. However, this study focuses not only on SDM but also on how this level of horizontal collaboration is attained in achieving health outcomes. This approach is important because of the current post-pandemic COVID-19 situation, where communication between healthcare workers and patients has deteriorated in some respects, especially at the community level, affecting older people (Nicklett et al., 2022). In addition, SDM is increasingly established in clinical settings where patients have life-critical situations. In this respect, there is a gap in the literature in the community setting, with fewer studies exploring this aspect. For this reason, it is necessary to broaden knowledge by analysing how different communication strategies can affect nursing care and what new roles can be adopted (Taylor et al., 2022). Therefore, health communication can be a powerful tool to reach SDM efficiently. Nevertheless, due to the significant variability of discourses, influential elements and the sociosanitary contexts in which they are generated, it is essential to explore the role of health communication in SDM between nursing staff and older people in the community setting.

This integrative review aimed to explore the role of health communication in SDM between nursing staff and older people in the community setting, focusing on the holistic understanding of older people. This includes their physical health and psychological, social and emotional needs and how these diverse aspects can be effectively addressed through therapeutic communication and SDM. Thus, our rationale gave rise to the following research question:

How is health communication related to SDM, and what elements shape this relationship between nursing staff and older people in the community setting?

2 | METHODS

This study was designed using the integrative review methodology by Whittemore and Knafl (2005) and followed considerations for systematic review studies, guided by the PRISMA statement (Page et al., 2021). This methodological approach facilitated the collection of both qualitative and quantitative empirical literature (Appendix S1).

The methodology's first step involved problem identification and selecting a central objective. The second step involved conducting a literature search based on this designated objective. In the third step, we performed a data evaluation from selected articles. The fourth step involved data analysis. Finally, in the fifth step, we ended with a data presentation.

3 | LITERATURE SEARCH

For this integrative review, appropriate search strategies were developed using pertinent keywords combined to obtain the desired results. These strategies were employed in the following databases, tailored to the requirements of each: PubMed, CINALH, Web of Science, Scopus and PsycINFO. The primary studies must meet the following selection criteria:

Inclusion criteria:

A Primary studies focused on:
   a. Shared decision-making.
   AND
   b. Health communication.
B Primary study participants must be:
   a. Older adults.
   AND
   b. Nursing staff.
C Primary studies must be conducted in a community setting.

Exclusion criteria:

D Primary studies involving participants who were unable to communicate verbally.
E Grey literature.

We decided to use determined database filters further to ensure a thorough practice in the literature search. The filters used in the databases are the following: (1) Last 5 years because the research team considered the COVID-19 pandemic to be a pivotal factor in

reshaping how health communication is maintained with older patients. Consequently, the decision was made to focus exclusively on studies conducted before, during and after the pandemic. The goal was to comprehensively understand the dynamic evolution of health communication by incorporating studies from diverse time frames. The emphasis on the pre-pandemic period provides a comparative framework, allowing for a thorough assessment of how the pandemic has influenced the restructuring of communication strategies. This holistic approach enables a nuanced exploration of the complete trajectory of health communication with older patients, from its state before the pandemic, navigating the challenges during the pandemic, to the adjustments made in its aftermath. (2) English/Spanish because they are the languages that the research team mastered. (3) Exclude MEDLINE records in those databases other than PubMed that had it available to eliminate duplicates. (4) Articles in those available databases to ensure retrieving only original studies. Both the filters applied, and the search terms were adapted to the configuration of each database. The results of the database search are in Appendix S2.

EJ-A searched Scopus on 16th January 2023 and PubMed, CINAHL, Web of Science and PsycINFO on 17th January 2023. Finally, all databases were searched again on 14th March 2023. This process was supported and followed by MA-P. At the beginning of the article screening phase, consensus meetings were held to agree on each step that would be carried out. We decided to use EndNote for screening. EJ-A performed all screening stages, applied the above eligibility criteria and selected studies through a detailed review for their inclusion. Both authors read and reviewed all potentially relevant articles. All the research team agreed with the decisions and steps.

4 | DATA EVALUATION

All included studies had qualitative, mixed-methods or cross-sectional designs. EJ-A and MA-P independently assessed the selected studies' quality using standardised JBI Critical Appraisal Tools (JBI, 2023). Qualitative studies were evaluated using the checklist for qualitative research. Cross-sectional studies were assessed using the checklist for analytical cross-sectional studies. Mixed-methods studies were evaluated using qualitative and cross-sectional checklists for each part of the studies.

5 | DATA ANALYSIS

The data classification involved identifying, extracting and tabulating data from selected studies, specifically authors and year of publication, country, study design, study aims, no. of participants, participants' characteristics, data collection and relevant outcomes from primary studies. This tabulation was used to compare and summarise data between studies to facilitate data presentation. We methodically examined various topics in analysing the data sources to achieve the research objective of comprehending the role of health communication in SDM between nursing staff and older people in the community setting. These topics collectively contributed to outlining the multifaceted role, and examples included in our analysis encompass communication strategies, communication barriers and facilitators and adaptations made during the COVID-19 pandemic.

EJ-A conducted the analysis phase, which MA-P supervised. The analytical process involved thematic categorisation, which meticulously considered each data source to ascertain its contribution to fulfilling the research objective—namely, to explore the role of health communication in SDM between nursing staff and older people in the community setting.

6 | DATA PRESENTATION

The thematic categorisation yielded patterns and themes (extracts from narratives, findings or original constructs) that were consistent across the original studies. Following this process, the research team maintained close and ongoing communication, synthesising the data into a final understanding of the phenomenon.

7 | ETHICAL CONSIDERATIONS

Ethical approval was not required to conduct this study, and the research team confirmed that this integrative review meets the ethical guidelines, including adherence to the legal requirements of research.

8 | RESULTS

Using the specific search strategies for each database, 161 articles were obtained. Titles and abstracts were examined to determine whether they aligned with the objectives of this review, leading to the exclusion of 144 articles. After analysing the full text of the remaining 17 studies, five were excluded as they did not focus on the nurse–patient relationship, resulting in 12 selected original studies, as Figure 1 following the PRISMA diagram illustrates (Page et al., 2021).

Data extracted and tabulated from the 12 selected primary studies and the previously mentioned characteristics are in Table 1.

Regarding the data evaluation results (Appendix S3), each study met a minimum of seven out of the 10 criteria on the JBI critical appraisal checklist for the qualitative studies and the qualitative aspect of the mixed-methods studies. For the included quantitative study and the quantitative part of the mixed-methods studies, at least five criteria were answered affirmatively out of eight on the JBI critical appraisal checklist.

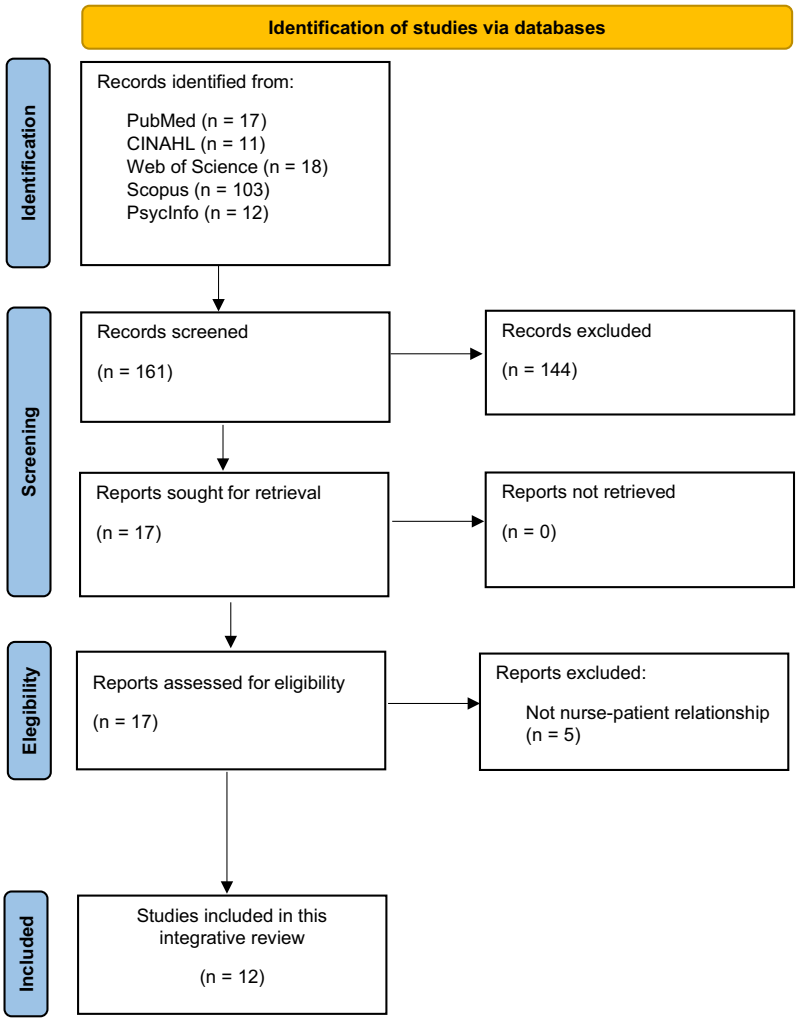

FIGURE 1 PRISMA Medeiros et al., 2020 flowchart for the selected studies.

9 | PRESENTATION OF THE RESULTS

The findings have been visually and narratively presented and organised according to three study patterns encompassing various related themes. These patterns inherit the role of health communication regarding SDM between older adults and nursing staff in the community setting. The study patterns were (1) nurse–older patient health communication relationship, (2) older patients' perspectives and (3) nontherapeutic communication in end-of-life care (Table 2).

10 | PATTERN 1: NURSE–OLDER PATIENT HEALTH COMMUNICATION RELATIONSHIP

This first study pattern integrated three themes: communication channels, health communication facilitators and health communication barriers (Appendix S4).

In the community setting, information about the health status of older people can be conveyed through various channels. Multidisciplinary working (especially with nursing assistants) represented an important communication channel, as all the gathered data relied on teamwork to realise older patients' preferences (Goossens et al., 2020; Peat et al., 2022). The interprofessional healthcare staff, along with engaging informal caregivers, played a significant role in health communication, improving emotional and physical distress among older patients due to their close attention and care, also making them reliable and up-to-date sources of information (Gonella et al., 2023; Ploeg et al., 2019). Likewise, there were alternative communication channels through the development of tools with detailed information on how to stay active and independent at home or even providing information on different options and aids if the user opted for other aspects of care. In this sense, Garvelink et al. (2020) developed an interactive website to maintain the autonomy of older people at home, where participants had access to health information and individualised lifestyles according to their condition and health status. This tool was very well received among participants, improving their autonomy in different areas. Among the proposed improvements for the website, participants highlighted providing specific information for caregivers and improving accessibility for people with disabilities.

Nevertheless, some facilitators and barriers affecting the health communication relationship caused differences between cases. For recommendations conveyed by the healthcare staff to be well accepted by the older patient, it was necessary to have a pre-existing relationship based on trust forged through numerous encounters and

TABLE 1 Data tabulation of primary studies included in the integrative review ($n = 12$).

Author(s)/Year of publication	Country	Study design	Study aims	No. of participants[a] (men/women)[b]	Participants' characteristics[c]	Data collection[d]	Relevant outcomes from primary studies
Gonella et al. (2023)	Italy	Instrumental case study	To develop a situation-specific theory of end-of-life communication in Nursing homes by refining an existing theory	Four nurses 11 residents' clinical records	Nursing home staff ($n = 3$) Nursing home manager ($n = 1$)	Residents' clinical records consultation Self-administered scale Semi-structured interview In-the-field notes	Residents' preferences for end-of-life care were poorly understood by their caregivers overall The taboo on death made it difficult to communicate at the end of life and to learn about residents' care preferences
Peat et al. (2022)	England	Qualitative study	To explore the barriers/facilitators to deprescribing in primary care in England from the perspectives of clinicians, patients living with frailty who reside at home, and their informal carers, drawing on the Theoretical Domains Framework to identify behavioural components associated with barriers/facilitators of the process	Nine older peoples (6/3) Five nurses (0/5)	Older people: 70–80 years old ($n = 5$) 80–90 years old ($n = 3$) 90–100 years old ($n = 1$) White British ($n = 9$) With nonformal caregivers ($n = 3$) Without caregivers ($n = 6$) Nurses: White British ($n = 5$) >10 years worked in primary care ($n = 4$) <10 years worked in primary care ($n = 1$)	Semi-structured interview	Positive relationships based on trust and correct communication were related to better pharmacological management Therapeutic management was carried out more successfully when the patients felt they were in control before sharing advantages and disadvantages The lack of time in meetings with the patient influenced poorer communication and shared decision-making
Gonella et al. (2021)	Italy	Qualitative study	To explore nurses' perspective about the process by which end-of-life communication impacts on the goal of end-of-life care in nursing home residents	14 nurses (1/13)	Foreign worker ($n = 3$) Age, years, mean ($n = 39$) overall working experience, years, mean ($n = 14,4$) working experience in nursing home, years, mean ($n = 8,6$) Permanent full-time ($n = 6$) Permanent part-time ($n = 3$) Freelance ($n = 3$)	Semi-structured interview	Several factors influenced the occurrence and quality of the communication process at the end of life. The transition to palliative care was facilitated by learning about family members and residents' end-of-life care preferences and informing family caregivers and residents about the prognosis and available treatments. This allowed them to understand the situation and encourage shared decision-making
Laging et al. (2021)	Australia	Secondary analysis of data from an ethnographic study	To identify how advance care planning influences the relationship between resident values and clinical expertise when determining a direction of care at the time of a resident deterioration	In the observation phase: eight older peoples eight nurses In the interview phase: five older people 20 nurses	[Data on age, gender, and other characteristics were not collected due to the small size of the metropolitan public facility and the potential for identify the participants]	Participant observation Semi-structured interview	Patients with mild–moderate dementia wanted to participate in shared decision-making, given the possibility that their preferences did not correspond to those of their relatives Not all participants and families decided to participate in advance planning; some preferred to make decisions at the time of deterioration Not all professionals were trained to facilitate discussions on advance planning, generating mistrust among the participants

TABLE 1 (Continued)

Author(s)/Year of publication	Country	Study design	Study aims	No. of participants[a] (men/women)[b]	Participants' characteristics[c]	Data collection[d]	Relevant outcomes from primary studies
Ludlow et al. (2021)	Australia	Mixed methods study	To investigate aged care residents' prioritisation of care	38 older peoples (13/25)	Age range <79 (*n* = 4) 80–84 (*n* = 7) 85–89 (*n* = 9) 90–94 (*n* = 14) >95 (*n* = 3) Not disclosed (*n* = 1) Time living in the facility <1 year (*n* = 7) 1 year–2 years, 11 months (*n* = 13) 3 years-4 years, 11 months (*n* = 6) 5 years–6 years, 11 months (*n* = 8) >7 years+ (*n* = 4) Self-rated health Poor (*n* = 3) Fair (*n* = 7) Good (*n* = 16) Very good (*n* = 11) Excellent (*n* = 1)	Questionnaire Semi-structured interviews	Residents prioritised respectful treatment, management of medical conditions and independence Recommendations to provide care aligned with resident priorities included establishing open communication channels, supporting resident independence and enforcing safer staffing ratios
Sopcheck and Tappen, (2022)	USA	Secondary analysis of data from a qualitative study	To understand the resident's perceptions regarding communication about their preferences for care at end-of-life with providers and family members and the corresponding views of family members and staff regarding these end-of-life conversations in the nursing home	15 older peoples (5/10) 13 nurses (0/13)	Older people: Self-rating of health Good (*n* = 7) Fair (*n* = 7) Poor (*n* = 1) Length of stay, mean, 3.1 years (*n* = 13)	Semi-structured interview	End-of-life discussions were infrequent, and residents were not well informed about their health conditions and future management of their situation Another person's end-of-life experiences may influence a resident's end-of-life care preferences or decisions made by family members Recognition by nurses of subtle signs of a resident's life decline may trigger end-of-life conversations initiated by nursing staff
Cranley et al. (2020)	Canada	Qualitative study	To explore shared decision-making among residents, their families and staff to determine relevant strategies to support shared decision-making in long-term care	Three older peoples One nurse	Older people: Age range, 72–88 years (*n* = 3) Length of time living at the long-term care home, 1–3 years (*n* = 3)	Semi-structured interview	Five key strategies were found to be essential in facilitating shared decision-making: (1) train staff to communicate effectively with residents and family; (2) strengthen personal-family relationships by facilitating communication channels between them; (3) facilitate open and proactive communication between residents, family, and staff; (4) engage the residence management team to support shared decision-making; and (5) actively involve staff in shared decision-making and seek their contributions and ideas

(Continues)

TABLE 1 (Continued)

Author(s)/Year of publication	Country	Study design	Study aims	No. of participants[a] (men/women)[b]	Participants' characteristics[c]	Data collection[d]	Relevant outcomes from primary studies
Garvelink et al. (2020)	Canada	Qualitative study	To perform an in-depth exploration among potential end users about how to improve the interactive website to better inform older adults and caregivers about ways to stay independent at home	Five older peoples (1/4)	Age Mean, 74.6 years ($n=5$) Range, 66–83 years ($n=5$) Education High school diploma ($n=1$) College diploma ($n=1$) University degree ($n=3$)	Individual interview	Older adults demanded to have a support and communication network based on personalised information and focused not only on maintaining their independence at home but also information on housing options
Goossens et al. (2020)	Belgium	Cross-sectional study	To explore how health professionals and residents with dementia perceive the level of shared decision-making during advance care planning conversations To investigate professionals' perceptions of the importance of shared decision-making, their perceived competence and self-report about the frequency of utilising shared decision-making	42 older peoples 85 nurses	[Regarding nurses, there is no specific information on this group, as they belong to a larger sample with undifferentiated characteristics. Regarding the older people, the authors declared that they had not collected any characteristics about them]	Dutch version of two internationally validated self-descriptive instruments (SDM-Q, CollaboRATE)	Residents with dementia were appreciative when they participated in discussions about their care but found it difficult to report on the topic of discussion during the conversations Receiving more information about advance care planning could provide them with the necessary knowledge to prepare for such a conversation External evaluators noted a discrepancy between the shared decision-making model and the methods used in daily practice Training programs should focus on providing professionals with better knowledge and skills for shared decision-making Team collaboration should also be promoted to increase patient-centred care in dementia homes
Bennett et al. (2020)	Australia	Qualitative study	To gather resident perceptions of the opportunities they have to communicate with both staff and other residents in residential aged care, including the opportunity to express their care preferences and contribute opinions about their care	102 older peoples (33/69)	Age, mean, 84.7 years ($n=102$)	Individual interview	The residents demanded more opportunities to communicate and participate in conversations because they reported spending much time alone The residents affirmed the need to carry out more social activities and that they be adapted to their interests Considering her abilities, the importance of guaranteeing and maintaining the patient's autonomy and dignity was underlined

TABLE 1 (Continued)

Author(s)/Year of publication	Country	Study design	Study aims	No. of participants[a] (men/women)[b]	Participants' characteristics[c]	Data collection[d]	Relevant outcomes from primary studies
Ploeg et al. (2019)	Canada	Qualitative study	To explore the experiences of a broad range of healthcare providers working in primary care and home care settings in supporting older adults living in the community to manage their multiple chronic conditions	21 nurses	Professional category Nurse Case Manager ($n=1$) Nurse Practitioner ($n=1$) Registered Nurse ($n=12$) Registered/Licensed Practical Nurse ($n=7$)	Semi-structured interview	It was necessary to have a multidisciplinary team in continuous collaboration to guarantee comprehensive and holistic care for the patient since if communication is deficient, the information provided will also be poor. Communication with the patient was crucial for promoting health, preventing diseases and minimising risk factors Involving the patient in their care caused a greater understanding, and they could assume more responsibility for their health
Oliver et al. (2018)	USA	Secondary analysis of data from a qualitative study	To evaluate the shared decisions between hospice nurses and patients and family members	65 nurses (6/59)	Age Mean, 44.2 years ($n=65$) Range, 25–69 years ($n=65$) Race White ($n=48$) Black/African American ($n=4$) Asian ($n=2$) Other ($n=2$) Unknown ($n=9$) Degree Associate's degree ($n=41$) Diploma ($n=3$) Bachelor's degree ($n=17$) Graduate degree ($n=3$) Unknown ($n=1$) Nursing experience Mean, 13.6 years ($n=65$) Mean, 3.3 years hospice ($n=65$)	Subsample of audio tapes collected from a nationwide national hospice study	In various ways, home hospice nurses used all the recommended elements of shared decision-making during home visits with patients and families; however, not all items were used on all visits The most used element was the definition of the problem, and the least used aspect was evaluating the understanding of the patient and the family

[a]Only those relevant participants for the present integrative review have been indicated.

[b]It has only been indicated for those primary studies in which the sex of the participants has been clearly reflected.

[c]Only those relevant characteristics of interest for the present integrative review have been indicated.

[d]The original nomenclature used by the authors of the primary studies has been respected.

TABLE 2 Study patterns and themes.

Patterns	Themes	Primary studies
Nurse–older patient health communication relationship	Communication channels Health communication facilitators Health communication barriers	(Cranley et al., 2020; Medeiros et al., 2020; Garvelink et al., 2020; Gonella et al., 2021, 2023; Ludlow et al., 2021; Oliver et al., 2018; Peat et al., 2022; Ploeg et al., 2019)
Older patients' perspectives	Older patients' wishes Older patients' reality Older patients' spiritual and social needs	(Bennett et al., 2020; Cranley et al., 2020; Medeiros et al., 2020; Garvelink et al., 2020; Gonella et al., 2021; Ludlow et al., 2021)
Nontherapeutic communication in end-of-life care	Discrepancies and controversies in SDM Advance care planning as a communication strategy	(Bennett et al., 2020; Medeiros et al., 2020; Gonella et al., 2021, 2023; Laging et al., 2021; Sopcheck & Tappen, 2022)

an understanding of the process to be followed, allowing the older patient to feel in control and managing their clinical situation on their own (Gonella et al., 2021). Informal caregivers played a crucial role in facilitating this. Furthermore, effective treatment with the older patient involved interprofessional communication and a holistic approach to fully understand the challenges' complexity (Peat et al., 2022; Ploeg et al., 2019). For this purpose, a concise and precise definition of the health issue was crucial to provide the most realistic and tailored diagnostic and therapeutic options for their situation (Oliver et al., 2018).

Regarding barriers, the lack of time in patient care and clarity in message transmission hindered the establishment of a cordial and close relationship (Ludlow et al., 2021). It led to misunderstandings of the decisions, resulting in lower treatment adherence and noncompliance (Cranley et al., 2020). Likewise, the challenges still needed to address the healthcare system's structure were emphasised to provide more significant support for community care (Peat et al., 2022; Ploeg et al., 2019).

11 | PATTERN 2: OLDER PATIENTS' PERSPECTIVES

The second study pattern integrated another three themes: older patients' wishes, older patients' reality and older patients' spiritual and social needs (Appendix S5).

In the community care setting, older patients desired to be adequately assessed for all their needs and actively participate in their care. They were interested in understanding their health conditions and what activities or processes they could use to improve their health status. SDM was identified as the most effective tool for achieving this (Bennett et al., 2020). Unanimously, all older patients wished to maintain their autonomy and independence for as long as possible, regardless of location or situation (Gonella et al., 2021). Even during setbacks, they wanted to retain their autonomy in carrying out tasks they could still perform.

However, patients with cognitive impairment had minimal involvement in SDM regarding their self-care, and any actions that did consider their input were generally insignificant decisions (Goossens et al., 2020). Additionally, no objective assessment would enable healthcare staff to determine an older person's capacity for self-care. This resulted in a breakdown in communication due to the professionals' lack of understanding in managing such situations (Cranley et al., 2020; Goossens et al., 2020).

The staff shortage and work overload led to a deficit in care (Ludlow et al., 2021). Surprisingly, this was not seen as a problem by most older people; instead, they saw it as an opportunity to complete simple tasks without assistance. This was a circumstance that older people had to face, as their ability to perform activities was underestimated, assumptions were made that they could not manage, and the mistake of substituting instead of assisting was made, leading to a progressive increase in more dependent users requiring a more significant amount of care (Ludlow et al., 2021). This discovery underscores the potential pitfalls of assuming the capabilities of older people and adopting a substitution rather than assistance approach, leading to a misinterpretation of their needs. This miscommunication, rooted in underestimating the abilities of older adults, contributes to a gradual increase in dependence and a heightened requirement for more extensive care.

In the case of nursing home care settings, maintaining a sense of spirituality was crucial and often one of the aspects that went unnoticed by healthcare staff, along with the right to privacy (Ludlow et al., 2021). Regarding this point, establishing a communicative relationship of trust was important, especially in this clinical environment, as it allowed not only older patients to communicate their affected needs but also to express aspects of unsatisfied care, which hindered the process of adaptation and sense of belonging to the new place they were in (Gonella et al., 2021; Ludlow et al., 2021). Additionally, tailored information such as services or social activities could enhance older people's autonomy (Bennett et al., 2020; Garvelink et al., 2020). Regarding activities, conversations with people who shared common interests were preferred (Bennett et al., 2020).

12 | PATTERN 3: NONTHERAPEUTIC COMMUNICATION IN END-OF-LIFE CARE

Finally, the third study pattern integrated the last two themes: discrepancies and controversies in SDM and advance care planning as a communication strategy (Appendix S6).

End-of-life care was a topic of great controversy, often leading to discrepancies between the preferences of informal caregivers and the older people themselves (Gonella et al., 2021). Families tended to opt for nonaggressive care or palliative treatments to alleviate the clinical aspects associated with the last moments of life (Gonella et al., 2021). However, there was sometimes therapeutic obstinacy as they needed to exhaust all possibilities before giving up any hope of improvement. This issue arose from poor communication with the healthcare staff, leading to the creation of false hopes.

Older patients' preferences often differed from those of their caregivers. In many instances, the lack of conversations about care preferences resulted in situations where family members assuming the role of caregiver were unaware of the options considered by the older people (Gonella et al., 2021, 2023). Furthermore, life circumstances and experiences proved to be of great importance to older patients, as they influenced their perspective on different types of treatment (Sopcheck & Tappen, 2022).

As an emerging solution, advance care planning proved to be a helpful strategy to address communication absence in SDM (Bennett et al., 2020; Goossens et al., 2020; Laging et al., 2021; Sopcheck & Tappen, 2022). The reason for the occasional lack of advance care planning was often rooted in unawareness, both on the part of the older patient and the family (Sopcheck & Tappen, 2022). Even once aware, there were cases where SDM planning was delayed until the very moment of deterioration, thus developing delayed health communication (Gonella et al., 2021). However, this communication strategy had some limitations concerning the inflexibility of decisions, religious and cultural beliefs, and the rapidly changing clinical context (Laging et al., 2021).

13 | DISCUSSION

This study highlights the crucial role of health communication in SDM regarding older patients in community settings. We also emphasise the significance of interdisciplinary collaboration among healthcare professionals, particularly nurses and nursing assistants, which is instrumental in enhancing the quality of care and overall patient satisfaction (Campbell et al., 2020).

Furthermore, our findings underscore the potential of new technologies in facilitating effective health communication for older patients, their families and healthcare staff. We delve deeper into the transformative role that technology can play in healthcare communication for older patients, examining specific examples of technologies and their direct impact on both patients and healthcare professionals (Sen et al., 2022).

Turning our attention to the communication with the families and informal caregivers of older patients, it becomes evident that they have a strong desire to actively participate in the decision-making process regarding the care of their older loved ones. This necessitates a more detailed examination of communication dynamics with family members and informal caregivers, as suggested by Puurveen et al. (2018). Every clinical encounter with healthcare staff allows families to contribute valuable insights into the patient's life history and preferences. This section also addresses the importance of fostering regular, informal communication and the need for ongoing evaluations following the implementation of communication measures.

In addition, communication with older patients must be based on respect and trust, particularly given the discomfort they may experience during transitions from their homes to care facilities. Furthermore, we should acknowledge the importance of nonverbal communication, which, as Höglander et al. (2023) argue, is often overlooked despite its potential to reveal emotional or physical discomfort.

To recognise the problem, it is essential to ensure that older patients have sufficient time and information about their health issues and the various diagnostic and therapeutic options available. This consideration is explored further as we delve into the complexities of therapeutic communication. The care transition model developed by Groenvynck et al. (2021) emphasises that emotional support should accompany communication during the transition of older patients from home to care facilities. Significantly, this emotional support should extend beyond residential settings, as highlighted by the integrative review conducted by Pun et al. (2018), which emphasises the extensive community context and the need for support among noninstitutionalised older individuals visiting primary care centres.

Moreover, patient involvement in decision-making requires a more comprehensive examination. Our results indicate that older patients strongly desire to be actively involved in all aspects of their care. However, it is crucial to recognise that determining a patient's capacity to assume this responsibility is multifaceted. This notion is explored further, considering the influence of emotional and cognitive factors on a patient's ability to engage in decision-making, as discussed by Duque-Fernández et al. (2020) and Parada Muñoz et al. (2022).

Finally, the challenges associated with end-of-life communication warrant a closer look. Delivering complex news challenges nurses, often leading to nontherapeutic communication due to fears of extinguishing hope. However, as older patients approach the final phase of life, they desire clear and objective information about prognosis and clinical course. We also delve into the contrasting findings regarding the engagement of older people, as suggested by Saretta et al. (2022). In this sense, patients need to take the initiative in making decisions regarding their end-of-life care, while healthcare professionals must be prepared to provide support during these crucial moments. Thus, working on end-of-life care and the entire palliative care process is necessary. For these reasons, healthcare professionals need training and guidelines on involving older people in decision-making and addressing communication about palliative care (Saretta et al., 2022).

Last, ethical conflicts in SDM communication about end-of-life care, particularly concerning the risk–benefit relationship and respecting the older patient's dignity. The family's preference for pain and suffering relief throughout the entire process leading

to death, sometimes intensifying therapeutic interventions occasionally leads to disregarding healthcare recommendations, as noted by Sierra Leguía et al. (2019). This can result in a contradiction in the principle of autonomy, as pointed out by Medeiros et al. (2020).

In conclusion, this comprehensive examination of health communication in the context of shared decision-making with older patients underscores its multifaceted nature. Interdisciplinary collaboration, technological advancements, family involvement, nonverbal communication, patient empowerment and ethical considerations are pivotal in achieving effective, patient-centred healthcare communication. Recognising and addressing these complexities is crucial for improving the quality of care and the overall well-being of older patients in community settings. As we move forward, it is imperative that healthcare professionals and researchers continue to explore innovative approaches and strategies to optimise health communication and shared decision-making further, ultimately ensuring that the voices and preferences of older patients are at the forefront of their care.

14 | IMPLICATIONS FOR NURSING PRACTICE AND POLICYMAKERS

The findings of this integrative review highlight the gaps that still need to be addressed regarding health communication between nursing professionals and older patients in the community setting within SDM.

Implementing educational measures on health communication, ranging from job training for all healthcare professionals, mainly the nursing staff, is deemed necessary. Nurses are the closest healthcare providers to older people and their families and are essential to care coordination. This training could be beneficial if it focuses on verbal and nonverbal health communication, especially for older people with cognitive impairments or verbal limitations.

Furthermore, nursing research could continue to develop and refine specific communication plans for end-of-life situations in conjunction with advance care planning, an intervention proven beneficial in this study.

Similarly, the lack of primary studies addressing the cultural and gender aspects of health communication related to SDM between older adults and nursing professionals highlights that these specific communication plans could be integrated with SDM protocols and further adapted to the social determinants of health, especially after the challenges posed by the effects of the COVID-19 pandemic, which are still present to this day.

15 | STRENGTHS AND LIMITATIONS

This is one of the first integrative reviews on health communication regarding SDM between older adults and nursing professionals in the community setting that provides an overview of the influential factors in its development, as well as situations at end-of-life care where health communication becomes crucial to reconcile SDM between the formal care team, the family and the informal caregiving environment. Another strength of this review is the methodological transparency the research team has followed to facilitate future investigations that continue the path outlined in other clinical settings and serve as an incentive for further primary research on this topic.

However, this review has several limitations. First, only 12 articles from five English-language databases were included; any missing studies could have added additional information. This could be attributed to the narrow focus on nursing professionals as the sole healthcare staff study participants.

Furthermore, not all the studies included in this review provided sufficient characteristics to contextualise the participants of each study, such as segregated information by sex or gender. Nevertheless, this has helped us highlight this deficiency for future researchers considering this issue.

16 | CONCLUSION

This comprehensive review affirms that effective health communication is pivotal in shaping SDM dynamics between nursing professionals and older individuals within the community context. The transparent exchange of information, objectivity and direct communication, coupled with establishing a trustworthy relationship, emerge as crucial elements influencing SDM. The study underscores the communicative role of nurses and emphasises the importance of maintaining interdisciplinary and horizontal communication channels with older patients, including their informal caregiving network.

The communicative actions inherent in SDM are strategically aligned with preserving the autonomy and independence of older individuals for as long as possible. Additionally, the review succinctly characterises older patients in the community setting as proactive participants inclined to communicate and receive information regarding their health and the measures available to enhance their physical, emotional and affective well-being.

Conversely, the review sheds light on communication challenges, particularly in end-of-life situations, stemming from deficiencies in communication among older individuals, healthcare professionals and families. As illuminated in this study, advanced care planning emerges as a tangible solution to address these communication shortcomings.

AUTHOR CONTRIBUTIONS

EJ-A and PM-A conceived the study and the study design. EJ-A and PM-A developed and executed the search strategy and conducted the initial review, data evaluation and analysis. MA-P supervised the search strategy. AL-JM and JM-MR facilitated theoretical knowledge. EJ-A and MA-P wrote the first draft. AL-JM, JM-MR and MA-P edited the draft of this study. All the authors read and approved the final manuscript. Funding for Open Access charge: University of Cordoba/CBUA.

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No conflict of interest has been declared by the authors.

DATA AVAILABILITY STATEMENT

The data that supports the findings of this study are available in the supplementary material of this article.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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