Geriatric Mental Health Training Series: Revised

Getting the Facts:

Effective Communication with Elders

Support Materials

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Getting the Facts:
Effective Communication with Elders

CONTENTS

The revised version of this training module includes the following components. To facilitate use, some components are combined in a file, others are located in independent files, and all are provided in at least two formats – the electronic processing format in which they were created (Microsoft Word or PowerPoint) and a PDF version. A brief description of each is provided to enhance overall use of these training materials.

- Statement of Intended Use: Contained in this file. Provides guidelines for use of the training materials.
- Statement of Purpose, Learning Objectives, Content Outline: Contained in this file. Provides guidance about both content discussed in the module and provides the basis for applying for continuing education credits for teaching the module to a group of people. The program is about an hour long.
- Notes for the Instructor: Contained in this file. Provides an overview of the goals of the module, along with suggestions to personalized the content and make the training more individualized to the audience.
- Handouts, Bibliography: Contained in this file. Handouts that address program content are provided. These may be used independently, or in conjunction with handouts made from PowerPoint. The bibliography is provided for your reference and consideration. As before, these materials are provided in two formats to best accommodate all users.
- PowerPoint Program: Separate file(s), provided in both PowerPoint format and in PDF (slides only). The module contains 57 slides. If opened using PowerPoint, they may be viewed and used in a variety of ways: 1) slides may be shown in Presentation View using a projector, 2) lecture content is provided in Notes View, and may printed for use to lecture, 3) slide content may be printed as handouts. Because some users may not have PowerPoint, the slides have also been converted into a PDF file which allows you to print a hard copy and make overheads or 35mm slides if desired to accompany the training program.
- Lecturer's Script: Separate file (s), provided in Microsoft Word and PDF format. This content provides the narrative to accompany and explain the slides and is also found in Notes View in the PowerPoint program.

Supportive Materials: List

The following materials are found in this file:

- Statement of Intended Use (1 page)
- Purpose, Objectives, & Content Outline (3 pages)
- Notes for the Instructors (4 pages)
- Handouts
  - ✓ Overview of Communication (1 page)
  - ✓ Barriers to Communication (2 pages)
  - ✓ Interventions to Improve Communication (3 pages)
- Bibliography (2 pages)

Statement of Intended Use

This training module is provided by the Hartford Center of Geriatric Nursing Excellence (HCGNE), College of Nursing, University of Iowa, as a free service. The training program, "Getting the Facts: Communicating with Elders" is revised and updated from a module by the same title that was first published in *The Geriatric Mental Health Training Series (GMHTS).* The GMHTS was developed and evaluated during a five year grant from The Division of Nursing, Bureau of Health Professions, Department of Health and Human Services, Grant # D10NU2711801, between 1989 and 1994. Other titles in the GMHTS include:

- Whose Problem Is It? Mental Health and Illness in Long-term Care Centers
- Help, Hope, and Power: Issues of Control and Power in Long-term Care
- When You Are More Than Just Down in the Dumps: Depression in the Elderly
- When You Forget that You Forgot: Recognizing and Managing Alzheimer's Type Dementia, Part I (Introduction and Overview)
- When You Forget that You Forgot: Recognizing and Managing Alzheimer's Type Dementia, Part II (Interventions)
- Acting Up and Acting Out: Assessment and Management of Aggressive and Acting Out Behaviors

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Getting the Facts:
Effective Communication with the Elderly

Purpose:

Both family and paid caregivers may overlook various barriers to effective communication with impaired older adults and consequently misinterpret verbal and behavioral messages. The importance of communication as fundamental aspect of human relationships is underscored. General principles of the communication process are reviewed with an emphasis placed on problems created by attitudes and beliefs, various types of disease and disability that may affect the older person, and environmental features of health care settings. The potentially detrimental effects of task-oriented care, and attitudes that "talking is not working" are emphasized. Strategies to promote more effective communication are offered.

Objectives:

1. Explain how communication contributes to person-centered care.
2. Give examples of nonverbal communication, verbal communication, and the context of communication.
3. Explain how attitudes and/or beliefs can affect the communication process.
4. Describe how changes in hearing and vision may affect an older person's ability to communicate.
5. Identify 2 common diseases or disabilities that can interfere with an older person's ability to communicate.
6. List 5 things that caregivers can do to improve communication with elders

Content Outline:

Introduction and overview

"Chain of events" and behavioral symptoms

Getting the facts: Observing, reading, listening, asking

Barriers to effective communication

Six key ingredients

Purpose of Communication

Communication: More than the exchange of information

Task-oriented care interferes

Value of being person-centered

Caring and communicating are inseparably linked

Basic components of communication

Communication as a process

Verbal vs. nonverbal messages

Context or environmental influences

Importance of sensitive listening

Perception, evaluation, transmission

Attitudes and beliefs

Case history & illustration

Stereotyped attitudes affect outcomes

Age-related changes

Sensory losses/changes

Reaction time

Effects of disease or disability

Dysarthria

Oral health problems

Lung disease

Brain injury & disease

Stoke, head trauma

Dementia

Multiple factors interact

Environmental factors

Physical environment

Expectations shape social environment

Influence of facility values & culture

Interventions

Communicate concern

Show interest in positive as well as negative

Slow down and be person-centered

Adjust the environment & routines

Increase sensory information

Decrease environmental noise, distractions

Assure personal comfort

Allow time to respond, give cues

Adjust language, terminology

Adjust approach: receptive abilities

Monitor nonverbal messages

Adjust approaches: expressive abilities

Summary

Notes for the Instructor

In this program we expand on the idea of "looking beyond the behavior" that was introduced in the program, "Whose Problem Is It?", and offer staff more information about possible causes of behavioral and psychological symptoms and methods to improve interactions with residents.

The title of this program, "Getting the Facts," is intended to underscore the need to look for the "chain of events" that led to the "problem" behavior observed in the older adult. This approach is intended to help staff see that the "problem" is actually only a symptom of another, underlying issue or concern. Assessment, or "getting the facts," then, becomes the vehicle by which staff are able to identify the "real" problem, and subsequently to develop interventions to assist the resident to function in a more adaptive and healthful manner.

The communication process is integral to "getting the facts." To identify the underlying problem and factors that precipitate or aggravate the difficult behavior, caregivers need to be able to communicate effectively with the older person, the family, other staff and professionals. As a result, basic components of the communication process are introduced and applied to older adults.

The rationale for emphasizing assessment and communication, which is fairly basic to patient care, is that most day-to-day care providers are not nurses. The vast majority are nursing assistants who haven't had the educational preparation to understand all the different factors that can affect the resident's ability to get along with others. Likewise, care in assisted living residences is typically provided by universal workers who have little or no training.

Of equal importance, recent research documents that while nurses often have been educated in communication skills, in practice, they tend to neglect psychosocial care, including talking with patients, and more likely to focus on physical cares. The task-oriented emphasis of most care settings results in nurses and other caregivers “doing things to” older adults versus “talking them through care. Task orientation too often creates unwanted dependence, arouses resistiveness and resentment, and contributes to a downward spiral of avoidance and frustration.

Lack of knowledge and skills too often contributes to seeing all behavioral symptoms as "problems." For example,

> Older adults may be viewed as "manipulative" when the person is actually mentally impaired because of dementia.
>
> Hearing impaired older adults may be labeled as "confused" because they didn’t hear the question and then responded "inappropriately."
>
> “Uncooperative” and “verbally agitated” behaviors may be triggered by staff behaviors, verbal or nonverbal, which unintentionally offend, upset, or embarrass the older person.

There are lots of possibilities, but once the older adults is labeled as "difficult" or "confused" or as a "problem," there is increased risk that staff will

1) avoid the person,

2) not attempt any type of rehabilitative or remedial intervention with the person, and/or

3) actually precipitate or "participate in" the difficult behavior by becoming defensive or engaging in power struggles.

As a result, it is critically important to reinforce the need for assessment of the "real" problem -- in the older adult, and *potentially in the staff*.

In this revised edition of the communication module, we place an increased emphasis on the importance of person-centered care, and the critical role that communication plays in developing and maintaining human relationships. This emphasis is the result of research evidence that continues to support the fact that most nursing care emphasizes *physical care* and *communication with patients ONLY as it relates to the provision of physical care*. Psychosocial aspects of care are too often neglected – creating an opportunity for frail older people to feel devalued and demoralized.

Regrettably, considerable evidence continues to support the fact that task-orientation, and the attitude that “talking is not working” is the result of administrative polices of the institution in which care is provided. The impact of these often “unwritten” but “clearly communicated” rules within organizations creates a climate of care in which caregivers may actually be AFRAID to spend much time talking with older adults in their care. They FEAR being labeled as “slacker” and may also be worried about “retaliation” – such as being assigned the most difficult patients with which to work, the worst hours, or other “indirect” punishments. In short, considerable additional work is needed to assure that nurses and other nursing personnel not only understand the VALUE of communication with older adults, but are also SUPPORTED to provide psychosocial care!

We begin the program by asking staff to think about possible barriers to communication. We find that this approach is often very effective in identifying problems and issues that are relevant to YOUR care setting (e.g., the place where you/staff work). We suggest that you continue to integrate ideas and/or problems identified early in the program as barriers are reviewed to personalize the content to your unique setting.

After reviewing basic information about the purpose of communication and the communication process, we discuss various barriers, including attitudes and beliefs, age-related changes, diseases and disabilities that may interfere with communication, and environmental influences. The goal is to think about the array of factors that may impede caregivers’ assessments of older adults, and their long-term ability to interact with the person.

Although we do NOT say this directly in the program, it is important staff understand that “talking” with older adults and other care recipients should always focus on THE OLDER PERSON and his/her situation, needs, and activities. We DO NOT endorse psychosocial

interactions in which caregivers disclose and discuss their personal problems, issues, and needs with the older adults to whom they provide care. We acknowledge that exchange of information between caregivers and older adult care recipients in long-term care settings is often social in nature, but the emphasis must continuously be placed on the older person and his/her needs. Staff should be helped to identify "appropriate" versus "inappropriate" levels of personal disclosure to residents and tenants (or hospitalized patients, for that matter).

One alternative is for facilities to offer "staff support" groups or activities to assure that caregivers do, in fact, receive needed assistance to discuss problems, ventilate feelings, and problem-solve about current challenges in their lives. Employee assistance program that provide counseling as a service may also help caregivers cope with personal issues, and in turn, be more tolerant and emotionally available to older adults in their care.

As we noted in our "General Instructions," we do ask that you "try out" the concepts and interventions in advance of teaching the program so that you can relate, from you own personal experience, how they may work out in a real life setting with a real, live resident! After reviewing the program materials, think about the following questions and suggestions and make some notes to yourself in the margin of the lecturer's script or the handouts.

1. If possible, think of an example to illustrate how communication is a fundamental aspect of human relationships.

2. Consider developing two sets of interventions, one that emphasizes "instrumental communication" and the other that illustrates "person-centered" care for a specific older adult that everyone knows. Use this "case" to discuss ways that care approaches might be adapted in your care setting.

3. Practice your nonverbals and be prepared to do "show and tell" during the program: frown, gesture, cross your arms, etc. -- not just when the script says to do so, but throughout the program! Remember, how it is said is as important as what is said!! Be sure to overemphasize the "s, sh, and ch" sounds for your audience.

4. Watch yourself in the mirror. Can you see anything that you didn't notice before about your nonverbal message? Do you have any habits that might be misleading? (E.g. I frown when I am thinking and sometimes people think I'm mad at them.)

5. Can you relate an experience (personal or professional) in which your lack of "sensitive listening" may have contributed to difficulties? Or in contrast, can you think of an example when listening for meaning really made a difference in the outcome?

6. Can you think of a situation (personal or professional) where your attitudes or your belief system led you to a false conclusion? Can you tell a story about that?

7. Who in your facility has sensory impairments (particularly those who are hard of hearing)? Can you think of an example of miscommunication that resulted from their lost abilities?

8. Do you have any residents who are edentulous? Or suffering from COPD? Do they have difficulty speaking clearly at times?

9. Do you have any residents with a neurological disorder that may affect their ability to speak, but who are mentally intact?

10. Do you have any individuals with dementia who have difficulty with language? Have you seen any evidence of receptive or expressive aphasia? For example, do they have trouble finding words? Or with correct use? Do they substitute phrases? (E.g. "what-cha-ma-call-its.")

11. Can you think of someone who has aphasia because of stroke? What kind of losses do they have?

12. Discuss YOUR care setting, and ways to improve communication – both between caregivers and older adults and between caregivers. If possible, address known barriers to communication in your unique care setting, and generate a list of ideas about how to improve quality of care and quality of work life for staff by adjusting routines and approaches, and modifying factors in the physical, social, and organizational environment.

If you taught "Mental Health and Illness" you may have asked staff to try to observe residents and look for various psychological and behavioral symptoms (and to think about how these behaviors affect staff). If so, you may want to ask staff, at the end of your presentation, to think about older adults on this “list” who might be having communication problems.

Again, DO REVIEW THE HANDOUTS in advance and be prepared to give examples of both the problems and the interventions!

As always, *HUMOR IS APPRECIATED*! Tell a joke about miscommunication if you know one. My favorite goes like this:

Helen and George were sitting on the front porch. Helen was swinging in the swing, doing her needlework, and George was in the chair nearby, whittling. It was a nice spring day and they were just enjoying each other's company and the good weather. Then Helen put down her needles and turned to George and said, "George, whatever did happen to our sexual relations?" George looked at her, and scratched his head. He thought for a long time and then said, "You know, I honestly don't know. I don't think we even got a Christmas card from them last year, did we?!"

Overview of Communication

Communication is the largest single factor in [terms of] what kind of relationships we with have with others and what happens to us in the world. – Virginia Satir, 1972

Purpose of Communication: to exchange information AND to maintain relationships with other people. Communication is

- a fundamental aspect of all human relationships
- the way we "connect" with other people

Caring and communication are inseparably linked. You cannot hope to communicate effectively if you do not care about the person on the receiving end.
– P. Morrison & P. Bernard, 1997

Components of the Communication Process

Sender: person sending the message

Receiver: person taking in the message

Verbal message: the words that are actually spoken.

Nonverbal message: the way that the words are spoken, including the look on your face, your tone of voice, the posture of your body, and gestures that you use.

Feedback: the return of information to the sender

Context: the physical and social environments or settings in which messages are sent

Perception: our ability to select, organize, and interpret sensory information into an understandable and meaningful picture of the world;

-- perception is affected by our sensory abilities.

-- there may be differences between our perception and "reality."

-- behaviors and responses depend on what is perceived!

Evaluation: our ability to analyze the information we receive; the ability to take it in and make sense of it based on past experiences and knowledge.

Transmission: the actual expression of information from the sender to the receiver (verbal and nonverbal messages).

Barriers to Communication

AGE-RELATED CHANGES

With advancing age, all five senses tend to decline. Changes in hearing and vision are most likely to affect communication, but other losses may affect how we think about older adults.

Hearing: A general loss of hearing may result from disease, noise, or bone changes; gradual loss of ability to hear certain sounds such as "S, SH, and CH" and high frequencies is common

Vision: Changes in vision often include reduced ability to see distant objects, objects that are too close (even faces) and certain colors; loss of ability to see to the sides (peripheral vision) is common

Smell and Taste: Reduced ability to smell and taste (both good and bad things) is experienced.

Touch: Reduced ability to feel touch in general; also reduced ability to feel hot, cold, and pain may be experienced

Reaction time slows: More time is needed to "process" the information and come up with "the answer"

DISEASE AND DISABILITY

Many different types of disease, illness, and even medication side-effects may alter the person's abilities to communicate.

Dysarthria: A medical term that is used to mean that a person has difficulty speaking because they aren't able to form (articulate) the words; speech may be slurred or difficult to understand

Oral Health: Loss of teeth may impair speech; medication side-effects that decrease saliva and cause "dry mouth" may interfere

Lung disease: Inadequate "wind" or respiratory capacity to speak can make the person difficult to hear or understand; e.g., emphysema, asthma, COPD

Brain Injury: Several different types of brain disease and injury may result in loss of language

Aphasia: The medical term that is often used for disease-related loss of language; may be either receptive and expressive; type of impairment include the loss of ability to name items, put together sentences, understand and act on what is heard and read or write

Expressive aphasia: involves the loss of ability to express oneself through speech

Receptive aphasia: involves the loss of ability to understand the spoken word

Stroke: Cardiovascular accident (CVA), commonly called stroke, destroys brain cells in specific areas of the brain; losses tend to be stable; may create either receptive or expressive aphasia

Head trauma: Injury that causes brain cell death; losses tend to be permanent and stable

Dementia: Alzheimer's and other types of dementia destroy brain cells gradually with loss of language occurring over time; losses are permanent and interfere with every aspect of person's ability to communicate

Multiple factors: Brain diseases, particularly dementia, cause many different types of disability along with loss of language; taking time to understand lost abilities AND long standing habits and traits is essential to high quality of care

ENVIRONMENTAL FACTORS

The physical and social environment in which communication and care occurs may have positive or negative influences. Taking time to think about the health-care setting in which you work with older adults may help identify factors that should be changed or adjusted.

Physical environment: Characteristics of health-related facilities, like nursing homes and assisted living facilities, influence the quality and quantity of interactions; factors to consider include noise, confusion, competing demands for the person's time or attention, inadequate lighting, living configurations that are not conducive to social interactions

Social environment: Role expectations in health care settings, including the "task-orientation," of staff, beliefs that "talking is not working," and fears of being viewed as lazy for talking with older adults, have a negative impact on psychosocial care

Facility culture: Unwritten organizational "policies" that emphasize physical tasks vs. psychosocial care may be communicated "top-down" by supervisors to day-to-day care providers; changing facility culture to value psychosocial care enhances satisfaction among older adults and promotes positive outcomes

Interventions to Improve Communication

Apply principles of person-centered care

- Let the person know you care through your
  - ✓ tone of voice
  - ✓ facial expressions
  - ✓ words
  - ✓ gestures
  - ✓ ability to listen to criticism, complaints, sadness without disagreeing, "correcting," retaliating, or withdrawing
- Apply principles of sensitive listening
  - ✓ Listen without interrupting, cutting the person off, or "tuning out" what is being said
  - ✓ Listen for MEANGING. What is the real problem?
- Take time to be interested in the things that are right (positive parts of their life) as well as to talk about their problems
  - ✓ Show interest in positive attributes/strengths while talking about problems
  - ✓ Over emphasis what is "wrong" may leave the person feeling worse
  - ✓ Listen thought-fully to personal stories, experiences: What is the person saying?
  - ✓ Reinforce strengths, abilities, what is going well for person
- Slow down and focus on the PERSON, what he/she is saying, doing, communicating!
  - ✓ Hurried, task-oriented approaches interfere with seeing the person as a human being
  - ✓ Talk while cares are being provided, and not ONLY about the care itself!
  - ✓ Think about the older person, long life lived, meaning of the current situation

Adjust the environment and routines

- Accommodate changes in vision
  - ✓ Provide more light so that the older person can see you

- ✓ Avoid standing too close so that you don't get blurry
- ✓ Stay in front of the person where they can see you
- ✓ Use yellows & reds vs. greens and blues for signs or markers
- ✓ Make sure that glasses are clean, comfortable, and ON the person!

- Accommodate changes in hearing
  - ✓ Make sure that the person can read your lips.
  - ✓ If you need to talk louder, try to lower your tone of voice.
  - ✓ Check for earwax buildup.
  - ✓ Make sure hearing aides are IN and batteries are fresh!
- Look carefully at the effects of the environment
  - ✓ Is noise interfering with your attempt to communicate?
  - ✓ Is the room light enough for them to see you and read your lips?
  - ✓ Are they afraid that someone else will hear what they are saying, or that you will be interrupted? (e.g. Is their privacy being respected?)
- Assess the person's level of personal comfort
  - ✓ Are they physically comfortable?
  - ✓ Are they distracted by hunger, thirst, pain, or needing to use the toilet
  - ✓ What are they thinking or feeling? How might that interfere?

Adjust how you interact with the older person

- Think about your approach and language
  - ✓ Give them time to answer your questions or tell you what they have to say (Remember: reaction time slows!)
  - ✓ Use words that are familiar and understandable; avoid medical jargon and slang
  - ✓ Be clear and concise; avoid long, wordy explanations or instructions
- Adapt your approach to accommodate changes in RECEPTION
  - ✓ Use "yes/no" questions if needed to help participation

- ✓ Try large-print instructions or signs to improve function
- ✓ One-step instructions may increase comprehension and cooperation
- ✓ Add physical gestures to verbal cues to get the person started
- ✓ Limit choices to two options as needed to promote success

- Give them cues to help them think about "when" something happened or "how long" it's been going on
- Check out what they are "telling you" with their nonverbals
- Take responsibility for misunderstandings; apologize and explain what you were thinking/experiencing
- Adapt your approach to accommodate changes in EXPRESSION
  - ✓ Listen for meaningful words and ideas, trying to identify the main theme or goal
  - ✓ Respond to the person's emotional tone and validate feelings (e.g., understandable to feel frustrated, angry)
  - ✓ Accept/understand cursing or other foul language as an expression of distress and discomfort – not an "insult" to you
  - ✓ Using guessing (e.g., trying to replace words the person is having difficulty saying) based on how well you know the person and the relationship you have; guessing can been annoying to the person and may further increase confusion

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