Staff-resident communication practices in residential aged care: Strategies for enhancement

Facilitator notes for communication training workshops

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Staff-resident communication in residential aged care

The role of communication in residential aged care

Communication plays an essential role in maintaining resident autonomy and sense of self, and ultimately affects mental and physical wellbeing (Tinney 2006; Nussbaum, Pecchioni et al. 2000; Kitwood 1997). It provides opportunities for making sense of being old and in care – old people see no special significance in age, but are simply themselves grown older (Kaufman 1986; Keith 1982). Self-esteem hinges on personal control, respect and dignity (Coleman 1995). A person-centred rather than task-centred approach to care allows for recognition of the whole person, including the value of that person’s previous history and experience as well as present worth as an adult human. Conversely, communication of ageist attitudes and stereotypes can undermine resident confidence, self-esteem and wellbeing. These disrespectful attitudes can be communicated through:

- Language to and about older people: use of pejorative, disrespectful, dismissive language and attitudes, ignoring or ‘talking over’ (Hummert, Shaner et al. 1998).
- Use of Secondary Baby Talk (patronising, infantilising language and tone; authoritarian, parental ‘bossy’ language and tone of voice, ignoring etc. (Caporael 1981; Caporael 1983).
- Care practices – not seeing the whole person, not consulting, not allowing residents the right to make choices and have them executed.
- Underestimating the older person: impaired communicative capacity is frequently interpreted as impaired cognitive capacity. Negative expectations of older person’s capacity/value as a conversation partner are frequently self-fulfilling, resulting in loss of confidence, self-blame, and unwillingness to try to communicate (Ryan, Hummert et al. 1995).
- Failure to confirm the resident as a person of value, denial of full adult status.

Impact on residents

A common deficit for residents in care is unmet social needs; lack of meaningful, supportive communication, resulting in:

- Lack of opportunities to tell own stories (validating own lives, recognising current selves and seeing continuity in who they are i.e. making sense of being old) (Tinney 2006).
- Loneliness, loss of previous conversation partners, social groups and support systems, (Savishinsky 1991) loss of feeling of being ‘in place’ (McHugh 2003). This also entails a threat to identity.

Barriers to communication

- Residents’ own health; physical, cognitive and communication impairments (Gravell 1988).
- Institutional barriers: physical factors (building design and layout, width of doorways and corridors, size and placement of furniture, lighting, privacy, environmental noise etc) (Nussbaum, Pecchioni et al. 2000; Black et al. 2006).

- Institutional barriers: social (cultural and social norms generating the organisational hierarchy, routines, values and attitudes of staff) (Tinney 2006).

**The role of staff-resident communication**

Many aged care staff are rewarded by building relationships with residents, and have higher levels of job satisfaction when they can do so. Many prefer aged care to acute care because of these relationships, and those who see communication as an integral part of the job are often stressed when they are unable to meet residents' needs. "Good relationships seem to be integral to enhanced job satisfaction and retention of staff" (Nay, Closs et al. 1998).

Staff are best equipped to meet residents’ needs with:

- A person-centred care model which recognises the whole person, and fosters dignity and respect.
- Staff ratios and mixes which allow for flexibility in work routines.
- Continuity of staffing, mentoring of new staff.
- Orientation and professional development programs: general awareness raising, breaking down of negative stereotypes, recognition that old people have the same needs and rights as the rest of the community; fostering of empathy, capacity to imagine how they would like to be treated themselves; communication skills – awareness of value-laden language and conversational behaviour; communicating respect; communication with speech, hearing, or vision impaired residents; respect for cognitively impaired residents. Old people are not like children (Hockey and James 1993).
- Practical training in use, fitting and maintenance of hearing and vision aids.
Facilitator notes

Important: These notes are suggestions, not directions about how to conduct the training sessions. It is expected that facilitators will decide how applicable the notes and activities are for a) their own groups, b) the length and format of the training session and c) their own confidence and experience in conducting training sessions on similar or related topics. Similarly, facilitators are advised to adapt the length of the training sessions and the number of slides used at a single session to fit their training needs.

Module 1

Slide 1 - Introduction

i) Introduce yourself and welcome the participants – check for names, make sure they know each other
ii) Using Handout 1 (workshop aims and learning objectives), explain why this is an important topic and why the workshop is being offered.
iii) Show slide 2, and briefly explain the breakdown into the following subject areas.

Slide 2 - Overview

What is communication? Why is it important? NB it is a fundamental element of person-centred care
Communication needs of residents. This section will include the topic of ageism
Staff role in meeting residents’ social needs
Barriers (and enablers) to good communication
Building resident self-esteem/positive communication

Discussion

Ask the participants to work in groups of 3-4 (or fewer if overall numbers are small) to discuss the questions raised, then to report back to the larger group. Answers can be recorded on butcher’s paper if you have the space for participants to spread out, or on simple A4 paper.

a) What is communication?

Any contribution to the discussion is acceptable – the goal is to get people thinking about the different elements of good communication
b) Dual role of communication in residential care

c) Effects of positive and negative communication. Get ideas from the groups.

d) Understandings of person-centred care.

As a group look at handout 2. Person-centred care is more than just being kind – it sees the whole person. Carers try to put themselves in the shoes of the residents.

*Slide 3 - Communication*

a) Some elements of communication:
   - A message/sender/receiver
   - Words, gestures, facial expressions, body language, tone of voice, attitude
   - Active listening
   - Speaking clearly

b) Dual role = care delivery and emotional support

- enabling good physical care and resident safety
- providing companionship and emotional support – reminding residents that they exist and matter
- good communication reduces misunderstanding, leads to better diagnosis and understanding of resident needs
- higher resident self-esteem
- reduced resident loneliness

c) Effects of positive communication

Ask participants what makes them feel good about themselves. Answers might include:

- Being taken seriously
- Being recognised by others
- Being respected
- Feeling accepted
- Feeling useful in some way
- Feeling like a competent adult
- Having a sense of control
- Being encouraged to feel independent
Slide 4 - Effects of negative communication

- Feeling left out or rejected
- Loneliness increased by lack of opportunities for conversation or other social interaction
- Loss of confidence and lower self-esteem – if expected to fail, will fail. If not expected to hear or understand, will be less able
- Infantilising or demeaning communication can make an older person feel of little value and without power.

Infantilising communication behaviour (as if to a child) includes ignoring, talking down, talking over, using baby talk, or being bossy.

Ask the question – “How do you feel when others are rude, critical or impatient eg bus drivers, service people, bank clerks, sales assistants”.
Short role play (optional)

Role play:
Ask one or two pairs of volunteers to demonstrate non-listening behaviour. One tries to tell an interesting story about what happened last weekend (for example) and the other avoids eye contact, and makes no response at all. Ask for comments/observations from the role players and the group.

Slide 5 – Communication needs of residents

Small group discussion: participants discuss and record their answers to the following questions:
1. What are the social needs of residents?
2. What are some of the barriers and enhancers to good communication in this setting? Give examples.

Feedback to larger group
1. What are the social needs of residents? Possible answers:
   - the same as the needs of any other group – to have human contact, affection, relationships
   - to feel safe
   - to have opportunities to communicate
   - to participate socially, achieve tasks and use skills
• recognition, social support, if a person has always liked music or football, he/she is likely to still like it

NB – Older people in care often have a reduced social circle. The loss of previous partners and friends means loss of recognition and the chance to be seen as an interesting and valued person. It is important to provide opportunities for residents to talk about the past, remember achievements.

This question may prompt a discussion of ageism, with Handout 2 as a backup providing a list of beliefs and attitudes about older people and their needs. Ask participants to discuss these statements with a partner for one or two minutes, then feed back for discussion as a group. It is important not to judge participants who might express ageist views, but to open the discussion to arguments against these. For example, in what ways are older people different from children? (psychological differences; adult status in the law; lifetime experience). What evidence is there to suggest that older people don’t worry about privacy or do not have sexual needs?

Possible answers:
• there is no definition of ‘older people’. Older than what?
• they are all generalisations which suggest that ‘older people’ are a single unit rather than a very diverse group of individuals. The evidence suggests that older people are as different from each other as any other age group (or more different because of the longer lives and wider range of experience they have had).
• there is no evidence for any of the claims.

Encourage participants to list the factors which might make older people different from each other rather than from other age groups.

Slide 6 – Staff role

What can staff do to meet residents’ social/communication needs?
• Answers are likely to include both positive and negative comments – try to focus on good communication practices staff already employ.

Negative comments are likely to include time, work pressures, fear of leaving others to carry the work burden, frustration etc.

What can staff do? Some possible examples:
• Greet residents and address them by name; wave if you’re too busy to stop
• Try to find time to talk to residents
• Combine conversation with care tasks
• Ask residents about their families; tell them about yours (or your dog or garden)
- Include isolated residents in conversations and activities

**Slide 7 - Barriers to good communication**

What prevents staff from doing more?

Elicit suggestions from the whole group. These might include:
- Time; workloads; resident health/cognitive/communicative capacity; resident personality; cross-cultural barriers; management practices
- Staff knowledge, attitudes, personality, physical condition and mood

Some might say they don’t know how to do more – who or what could help?

Discuss Handout 5

**Slide 8 – Communicating positively (i)**

Points to highlight:
- person-centred care – looking at the individual behind the appearance and behaviour; putting the person at the centre of their care
- stereotyping and negative expectations of resident ability:
  - What makes us think a resident is not capable of understanding or making a decision? Do we change our behaviour because of what we expect or what we know?
  - Do we ever confuse deafness with dementia?
- relational communication – conversation aimed at strengthening social relationships. Compare reasons for saying good morning to colleagues, for asking family if they have slept well.

Questions to consider:
- How can we make the most of time spent with the resident during care tasks?
- Where are the opportunities for making people feel that they matter?
- What does it mean for a resident to be talked about in his presence?
Slide 9 – Communicating positively (ii)

1. How can words be contradicted by facial expression or tone of voice?
What does an irritable tone of voice or an expression of impatience suggest? How can polite words be contradicted by these? (Think of false “Have a nice day” messages)

Role play exercise (optional). In pairs practise saying “I’m sorry” and “Thanks” using as many tones of voice and facial expressions as possible

2. Empathy: standing “in their shoes”

What do you do when you don’t know what a resident wants? Do you know the resident well enough to be able to imagine the answer?
Can you put yourself in her shoes? What would you want? What would you want for your mother/grandmother?

Slide 10 – Building resident self-esteem

1. Respect is communicated by:
   - Language used to talk to and about residents (and other older people)
   - Tone of voice and facial expressions
   - Actions – body language; behaviour; respecting and carrying out resident wishes (where possible); remembering promises.

2. Adult status is reinforced by respect, avoidance of bossiness or baby talk

3. Autonomy – respect for wishes, encouraging sense of control

4. Privacy – challenge of respecting the body (nakedness, body functions); bodily functions (bowel and bladder functions); health status and records; personal space; private life

Slide 11 – Review of this session (optional)

This slide allows for review of what has been covered during the session, and feedback from participants.

Slide 12 – Outline of topics in Module 2 (optional)

Outline of topics to be covered in Module 2.
Module 2

Slide 1 - Introduction
Welcome the participants, and make sure everyone is comfortably seated where they can see you and each other. If there are new participants in the group, ask everyone to introduce themselves in turn, and say a few words about themselves, i.e. their roles, experience or interests.

Slide 2 – Overview of the session
Identifying and overcoming communication barriers

Communicating with people from different cultural backgrounds

Dealing with dementia

Slide 3 – Individual resident barriers to communication
This section outlines individual resident barriers, and later slides will focus on strategies for trying to overcome them.

1. Ask for suggestions about aspects of physical condition which might affect a resident’s interest in talking or listening, or ability to communicate and understand.
   Answers might include: pain, illness, tiredness, level of disability. Staff might know of residents who are more capable on different days, or at different times of day, for example after they have exercised or rested, or before or after medication.

2. Ask for suggestions about factors affecting emotional condition.
   Answers might include:
   mood, personality, availability of social support (do visits from family and others make a difference?), loneliness, a negative experience with another resident or staff member, bad news e.g a bereavement, a deterioration in physical condition. Group members will probably be able to add other ideas.

3. What are some reasons why residents’ cognitive capacity might vary/Fluctuate?
   Answers could include:
   Medication regime; general health status; infections (eg UTIs); time of day; behaviour of other residents; activities program/diversional therapy.

4. Sensory impairments: These include hearing, speech and vision. Participants will probably all be familiar with challenges for residents with hearing and speech difficulties.
Ask them to think about the barriers presented by loss of vision, especially where there is also hearing loss.

- Lack of visual support to aid comprehension – no lip-reading, or picking up other cues from face and body expressions
- Lack of contextual cues – ie objects like a cup of tea, thermometer, medication trolley, meals menu etc.

**Slide 4 – Environmental barriers**

Using the group’s knowledge of this and other facilities, ask for opinions about environmental barriers to communication:

**Barriers** might include:

a) Physical environmental factors:
   - Building layout/design – size of rooms, length/width of corridors
   - Furniture size and placement
   - Ease of access to dining and dayrooms and outdoor areas
   - Noise, lighting

b) Social environmental factors
   - Staff time and work routines
   - Staffing practices – staff mix; use of Agency staff;
   - Lack of training/mentoring
   - Other???

Ask group for suggestions about ways barriers could be tackled.

**Slide 5 – Managing environmental noise barriers**

This slide asks staff for a few strategies for overcoming environmental noise barriers. Ask the group for comments and other suggestions.

Some points to consider:

1. Hearing aids vary in quality, fit and condition. If in doubt, have the resident’s hearing and the aids checked. Regular cleaning, replacement of batteries and correct fitting will help the resident to hear as long as the hearing aid is in order.
2. Consider alternatives to turning on the dishwasher while residents are still at the table
3. Residents may choose meals they will not eat if they do not hear correctly, or give misleading answers to questions eg queries about pain levels
4. Television noise can be a snowballing problem. Residents may increase the TV volume to mask noise from other sources, further increasing ambient noise levels.

**Slide 6 – Addressing hearing impairment**

This slide offers some strategies for overcoming hearing difficulties.

Ask participants for comments and suggestions. How do they attract residents’ attention? What other strategies do they use? Encourage discussion of residents staff know well, and their strategies for helping them to hear.

1. Attract the person’s attention, either by speaking or touching if appropriate, but in the least startling way
2. Greet the person by name, and if necessary repeat your own name
3. Make good eye contact, and keep your face in view, especially your mouth, while you are speaking – NB avoid speaking from behind the person’s back
4. Speak clearly and as slowly as the resident needs you to. Trial and error will find the right pace. You may need to raise your voice, but not to shout.
5. Use normal adult language – tone, vocabulary, grammar etc – avoiding over-simplification (and distortion) of language by dropping words from sentences or using baby-talk.
6. Repeat, but rephrase if the resident does not understand the first time (different words, a shorter sentence).
7. Provide a context (extra information words, props or actions to help the person know what to expect). NB We hear and understand partly by knowing or guessing what is likely to be said (predicting).
8. Avoid unfamiliar slang or use of words out of context. The listener is using predictive techniques to process indistinct sound patterns, and will be confused by information which does not fit with expectations.

**Slide 7 – Addressing speech impairment**

Ask participants how they deal with speech difficulties. These are a few suggestions.

1. Be unhurried. Allow plenty of time, and stay relaxed yourself. This should help the resident to relax.
2. Give encouragement without adding pressure. If the words do not come, suggest that you might come back later.
3. Repeat what you think the person has said, and ask for agreement. Check with simple yes/no questions, or point to objects
4. Use pencil and paper if they help; get help from another staff member who knows the resident well (if available).
5. Do not pretend to understand. You may be completely wrong, and you will be making the situation more frustrating for the resident. It’s always best to be honest. Apologise for not having understood, and try again when the resident has had time to relax.

**Slide 8**

Ask staff what they think about these two questions. In particular, ask staff from CALD backgrounds about their own experience, and any special problems they can identify.

**Challenges** may depend on previous language and employment experience, length of time in the country, confidence etc.

- Could have problems with range of accents, and with modifying own for the situation
- Language – ‘false friends’ are words which look similar but have different meanings in another language.
- Understanding paralanguage – tone of voice, underlying meanings of whole statements, not just the individual words.
- Styles of communication of other staff as well as residents
- Expectations; cultural factors a) of the community b) of this particular workplace
- Finding appropriate communication styles
- Written communication

**Possible strategies:**

Find a staff mentor; attend all training courses available through the workplace; talk to other staff.

If pronunciation is a big problem, find a short language course; try to develop awareness of problem words or phrases; speak English with a range of audiences (if possible); listen to radio or watch TV.

**Slide 9**

Communicating with residents from different language and cultural backgrounds

Ask for suggestions from the participants – how do they deal with language and cultural difference? Discuss their strategies as well as those suggested here.

It is important to always treat the resident:

a) with respect

b) as an adult – finding appropriate forms of politeness can be difficult, but it’s good for everyone if residents and families know you are trying.
What communication aids do the participants find helpful? Encourage discussion. Tip: Remember to use correct English sentences. It may confuse the listener if normal grammatical components are dropped.

Slide 10

Check how many staff have attended dementia awareness workshops and/or used training packages. Ask how staff feel about their level of skills in giving the best care to residents with dementia.

The points on this slide are reminders, useful to help new staff understand some of the behaviour of a resident with dementia.

Important points to note:

- Dementia is an illness of the brain affecting many aspects of a person’s behaviour, but it does not take away personhood. Some behaviours may be a real problem to be managed, but it’s important to ask how big the problem is, who it is a problem for, and what steps are necessary to ensure resident safety.
- There are a number of different causes of dementia, and symptoms can be different (for example, language loss in Alzheimer’s Disease will be different from the symptoms of vascular dementia, or dementia with Lewy bodies or Parkinson’s Disease).
- Each person with dementia is an individual - there is no One Size Fits All, no ‘them’. Each person will have different symptoms, feelings, levels of awareness, fears, and responses to situations.
- The person with dementia does not choose to be ill, dependent, confused and afraid. He may be overwhelmed by chaos – above all needs regular routine, people who make him feel safe.

Reminder: Dementia is not comparable with childhood. Some behaviours, like repetitive questioning, might be like a child’s, but the reasons for them are different, and the need for reassurance different.

Although the person with dementia is likely to need comfort and nurturing, he/she is an adult.

Slide 11

Ask the group to discuss the list of communication barriers and make comments and suggestions from their own experience.

Slide 12

Ask the group what they understand to be the social and emotional needs of the person with dementia.
Answers will vary, but in discussion of their suggestions, it is important to emphasise that the needs of a person with dementia are the same as those for every person.

Some suggestions:

- To feel safe, **to have reassurance and stability**.
- To have human contact, **affection, relationships**.
- To feel happy and comfortable.
- To have opportunities to communicate.
- To participate socially, **achieve tasks and use skills (previous interests, hobbies)**


Slide 13 – Strategies for overcoming communication barriers (Handout 2)

Use handout 2 to check staff knowledge and encourage them to identify their own good practices. Ask the group for their suggestions – it is important to share their experience and expertise with less experienced or confident staff.

Some of the suggestions on the handout apply to most residents, but others are especially important for people with dementia.

Use these suggestions to promote discussion. **It is important to acknowledge that staff who are stressed and pressed for time may find it difficult to follow these guiding principles at every encounter with a person with dementia.**

Tips

- It is difficult to always be patient, but important to continue to try!
- The best way to anticipate and deal with challenges is to know the resident well, and continue to learn about each individual’s likes and dislikes
- Compare your knowledge of residents and your communication strategies with other staff
- Consult lifestyle staff and residents’ families
- When you have tried everything without success, ask for help.

See Module 2 Handout 3 for comments from staff in project partner facilities.

Slide 14 – Dealing with ‘problem behaviours’

Using handout 4, ask group to describe a resident, the behaviour which is problematic, and try to define case (antecedents) and effect (results). How do they help this resident?
Ask participants to fill in the evaluation sheet, and check that they have copies of any handouts you have referred to.

Thank everyone for their attendance and participation in the workshop and close the session.
References


