Communication with Cognitively Impaired Residents/Patients

2 Contact Hours

Learning objectives

- Explain the difference between cognitive impairment and dementia. Give an example of each.
- Describe the characteristics of Alzheimer’s disease (AD).
- List and describe strategies to enhance communication with cognitively impaired individuals.
- Identify factors that interfere with communication with cognitively impaired individuals. Give an example of each.

Introduction

The role of a CNA often includes assisting individuals with moderate to severe cognitive impairment who require special care. Individuals with these types of cognitive impairments require round the clock supervision, specialized communication techniques, and occasional management of difficult behavior. They commonly need help with activities of daily living (ADLs), such as bathing, eating, transferring from bed to a chair or wheelchair, and using the toilet and/or other personal care.

Individuals with cognitive impairment have difficulty with one or more basic functions of the brain, such as perception, memory, concentration and reasoning skills. Common causes of cognitive impairment include Alzheimer’s disease and related dementias, stroke, Parkinson’s disease, brain injury, brain tumor or HIV-associated dementia. Although each disorder has its own unique features, caregivers often share similar issues and strategies when working with this population.

Cognitive and memory impairments can change how a person thinks, acts and/or feels. These changes often present special challenges for caregivers and family members. One common complaint is difficulty communicating with cognitively impaired individuals. An ordinary conversation, for example, can be quite difficult when the resident has difficulty remembering what has been said from one moment to the next.

As communication is essential to good care, CNAs must be able to overcome some of the common obstacles to communication that they encounter. This chapter will discuss strategies to make communication with cognitively impaired individuals more effective.

WHAT IS COGNITIVE IMPAIRMENT?

Cognitive impairment is a problem associated with the brain that may affect thinking, speaking, understanding or remembering. These problems may be permanent, or they may come and go – depending on whether they are the result of Alzheimer’s disease, stroke, brain injury or illness. In some cases, individuals suffer loss of cognitive function due to mental illness; others experience it as a side effect of some medications[1].

WHAT IS DEMENTIA?

The term “dementia” describes a group of symptoms that are caused by changes in brain function and cognitive impairment. Dementia refers to brain disorders that significantly affect a person’s ability to carry out daily activities. Dementia symptoms may include asking the same questions repeatedly; becoming lost in familiar places; being unable to follow directions; getting disoriented about time, people, and places; and neglecting personal safety, hygiene, and nutrition. People with dementia lose their abilities at different rates[2].

Damage to brain cells occurs with aging and causes dementia in some people. It creates language and communication difficulties along with disturbed cognition, loss of memory, altered personality traits, poor decision-making, and poor coordination/balance. Dementia is caused by multiple factors. Some conditions that cause dementia can be reversed; others cannot. The two most common forms of dementia in older people are Alzheimer’s disease and vascular dementia. These types of dementia are irreversible, which means they cannot be cured. Reversible conditions with symptoms of dementia can be caused by a high fever, dehydration, vitamin deficiency, poor nutrition, adverse reactions to medicines, problems with the thyroid gland, or a minor head injury.

Nursing consideration #1: Think of a resident in your care that has presented characteristics of cognitive impairment or dementia. What symptoms did he or she have and how did you adapt your skills to assist him or her?

WHAT IS MULTI-INFARCT (VASCULAR) DEMENTIA?

With multi-infarct dementia (MID), a series of small strokes or changes in the brain’s blood supply result in the death of brain tissue. The location in the brain where the small strokes have occurred determines the seriousness of the problem, as well as determines the symptoms that arise. Symptoms that begin suddenly may be a sign of this kind of dementia. People with multi-infarct dementia are likely to show signs of improvement – or they may remain stable for long periods of time, and then will quickly develop new symptoms if more strokes occur. High blood pressure is to blame in many people with multi-infarct dementia. One of the most important reasons for controlling high blood pressure is to prevent strokes.
What is mild cognitive impairment (MCI)?

MCI is different from both Alzheimer’s disease and normal age-related memory change. People with MCI have ongoing memory problems, but do not have other losses such as confusion, attention problems, or difficulty with language. Mild cognitive impairment (MCI) represents a transitional state between the cognitive changes of normal aging and very early dementia. MCI is becoming increasingly recognized as a risk factor for Alzheimer’s disease (AD).

WHAT IS ALZHEIMER’S DISEASE (AD)?

The most common form of dementia is Alzheimer’s disease (AD), which represents 45 to 75 percent of all dementia cases. In 2013, five million Americans had the disease; fourteen million Americans are projected to have AD by 2050[3]. AD is a progressive disease that initially involves the parts of the brain that control thought, memory and language. Although scientists are learning more every day, they still do not know what causes AD, and there is no cure. Researchers believe that genetics play a role in the development of the disease along with diet, environment and other disease factors. AD usually begins after age 60, and the risk increases with age. Although younger people may get AD, it is much less common.

Changes in the brain begin long before symptoms appear: AD begins slowly. The first symptom may be mild forgetfulness and can be confused with age-related memory changes. Most people with mild forgetfulness do not have AD. In the early stage of AD, people may have trouble remembering recent events, activities, or the names of familiar people or things. They may not be able to solve simple math problems. These difficulties may be a nuisance, but they are usually not serious enough to cause alarm. According to the CDC[3], someone

HOW DOES COGNITIVE IMPAIRMENT AFFECT COMMUNICATION?

Communication is the transfer of messages or information. It requires the use of cognition, memory and language skills, as well as the abilities to speak, hear and understand words. These abilities are damaged with many types of cognitive impairment or dementia. This is challenging for both caregivers and residents who need to communicate with one another to attend to daily needs.

A resident may not understand what is being said or may not be able to express his or her thoughts. Impeded communication is aggravating – often contributing to further frustration and agitation – and can make routine tasks difficult. Mood swings and personality changes can be symptoms of cognitive impairment. These issues compound frustration and communication problems. Communication is critical to patient care: The CNA must learn strategies to overcome barriers to be receptive and expressive in language. The CNA must also learn to manage behaviors that may result from cognitive impairment in order to deliver effective care.

Different terms are used to describe the types of problems encountered with cognitive impairment. Communication difficulties include dysarthria: Difficulty articulating words; agnosia: Difficulty recognizing people and things; and apraxia: Difficulty with voluntary movements. Aphasia, which literally means “no speech,” refers to the complete or partial loss of the ability to use or understand words. Aphasia may be the result of a stroke or other damage to the brain. Less severe forms of aphasia may be called dysphasia.

Expressive aphasics are able to understand communication, but may have difficulty sending messages. Receptive aphasics have difficulty understanding messages from others. Individuals with cognitive impairment may know what word they want to use, but will be unable to recall it; they may know what they want to say, but may not be able to articulate it in such a way that others will understand. Individuals often experience a combination of impairments.

Alzheimer’s disease may progressively damage the individual’s ability to communicate. It interferes with pathways in the brain, making it more difficult to recall and to understand words. Individuals with Alzheimer’s disease may feel like they have a word “on the tip of their tongue,” but are unable to recall it. In some cases, a word is incorrectly substituted for another, or the individual repeats the same word or question. Cognitive impairments can be especially challenging because the person’s words or behaviors may make little or no sense to others. Normal communication channels become increasingly difficult – frustrating both the resident and the caregiver.

As people with Alzheimer’s disease become increasingly unable to organize thoughts in a meaningful way, they grow more likely to lose their train of thought and require more time to interpret the words they hear. They may get frustrated or angry about barriers to communication, become agitated, curse or use offensive language. Remember, this is not the person; rather, it is the disease. These behaviors must not be taken personally. The patient may not know whom they are speaking to or why they are upset.

Nursing consideration #2: Think of the residents you assist. What communication difficulties can you identify? Do these difficulties affect their behavior? How do you know? Did you document the connection between communication problems and behavior?

COMMON BEHAVIORS ASSOCIATED WITH COGNITIVE IMPAIRMENT/DEMENTIA

Dementia is often associated with incontinence. Getting to the bathroom is very difficult if a patient is unable to remember where the bathroom is, or does not have the control or the awareness to make it there on time. Be matter-of-fact about pads and other products that protect clothing. If the individual is incontinent, be understanding. Do your best to maintain the individual’s dignity and reduce embarrassment. Because individuals with dementia may forget to go to the bathroom, it is useful to develop a routine to assist them. Be sure to remind the individual at reasonable intervals: Every two hours is usual, but some individuals will not need the facilities as frequently. Some residents find it easier to use a commode, or a toileting chair, which can remain in the bathroom overnight. Drinks with a diuretic effect
(including coffees, teas, sodas, or alcoholic beverages) may be limited, especially in the evening. Reduced liquid intake prior to bedtime may also be helpful – but only as ordered in the patient’s care plan. Careful supervision and assistance must be given to avoid falls.

Dressing

Getting dressed and undressed is often problematic for individuals with severe dementia; they should be guided toward choosing comfortable, practical clothes. Limit the individual’s choices of clothes, as decision-making with too many options can be overwhelming. Put each item of clothing out – one at a time – in the order it should be put on. Encourage the individual to dress him/herself as much as is possible. Always supervise dressing – assist the individual in a seated position, if balance is an issue. Check with the facility for a strategy when addressing cases where the resident wants to wear the same outfit repeatedly. Duplicates of similar styles, colors, and fabrics could solve this particular problem. Soiled clothing should be removed and cleaned. Label items and assure the client that his/her clothing will be returned promptly.

Agitation and frustration

Agitation is a term that refers to a number of behaviors commonly seen in individuals with dementia. It may include irritation, anger, animosity or violence in spoken words or behavior. The individuals may feel “revved up” at night, restless and unable to sleep. He or she may try to get up during the night, putting him/her at risk of falls. Proper safety equipment, such as bed rails, may prevent the individual from falling out of bed, but also may be an obstacle when getting up at night. Remember that each person has different needs and habits that must be addressed. Be sure to document and report nighttime behavior that should be addressed by the daytime supervisor or staff.

A tendency toward agitation increases as the dementia progresses. Like other behaviors, agitation is triggered by specific factors, which may be environmental or situational. Documenting these behaviors and determining the triggers will allow staff to anticipate difficult interactions, plan interventions, and devise prevention strategies. In many cases, the trigger is associated with the loss of control that comes with dementia. Patients with difficulty in expressive language may become aggressive when control is threatened. This is a common occurrence when carrying out ADLs.

Diet may contribute to agitation, such as consuming too many caffeinated drinks. Other common triggers include loud noises, too many people, or too many activities in the room. A feeling of security – achieved through a calm, structured environment, familiar people and surroundings, including furniture, bedding and photographs – can be soothing. Quiet and familiar music, a gentle speaking voice, reading aloud to the patient or taking walks to dispel the nervous energy can be soothing, but do not attempt to physically control or restrain. Express your care and concern regarding the situation. A gentle touch experience by acknowledging the individual’s frustration or agitation.

Frustration occurs when the individual encounters obstacles and finds himself/herself unable to do or say what he/she wants. Acknowledging this frustration is important. Empathize and validate the resident’s experience by acknowledging the individual’s frustration or agitation. A better strategy is to distract the resident by offering another activity that he or she enjoys, having a light snack, or taking a walk. Do not participate in an emotional exchange or argument, as this may increase agitation. Allow the individual to move on to a different topic; do not dwell on the unpleasant incident. Encourage as much independence as possible with ADLs, but do not let the activity become a frustrating or overwhelming experience.

Yelling, cursing, threatening

Many emotional outbursts have feelings of stress or loss of control at their centers. Remain calm and comforting, speak in a low voice, acknowledge and validate the resident’s feelings. Say, “I know it is very frustrating to lose or misplace items. I’ll help you look for it.” Then use the strategy of distraction or redirection with a pleasant activity or snack.

Inappropriate sexual behavior

Sexual comments, public nudity, or public masturbation are unpleasant side effects of some types of cognitive impairment. In rare cases, behavior may be sexually harassing or threatening. Most institutions have specific measures for addressing this behavior. Document all incidences of this and if it is a pattern, try to determine the triggering behavior. Report these behaviors to the supervisor for intervention and treatment.

Hallucination/delusions

Cognitive impairment sometimes takes the form of hallucinations or delusional thinking. The individual may see, hear, or think something that is not real, or may remember an incident that did not occur. Frequency of these events may increase as the disease progresses. Do not argue about what did or did not happen. Instead, state what you perceived and do not dwell on the incident. Keep rooms bright to reduce shadows, which can contribute to “seeing things.” Document and report these incidents, because further treatment may be needed if there is a risk that the individual might hurt him/herself because of hallucinations or delusional thinking. Provide information about activities to help the individual regain awareness of his or her surroundings to bring the patient back to reality. Always calmly reassure the individual that s/he is safe.
Paranoia

One of the unfortunate by-products of dementia is increased suspicion or paranoia – sometimes in the form of accusations against other individuals, including caregivers. Try to determine the triggers of paranoia and the feelings behind the words and actions. If it is fear, confusion or a non-preferred activity, provide structure, try to minimize the activity, redirect, and offer reassurance. Remember, what the person is experiencing is very real to him or her so do not argue or disagree. Paranoia is a common occurrence in patients with dementia and cognitive impairment: Do not to take it personally[4].

The disease may accentuate tendencies (such as competitiveness), or feelings (like jealousy). Let family members know that expressions of paranoia or delusional thinking are a recognized side effect of the cognitive impairment and may be directed at anyone around them.

Repetitive speech and actions

Individuals with cognitive impairment may repeat sounds or words over and over, or may ask the same questions repeatedly. This uncontrollable repetition of a sound or gesture is called “perseveration,” and is sometimes made worse by anxiety.5 Provide comfort and reassurance with words or through a gentle touch, if that is known to be effective with the resident. Be patient and continue to answer the question in an even tone, or try to distract the resident or change the subject. Avoid reminding them that they have asked that question before. Do not discuss future activities until just before an event. Engaging the patient in a new activity can reduce repetitive questioning.

Stay even-tempered and do not get annoyed or tell the patient that he or she has already asked that question before. Urge patience on the part of family members and inform them that this is a side effect of the condition. In some individuals, this effect is made worse by nervousness, boredom, fear or other environmental or situational triggers[4]. In some cases, certain behaviors signal fatigue, hunger, thirst or the need to use the toilet. Try to identify the behaviors or events that trigger the perseveration so you can address the problem, distract or redirect the person before the repetitive patterns begin.

Questions repeated continually such as “What time is lunch?” can be answered on paper and placed where the resident can easily refer to it: For example, writing “Your daughter is visiting at three,” (or drawing a picture of a clock showing 3 o’clock on a piece of paper and putting it where the individual can refer to it) may contribute to a greater sense of control. Pictures or symbols can also be used and limit the numbers of words.

Shadowing

An individual with dementia may follow or mimic a caregiver or may speak nonstop to him or her. This behavior is usually more pronounced later in the day. Stay calm and reassuring, and attempt to distract the resident or redirect attention to something else. Suggest a preferred activity or ask the individual to assist with a simple task they enjoy and can complete easily.

Nursing consideration # 3: Look at the behaviors above. Select three that you have observed among the residents in your care. Describe how the residents expressed those behaviors. What strategies did you use with them? Were your strategies effective? Why or why not? What would you do to change in your practice, based on the effectiveness of your work with these residents?

Wandering

A common symptom associated with Alzheimer’s disease is wandering – an activity in which the individual walks away from home, without an apparent goal. This kind of behavior presents special problems for institutions and individuals who are responsible for the resident’s safety. The individual may not act rationally, may be disoriented, and can be at great risk of getting hurt or suffering from exposure, from hypothermia, or from dehydration. Residents may exhibit no concern for their own safety.

Abut three out of every four individuals with AD wander during the course of the disease. The degree of risk depends on the severity of the dementia[4]. Verbal and nonverbal communication becomes more difficult as the disease progresses. A wanderer can be difficult to locate because s/he acts unpredictably, does not call for help, and does not respond when his/her name is called. When found, a person with dementia may not remember his/her current address, or even his or her own name. The individual may be frightened and found far from where s/he started.

Check with your institution for specific strategies and policies for addressing resident wandering. If a person is missing, a search of the building, grounds and nearby streets and walkways should begin immediately. The individual’s previous home locations or places of special meaning should be searched, along with areas along the sides of roads. Close supervision eliminates this problem completely.

People with Alzheimer’s wander for a number of reasons. They may attempt to go to a former home, work site, or a favorite place. Understanding why residents wander is an important part of keeping them safe. A resident who has just moved to the nursing home may be searching for something or someone familiar. He or she may be looking for a bathroom and/or food or water, but may not be able to remember where these things are located. Some people need to explore their immediate environment periodically to reorient themselves. An individual may be trying to get away from too much noise or stimulation, too many people, or a noisy, cluttered, or confusing environment. As the brain becomes more damaged by the disease, the individual with Alzheimer’s is more likely to feel overwhelmed, which can trigger wandering. If the person appears agitated, disoriented or lost, reassure him or her that he or she is safe and where he or she is should be. The patient may need to be reminded of staff names, the day, month, and year: This is also a good way to start each day. Simple visual cues can be used such as in pictures or on a dry erase board for drawing or writing information, depending on the level of cognition.
Sometimes wandering is associated with a former routine. If wandering occurs at a specific time of day, it may be related to the individual’s former business or family responsibilities. In these cases, it is useful to plan an activity at that particular time. This will distract the individual from the tendency to wander. To reduce the risk of wandering, put away coats, boots, purses, and other visual reminders of going outdoors. Some residents are much less likely to go out without familiar items like a coat, keys or a purse.

There is usually a trigger for wandering; a patient’s triggers can be determined over time. In some cases, wandering fulfills a physical need for activity; it can be associated with stress, or is an attempt to drink, eat or use the bathroom. Anticipating needs and offering a glass of water, a snack or assistance to the bathroom may discourage a wandering episode. Scheduling activities or exercise can help channel action into less wandering and more participation in other activities. Some institutions are able to provide a safe enclosed area where individuals can safely walk or explore. Creating a circular well-marked path or trail allows residents a secure route and an opportunity to stretch their legs. Be sure the individual is supervised at all times.

It is often useful to put signs with pictures on bathroom doors to signify where the toilet is, as residents may forget. Also, putting a “no entry” sign, along with an appropriate image, to keep the individual from wandering from his/her room is effective. A mirror, curtains over a door, a sign that says, “STOP” or a picture of a traffic stop sign may signal a barrier to an individual with dementia. In many cases, individuals with dementia often see obstacles where they do not actually exist. For example, placing a black mat or painting a black space outside the resident’s room may make it appear to be an “impassable space” to those with severe dementia.

**Sundowning**

Many difficult behaviors increase near the end of the day and last throughout the night. This tendency, called “sundowning,” is expressed in agitation, restlessness and disorientation, and is likely to be caused by increased fatigue and disruptions to internal factors that control patterns of sleep[6]. Encourage restful sleep by increasing daytime activity, especially movement or exercise, and in some cases, discouraging naps. Ingredients like caffeine can increase restlessness, so keep foods or drinks with these ingredients limited to early in the day. In some cases, a snack or light meal before bedtime encourages sleep.

Start by quieting the resident’s schedule in the afternoon or evening, introducing preferred structured activities like card or board games, reading aloud or listening to soothing music.

**Minimize stress**

Try to help patients stay calm in the evening hours. Encourage them to engage in simple activities that are not too challenging. Frustration and stress can add to their confusion and irritability. If they have mid-stage or advanced dementia, watching television or reading a book might be too difficult; instead, consider playing soft music to create a calm, quiet environment[6]. Ask the family for some items of comfort, such as a favorite blanket, pillow, Bible or other items to help them feel at ease. Try to learn as much as possible about the patient to determine other calming activities. The patient may relax when read or sung to, for example.

Opening curtains in the morning and closing them at night will reinforce what time of day it is and reduce disorientation. Keep lights on during the day and have a nightlight on at night in the bedroom and bathroom. Put away anything that might hurt the person if he/she bumps into it at night when going to the bathroom. Making sure the individual is safe and supervised at night is critical.

**Nursing consideration #4:** Give three examples of stress among your patients. How do they react when they are stressed? Give three examples and three strategies you could use to minimize or eliminate their stress.

**Diet**

Individuals with dementia may forget to drink and eat, so reminders are important for proper nutrition and fluid intake. Ensuring proper nutrition is even more difficult if there are any barriers to comfortably eating or drinking, like tooth sensitivity or trouble swallowing. Always document and report changes to the supervisor. Additionally, some medications decrease appetite or make other foods taste or appear less appetizing. Assess the individual periodically for weight loss; note any dental or denture issues or problems passing food or liquids. Because individuals with dementia have decreased appetites, a larger number of smaller meals at regular intervals throughout the day may be a better strategy to ensure proper nutrition; however, always remember to follow the prescribed dietary guidelines.

Make mealtimes as enjoyable as possible and encourage the individual to feed him/herself without concern for “table manners” or the correct use of eating implements, as this may be difficult for a person with cognitive impairment. Finger foods are often a good strategy. Cut the food into small bite-size pieces and add spices to suit the individual’s tastes. Drinking from a glass can be facilitated with the use of a straw or a cup with a lid and small opening for drinking. Provide adequate assistance to ensure the resident has eaten enough. Encourage chewing and swallowing by showing these motions yourself, as well as gently touching the jaw to encourage chewing, or stroking the throat to encourage swallowing. Never leave the patient unsupervised due to the chance of choking. Some patients will need to be monitored so they do not eat too fast or take large bites, which may lead to choking or vomiting.

**Hygiene**

Individuals with dementia may forget – or be reluctant to do – tasks related to their personal care and grooming. Elements of proper hygiene, such as brushing one’s teeth and hair, bathing and changing clothes, will likely require reminders or assistance. Because these activities are so personal, having someone assist them may symbolize a loss of control, triggering difficult behavior. It also may be frightening to the resident. Being undressed and cleaned or bathed may feel humiliating to some people: These activities have been done alone since childhood. These situations may be very stressful for both residents and caregivers, as well.
Other suggestions for communication to make the bathing process more successful include the following:

**Before bathing:**
- Determine the preferred time for bathing and set the schedule to establish the routine. Try to follow the patient’s previous bathing routine as closely as possible. Find out if there are preferred soaps, shampoos, or other products.
- Try to determine the correct temperature preference by letting the patient check the water with his or her hand, as you begin fill the tub.
- Give the resident choices for a sense of control: Determine if the patient prefers a bath or a shower and then present the choice of time within set parameters, such as 7:00 AM or 7:15 AM. If the individual cannot respond verbally, use picture cues.
- Involve the patient if possible. Ask him or her to help hold a washcloth, or other easy tasks.
- Consider the patient’s feelings. Is the patient frightened or threatened by the process? Determine the person’s reaction to getting in the tub. It may be better to fill the tub with only two or three inches of water until after the person is seated. Fear of falling in a bath or tub is very common, so help him or her feel as secure as possible, with all the assistive devices or help necessary. Use safety bars and bath mats to reduce the chance of slipping, and install bath and shower handrails or a shower seat. Hand-held showers can make bathing a much easier experience. Assure the patient that you are there to keep him or her safe and assist as needed. Be prepared for negative responses with soothing music, singing, or other activities to comfort, distract or redirected. If the person becomes too agitated, cease the activity. Always have a call button or a light in case other staff needs to assist. Have familiar staff, preferably of the same sex, outside the door or out of sight if you anticipate needing help due to the patient’s size.
- Respect the individual’s dignity and privacy: Always cover the person with a bath towel and blanket when undressing.

**During the process:**
- Be flexible and do not rush the process.
- If the patient has a certain order or bathing preference, follow his or her lead – as long as the end goal for hygiene is accomplished successfully. If he or she cannot communicate preferences verbally, use visual cues instead.
- Talk the person through each step and let them know what comes next. For example:
  - “Put your feet in the tub.” or “Wash your face.” “Now we are going to wash your hair.”
- Model or guide the person through the process. Demonstrate or gently guide the person’s hand through the washing process.
- Try a sponge bath instead. Bathing with a washcloth can be an alternative to a regular bath or shower. Try non-rinse soap products with warm towels applied under the guise of providing a “massage.”

In cases where the individual is very weak or frail, a bed bath may be in order. In this process, the individual is washed incrementally by soaking a part of the body, rinsing with a container of water and towel drying. Ensure that a curtain protects the individual’s modesty, or that the doors are closed during bathing and undressing. Keep a towel covering the breasts, and lower parts of the person and lift the towel to wash these areas.

**COMMUNICATION STRATEGIES FOR ALZHEIMER’S DISEASE AND OTHER DEMENTIAS**

**Getting ready to communicate**

Make sure the individual is prepared to focus on communication. Does he or she require a hearing aid, dentures or glasses? Has he/she just woken up from a nap or is he or she due for one? Trying to speak with someone who is drowsy makes communication more difficult. Always be sure they are fluent in the language being spoken. If not, an interpreter must be provided.

Approach the individual from the front, as you may startle him/her if you are not within the line of vision. Eye contact is an important element of nonverbal communication: It shows that you are ready to communicate. Try to get on the individual’s level so you can look him or her in the eye. Face the person as you speak, as some people with hearing loss or other issues may rely on lip reading more than hearing the words. Use the individual’s name to get his or her attention, and remember to identify yourself.

**Timing**

Timing your communication is important. The resident must be receptive, awake and alert. He or she must be ready to focus and listen to what you are saying. The ability to communicate or understand is more difficult when the resident is confused, sleepy, or medicated. Communication may be more difficult later in the day as the individual grows more fatigued. Some medications have side effects (such as drowsiness or lethargy) that make communication more difficult.

Give your complete attention to the resident. Do not attempt to communicate during other activities that require you or the resident’s full attention. Residents with severe dementia have difficulty focusing on one thing. Save unnecessary conversations for safe times when an ADL is completed; make sure your full attention is on communication.

Allow sufficient time for communication: Everything needs to be slowed down for a resident with dementia. He or she is likely to communicate poorly, or without focus, and may need additional time. Provide ample time. Do not appear rushed or distracted.

**Minimize distractions and noise**

Minimize external noise or distractions. This may require closing a curtain, shutting a door, or turning off a radio or TV – but always ask first. Reduce or avoid any background noise that may be distracting or drown out the conversation. The environment should be bright and quiet. Eliminate clutter, shadows, and sensory overload in the form of too many people, too much talking, or environmental distractions and noises.

**Keep it short and simple**

Communicate simply using common words and short sentences. Avoid hospital lingo. Always refer to other people using their names and a description, if necessary, rather than “him” or “her,” to provide a context for the resident. Example: “Did your daughter, Susan, visit today?” Acknowledge the resident’s response.
Speak slowly in a low tone of voice. Higher pitched voices may be more difficult to hear, while louder voices can sound angry. If the individual does not seem to understand, repeat it more slowly using the same words. If there is still no recognition, rephrase what you are saying or use a nonverbal method to be understood

Slow down and use pauses when speaking. Individuals with dementia cannot process information as quickly, so provide sufficient time for the patient to receive information, respond, or ask questions.

### One step at a time

Discuss one topic (or one part of a topic) at a time. Avoid complicated information and do not provide too much information at once, which can confuse or overwhelm a resident with severe dementia. Break ADLs and other projects into a series of short steps, instead of one long process. Inform the resident about each step, and let him/her complete it before you move on. Assist and remind the patient, as needed.

### Use behaviors to facilitate communication

- **Show**: Use pictures or symbols or show the item that you are talking about, if possible. Show a urinal, for example, and use the word “urinate.” Also, try writing, gestures, or pointing to items that help illustrate what you have to say. Visual clues are very helpful when getting a point across. See below for nonverbal communication.
- **Ask**: Ask only one question at a time and keep the question as simple as possible. The best questions can be answered with a yes or a no. Do not give too many choices. “Would you like a banana or an apple with lunch?” is better than “What kind of fruit do you want with lunch?” The best option is to show both choices.
- **Repeat or rephrase**: If repeating, say exactly the same thing while emphasizing key words. If after repetition the message still isn’t understood, try to find another way of saying the same thing. Repeat questions as needed; it may be necessary to repeat a great deal.
- **Listen**: Good communication requires good listening skills. Don’t interrupt, and give the resident ample time to respond. It may take individuals with dementia up to 30 seconds or more to respond to a question. Be patient, everything takes more time with dementia.

### Situations to avoid

- **Do not ask questions that rely on short-term memory**: Instead, encourage discussion about things that happened long ago in the past; the past may seem more vivid than recent memories. Asking what the resident had for breakfast may just be frustrating.
- **Do not criticize, hurry, correct, argue or contradict**: Focus on the feelings they are trying to express. Avoid rushing communication; be patient.
- **Avoid crowding the individual**: Give him/her “elbow room.” Do not stand over him/her.

### If you do not understand

- **Let the person know you do not understand him/her**: Do not pretend to understand what the person has said if you do not. Nod yes only if you understand.
- **Maintain eye contact and show that you are listening and trying to understand**.
- **Ask questions such as “Does it have to do with …” and end the sentence with categories like “eating,” “sleeping,” “dressing,” etc., to get a clue of what the individual is trying to say**.
- **Use nonverbal communication**, such as props, visual cues, charts, models, pictures or gestures to increase recognition of the message. Take the person to where the toilet is visible, for example. Point to it and then ask if he or she needs to use the toilet.
- **Ask the person what might help them communicate better – including using pictures, writing, or modeling**.
- **Use family, friends, or familiar staff members to assist in cases of difficult communication**: Someone who knows the individual better may be able to interpret what is being said.
- **Respond with verbal and physical reassurance**. Use a gentle touch to communicate and reassure when words do not get through; however, be aware that some people do not respond well to touch.

### Using nonverbal communication

There are two main types of communication: **Verbal (spoken) and nonverbal (non spoken)**. Nonverbal communication includes writing or communicating with signs or gestures, like a “thumbs-up” signal communicates good news. Nonverbal communication is sometimes better when communicating a message to an individual with cognitive impairments. Demonstrating or modeling an action (or using hand gestures) to ask someone to sit up or sit down is a non-verbal cue. Do not gesture near the individual’s face or stand too close, however. This may threaten the patient. A distance of at least eighteen inches is a respectful distance that allows for personal space.

Sometimes body language is easier to interpret than spoken words; watch for gestures and posture. Sometimes we communicate things that are unintended through body language; beware of facial expressions, posture, and movement. While people with dementia often may have difficulty communicating with spoken words, they are often very perceptive at reading nonverbal cues. Watching the way a resident stands and walks, or the look on his/her face to search for signs of pain, for example, can help the CNA nonverbally communicate with a patient when he or she cannot verbally describe how he or she feels.
Tone of voice

Even if you become frustrated, try to keep your voice calm and relaxed. If your words and the way your words are spoken do not match, it may be confusing to the resident. Your tone of voice often sends a clearer message than what is actually being said. Smile and maintain a positive attitude and frame of mind. Keep the tone of your voice pleasant, gentle, respectful and caring. Speak slowly and be reassuring and positive. Use facial expressions and a gentle touch to convey concern or care.

Visual cues

Visual cues are non-spoken ways of communicating important information. Use written language, symbols, pictures, or objects to help communicate meaning. When making signs, use large, easy-to-read letters and focus lighting to emphasize the information. A bathroom sign hung over the bathroom door may be all that is necessary to assist a resident who soils himself because he forgets where the bathroom is located. Different kinds of visual cues exist for different functions.

Elderly individuals are also prone to visual disabilities, such as difficulty seeing in low light. They could have problems with glare or may have age-related macular degeneration, leading to impaired vision. Use contrasting light and dark colors to make the sign as clear and as easy to read as possible, using heavy block print and sharp images.

Asking the resident to point to familiar pictures of common items within his or her environment may help when identifying what he/she needs. Paste these pictures in categories within a simple notebook. One page may be food, another may be activities he or she enjoys. This allows non-verbal patients to communicate their choices. These pictures can replace written language for those people who are limited in their ability to speak, read and write. There are a number of technology devices that can provide visual cues and auditory responses to help a patient communicate.

Nursing consideration #5: Describe three different communication problems you have encountered with clients.

What strategies can you use to enhance your practice in the following areas to address these problems?

• Non-verbal communication.
• Visual cues.
• Timing.
• Minimizing distractions.

Handling difficult situations and behavior

Difficulties communicating about ADLs can lead to frustration on the parts of both the CNA and the resident. Try to be flexible and consider changing the environment that triggers negative behavior. Adjust the plan of action and respond to the person’s needs in a different way. If the resident wants to nap in a reclining chair rather than the bed, and there’s no good reason not to, accommodate the new behavior. Sometimes changing the staff’s response to the behavior is the best way to change the resident’s behavior, so try to accommodate it whenever safety is not an issue.

Because people with dementia have barriers to communication, they may do things we do not understand; however, there is typically a reason for the behavior. Try to determine what triggered the behavior and what the individual is trying to communicate with the behavior. Is he or she trying to escape or avoid something? Is the patient seeking attention the wrong way? The trigger can be anything – such as a change in the environment that the resident finds disturbing. Plan plenty of time to get ready and complete activities at the patient’s pace.

Do not try to control the person or the behavior. This will increase the patient’s sense of loss of control. Always check with a supervisor or staff for strategies to manage behavior issues. Always document the patient’s behavior, actions taken, as well as the outcome. When tasks get difficult because the individual is upset or agitated, try the following:

• **Distract and redirect**: Try to change the subject or shift to a new project. Always acknowledge frustration or feelings before redirecting. Say for example, “I’m sorry you’re frustrated/sad/angry. Let’s try this again later. Right now, let’s go for a walk/get a snack/etc.”

• **Try different approaches to address difficult behaviors**: What works one day may not work the next. You will need to be flexible in trying new things and developing new strategies. Breaking a non-preferred task into a series of simple steps, and then explaining each step beforehand often has a calming effect. Telling the resident what is going to happen and answering questions gives the individual more sense of control.

• **Try to reinforce appropriate language and behavior**: Tell the patient when he or she speaks or behaves appropriately.

• **Consider the words or sentences you are using**: Do they sound as if you are telling a child what to do? When you say, “You need to…” or “You can’t…” it is likely to escalate agitation or anger. Try to be age-appropriate, even though the cognitive level may be limited. Remember that the dementia damages the person’s ability to be rational or logical. As the functioning adult, do not let the difficulty escalate.

• **Appear as nonthreatening as possible**: Backup about three feet to appear as nonthreatening as possible when dealing with an angry or agitated person. Smile and keep a pleasant expression and use a calm tone of voice.

• **Some difficult behaviors have medical reasons**: See if the behavior is a side effect of medication. Document and report behavior changes.

• **Consult staff trained in behavior management**: To assist you in developing a plan to keep everyone safe.

Important points

• Keep your sense of humor and do not take anything personally. Remember that personality changes are a part of dementia for many people. In most cases, it is the disease, not the person. Treat the resident with compassion and affection.

• The resident’s reasoning and judgment will decline over time. Avoid arguing or conflict, as the most likely outcome is increased anger and frustration for both of you.

• Be flexible. There may be a better time to approach the situation when the person will be more receptive and cooperative.

• Set priorities. Focus on what is most important to accomplish if the individual is having a difficult day.

• Recognize that you are human and have limitations. You will have good days and bad days. Self-care and support from peers is important on those bad days.
● Not all strategies work with all residents. Due to cognitive changes, a strategy may work one day and not the next. The CNA must develop and plan a variety of strategies that they are comfortable with using and be flexible and patient when scheduling activities and daily living skills.

### Nursing consideration #6: Review the behavior strategies above. Which ones have you used in your practice? Were they effective? Why or why not? Which strategies would you use in the future to enhance your practice?

### OTHER TYPES OF PROBLEMS THAT AFFECT COMMUNICATION

There are many other kinds of conditions that make communication with residents/patients more difficult, especially when coupled with cognitive impairment. Other obstacles to communication for patients with cognitive impairments include:

- Respiratory impairment.
- Nutrition or hydration issues.
- Inability to discriminate foreground and background noise.
- Illness or disease.
- Surgery.
- Weak or absent voice.
- Laryngeal edema/infection.
- Inability to understand or speak the English language.
- Oral deformities.

#### Strategies for communicating with the visually impaired

- Consult a vision therapist if possible.
- Use Braille materials if the person is able to use that method.
- Introduce yourself when entering the room and identify anyone else who is present.
- Inform the patient upon leaving and explain who else is staying.
- Use the name of the person you are speaking to when addressing him or her.
- Offer to read a menu or other written information, when necessary.

#### Strategies for communicating with the hearing impaired

- For many individuals with low vision, a bright light may help.
- Speak the person’s name and gently touch the individual to let them know you are listening.
- Say what you are doing as you do it, so the individual will know what is going on and what was done.
- Let the resident take your arm for guidance.
- Do not move anything in the room unless asked to by the resident.

- Consult with speech and language therapists, if possible.
- For those who wear hearing aids, ensure that the hearing aid is in the person’s ear, is turned on, and has a good battery. If there are still problems, document and report the issue for further evaluation.
- Speak in front of the individual, and face him or her. Engage in eye contact.
- Never speak while chewing gum or eating.
- Keep hands away from the face and mouth when speaking.
- The hard of hearing are often less able to understand if fatigued or ill.
- Minimize background noise.
- Speak clearly without shouting.
- Write messages if necessary: The person may be able to read or use pictures.
- Try a different way to communicate using gestures. If the patient does not understand, include visual aids or technology.
- Communicate simply, with short sentences, statements, or questions.
- Use body language, gestures, and other cues to assist with communication.

### Conclusion

Cognitive impairment and dementia are complex problems that may eventually affect all brain functions. CNAs should have a basic understanding of these disorders and how they impact their delivery of care with patients. Each patient will be affected differently, and at different rates, as the syndromes progress.

In addition to knowledge about the different types of brain disorders, CNAs must gather as much information on their patients and be focused on changes that may occur slowly at first. Careful documentation and collaboration with staff and supervisors can inform their practice to deliver the best possible care.

### Communication strategies are critical when delivering services effectively. CNAs must be patient, flexible, persistent and equipped with verbal and non-verbal approaches to help build communication systems with their patients.

A challenging barrier to communication with these patients may be behavior manifestations that result from brain changes. CNAs must understand that these behaviors are part of the disease process, and must learn how to work through them to achieve effective communication with their patients. The CNA’s care and the patient’s well-being will be enhanced through effective communication: This is the first step to building a relationship of trust.

### BIBLIOGRAPHY

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<thead>
<tr>
<th>Question</th>
<th>True</th>
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<tr>
<td>1. Individuals with cognitive impairment have difficulty with one or more of the basic functions of their brain, such as perception, memory, concentration and reasoning skills.</td>
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<td>2. Alzheimer’s disease is the most common form of dementia, which represents 45 to 75 percent of all dementia cases.</td>
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<td>3. Break ADLs and other projects into a series of short steps, instead of one long process. Inform the resident about each step, and let him/her complete it before you move on. Assist and remind the patient, as needed.</td>
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<td>4. Avoid arguing or conflict, as the most likely outcome is increased anger and frustration for both of you. Be flexible, but you must set priorities and accomplish your schedule – even if the patient is having a difficult day.</td>
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<td>5. Other obstacles to communication for patients with cognitive impairments include: Respiratory impairment, nutrition or hydration issues, inability to discriminate foreground and background noise, illness or disease.</td>
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