CHAPTER 3
COMMUNICATION WITH COGNITIVELY IMPAIRED RESIDENTS/PATIENTS
(2 CONTACT HOURS)

Learning objectives

- Define “cognitive impairment” and name some different types of cognitive impairment.
- Distinguish between cognitive impairment and dementia.
- List and describe strategies to improve poor communication with cognitively impaired individuals.
- Name other conditions that negatively affect communication with elderly individuals.

Introduction
As a CNA, you are likely to care for an individual with cognitive impairment, as many institutions take care of adults with this condition. Individuals with moderate to severe cognitive impairment often require special care, including supervision round the clock, specialized communication techniques, and 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, using the toilet and/or other personal care.

Cognitively impaired people have difficulty with one or more of the basic functions of their 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 common problems, situations and strategies in 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 from one moment to the next what has been said.

Because 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, while others experience it as a side effect of some medications. The following section will discuss different types of cognitive impairments and the special challenges they raise.

What is dementia?
The term “dementia” describes a group of symptoms that are caused by changes in brain function (cognitive impairment), and 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.

Damage to brain cells that occurs with aging 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, and 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 and poor nutrition, bad reactions to medicines, problems with the thyroid gland, or a minor head injury. In these cases, conditions should be treated as soon as possible.

What is multi-infarct (vascular) dementia?
In multi-infarct dementia (MID), a series of small strokes or changes in the brain’s blood supply results in the death of brain tissue. The location in the brain where the small strokes occur determines the seriousness of the problem and 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 remain stable for long periods of time, then quickly develop new symptoms if more strokes occur. In many people with multi-infarct dementia, high blood pressure is to blame. 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 like confusion, attention problems, and difficulty with language. Mild cognitive impairment (MCI) represents a transitional state between the cognitive changes of normal aging and early dementia and 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 among older people is Alzheimer’s disease (AD), which initially involves the parts of the brain that control thought, memory, and language. Although scientists are learning more every day, right now they still do not know what causes AD, and there is no cure. AD usually begins after age 60, and risk increases with age. While younger people also may get AD, it is much less common.

AD begins slowly. At first, the only symptom may be mild forgetfulness, which can be confused with age-related memory change. 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. Such difficulties may be a bother, but usually they are not serious enough to cause alarm.

However, as the disease progresses, symptoms are more easily noticed and become serious enough to cause people with AD or their family members to seek medical help. Forgetfulness begins to interfere with daily activities. People in the middle stages of AD may forget how to do simple tasks like brushing their teeth or combing their hair. They can no longer think clearly. They can fail to recognize familiar people and places. They begin to have problems speaking, understanding, reading, or writing. At some point, people with AD may become anxious or aggressive, or wander away from home. Eventually, patients need total care.

How does cognitive impairment affect communication?
Communication is the means by which we transfer messages or information. It requires the use of thought (cognition), and is dependent on memory, the use of language and the abilities to make, hear and understand words. These abilities are damaged with many types of cognitive impairment or dementia. This can be challenging for both caregivers and residents who need to communicate with one another to take care of daily needs.

A resident may not understand what you are saying, or not be able to express what’s on his/her mind. Impeded communication is aggravating, often contributing to further frustration and agitation, as well as increasingly difficult situations. Additionally, mood swings and personality changes can be a symptom of cognitive impairment, itself a risk factor for charged interactions. Because misunderstanding or not receiving messages from the resident is potentially detrimental to him/her, it is important that you learn about dementia so you can make communication easier and reduce difficult behavior.

Each individual confronts his/her own obstacles to communication. 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, and 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 have difficulty sending a message, while receptive aphasics have difficulty understanding a message from others. Individuals with cognitive impairment may know what word they want, but not be able to recall it, or may know what they want to say, but not be able to say the word in such a way that others will understand. Individuals often experience a combination of impairments. Other types of aphasia include:

- Anomic: Able to understand and speak, but may have difficulty with word retrieval.
- Broca’s: Able to understand others and speak slowly with small number of words; apraxia.
- Conductive: Able to understand speech, but may confuse sounds and words.
- Global: Unable to understand words or communicate with words; may repeat meaningless syllables.
- Wernicke’s: Able to speak but may be poorly understood and inclined to repetition; difficulty understanding others.

Alzheimer’s disease, language and memory
Alzheimer’s disease eats away at an individual’s ability to communicate. It damages 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 again and again. Cognitive impairments can be especially challenging because an affected person’s words and behavior may make little or no sense to you. Normal communication channels become increasingly difficult, frustrating both the resident and the caregiver.

As people with Alzheimer’s disease are 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 what you’re saying. They may get frustrated or angry with their barriers to communication, getting agitated, cursing or using offensive language. Remember, this is not the person, but the disease.

Common behaviors associated with cognitive impairment/dementia
Dementia is often associated with incontinence. Understandably, getting to the bathroom is very difficult if you don’t remember where the bathroom is or don’t think of it in time. Be matter of fact about pads and other products that protect clothing. Some medications are very effective in helping incontinence, so consulting a urologist may be in order. If the individual does not make it to the bathroom in time, be understanding and 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 for using the bathroom. 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, which can remain in the bathroom overnight. Drinks with a diuretic effect (including coffees, teas, sodas, or some alcoholic beverages) should be limited, especially in the evening. Reduced intake of beverages of all kinds before bed may also be helpful.

Clothing can be another obstacle for the individual with cognitive impairment who needs to use the bathroom. Knots, belts and buttons can be difficult to navigate. Clothing with elastic waistbands or Velcro closures can facilitate the process of disrobing and dressing before and after using the toilet.

Dressing
Getting dressed and undressed is often problematic for individuals with severe dementia. Choose comfortable, practical clothes with easy to open and close devices like snaps, Velcro, zippers and few, if any, buttons. Limit the individual’s choices of clothes, as decision-making with too many options can be overwhelming for someone with dementia. Put each item of clothing out, one at a time, in the order in which it should be put on, and encourage the individual to dress him/herself as much as is possible. Check with your institution for a strategy for addressing the situation in cases where the resident wants to wear the same outfit repeatedly. Soiled clothing should be taken away and cleaned.

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, and 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.

A tendency toward agitation increases as the dementia progresses. Like other behaviors, agitation is triggered by specific factors, which may be environmental or situational. The better you know a resident, the better you will be at anticipating difficult interactions. In many cases, the trigger is associated with the loss of control that comes with dementia, with behaviors like agitation expressing themselves when control is threatened, which may occur in carrying out ADLs.

Individuals prone to agitation should be limited in their consumption of caffeine and refined sugar, which can increase agitated behaviors. Other common triggers include loud noises and too many people or things in the room. A feeling of security, achieved through a structured environment and familiar people and surroundings (including furniture, bedding and photographs), can be soothing, as can quiet and familiar music, a gentle speaking voice, reading aloud to the patient or taking walks to dispel the nervous energy.

Frustration occurs when the individual encounters obstacles, finding him/herself unable to do or say what he/she wants. Acknowledging the frustration is important. Empathize and validate the resident’s experience by acknowledging the individual’s frustration or agitation, and express care and concern regarding the situation. A gentle touch may be soothing, but do not attempt to physically control or restrain the individual as this can contribute to out-of-control feelings that can further agitate him or her.

A better strategy is to distract the resident by offering another activity that the resident enjoys, like having a snack or taking a walk. Don’t allow yourself to be drawn into an emotional exchange or argument, as it will only increase agitation. Allow the individual to move on to a different topic, and 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 and loss of control at their center. Remain calm and comforting, speak in a low voice, acknowledge (validate) the resident’s feelings (“I know it’s very frustrating to lose or misplace items. I’ll help you look for it.”) Then use the strategy of distraction with a pleasant activity or snack.

Inappropriate sexual behavior
Sexual comments, public nudity or public masturbation are an unpleasant side effect of some types of cognitive impairment. In rare cases, behavior may be sexually harassing or feel threatening. Most institutions have specific measures for addressing this behavior. If this is a pattern, try to determine the triggering behavior. In some cases, medication may be an option.

Hallucination/delusions
Cognitive impairment sometimes takes the form of hallucinations or delusional thinking, in which the individual sees or hears something that others don’t see or hear or remembers an incident that didn’t occur. Their frequency may increase as the disease progresses. Do not get drawn into arguments about what did or didn’t happen. Instead, state what you perceived and do not dwell on the incident. Keep rooms bright to reduce shadows, which may contribute to “seeing things.” Medication may be in order if there is risk that the individual might hurt him/herself because of hallucinations or delusional thinking.

Paranoia
One of the unfortunate byproducts of dementia is increased suspicion or paranoia, sometimes in
the form of accusations against other individuals, including caregivers. The disease may accentuate tendencies such as a competitive nature, or feelings, like jealousy. Let family members know that expressions of paranoia or delusional thinking are a recognized side effect of the cognitive impairment.

Individuals with dementia may misplace things frequently; they may, for example, hide money and forget where it is. It is sometimes helpful to have the resident keep a small amount of money in a purse, pocket or hiding place, and remind him or her where it is if he/she is concerned it is missing. When an item is missing, help the resident look for it or remember where he/she put it. A resident may have a customary hiding place for money or jewelry, and the “lost” items may appear there.

Do not get drawn into an argument about what happened to the lost item or try to convince the individual that the item was just misplaced (rather than stolen). Let the resident know you are concerned on their behalf and take their emotions seriously. Accusations are often an expression of fear and loss of control. Imagine how scary and frustrating it would be to feel that your personal possessions were being taken or moved and you couldn’t trust the people around you.

**Repetitive speech and actions**

Individuals with cognitive impairment may repeat sounds or words over and over, or ask the same questions repeatedly. This uncontrollable repetition of a sound or gesture is called “perseveration,” and is sometimes made worse by anxiety. Be patient and continue to answer the question in an even tone, or try to distract the resident or change the topic. Getting the individual engaged in a new activity can reduce repetitive questioning.

Stay even-tempered and don’t allow yourself to get annoyed or tell the patient he already asked that question before. Urge patience on the part of family members and tell them that this, too, 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. In some cases, certain behaviors signal fatigue or the need to use the toilet.

Questions repeated continually, like “What time is lunch?” can also be answered on paper and put where the resident can 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 can contribute to a greater sense of control.

**Shadowing**

An individual with dementia may follow or mimic a caregiver, or 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 an activity or ask the individual whether he or she can help you, then give them a simple task that they are able to carry out.

**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. A “critical wanderer” is an individual with dementia who has voluntarily wandered away, leaving the care of a caregiver. This kind of behavior presents special problems for institutions and individuals responsible for the resident’s safety, as the individual may not act rationally and can be at great risk of getting hurt or suffering from exposure (hypothermia, dehydration). Residents may exhibit no concern for their own safety.

About three out of every four individuals with AD wander during the course of the disease. The degree of risk experienced by the individual is typically affected by the severity of the dementia. As the disease progresses, verbal and nonverbal communication become more difficult. Wanderers who get lost outdoors may become injured or even die of exposure. A critical wanderer can be hard to locate because they act unpredictably, do not call for help, and do not respond when their name is called. When found, a person with dementia may not remember their current address or even their own name. They may be frightened and disoriented, found far from where they 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 as soon as possible. Understanding why residents wander is an important part of keeping them safe. The individual’s previous home locations or places of special meaning should be searched, along with areas along the sides of roads. More effective searches mean less risk to the individual and fewer hours of worry.

Recent research focusing on wandering behavior at one institution showed that “people with Alzheimer’s [who] leave their own residence or nursing home and start to wander … are usually located (89 percent of all cases) within one mile (1.2 km) of the point last seen. If the person is not on the road itself (14 percent), he may be in a creek/drainage ditch (28 percent) or caught in briars/bushes (33 percent). The person is usually found wandering a short distance from a road. The majority of patients succumb to the environment (hypothermia, dehydration) and require evacuation (35 percent) or are deceased (19 percent).”

People with Alzheimer’s wander for a number of reasons. Sometimes, they attempt to go to a former home or a favorite place. A resident who has just moved to the nursing home may be searching for something or someone familiar, or looking for a bathroom, food or water but 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.

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 such cases, it is useful to plan an activity at that time that will distract the individual from the tendency to wander. To reduce the risk of wandering, put away coats, boots, purses, etc., as these are visual reminders of going outdoors. Some residents are much less likely to go out without familiar items like coat, keys or a purse.

There is usually a trigger for wandering, which one can try to determine over time. In some cases, wandering fulfills a physical need for activity, is 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 stem 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 walk or explore safely. Creating a circular well-marked path or trail allows residents a secure route and an opportunity to stretch their legs.

It is useful to put signs with pictures on bathroom doors to signify where the toilet is, as residents may forget. Also put a no entry sign (with an appropriate image) to keep the individual from wandering from his/her room. A mirror, curtains over the door or a sign that says “STOP” may also signal a barrier to an individual with dementia. In many cases, individuals with dementia see obstacles where they don’t really 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 caused by increased fatigue and disruptions to internal factors that control when we wake and sleep. Encourage restful sleep by increasing daytime activity, especially movement or exercise, and in some cases, discouraging naps. Ingredients like caffeine and refined sugar 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 quieting the resident’s schedule in the afternoon or evening, introducing structured activities like card or board games, reading aloud or listening to soothing music. 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 (going to the bathroom, for example). Making sure the individual is safe at night is critical. Medications that can help the individual sleep or tranquilize him or her to some extent exist, but may produce the undesired side effect of increased disorientation or lethargy the next day.

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. 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 over the day can be a better strategy to ensure proper nutrition. Weight loss can also be countered with the addition of healthy high calorie snacks during the day.

Make mealtimes as enjoyable as possible and encourage the individual to feed him/herself without concern for “table manners” or correct use of eating implements, which may be difficult for a person with cognitive impairment. Finger food is often a good strategy. Cut the food into small bite-size pieces and spice it to the individual’s tastes. Drinking from a glass can be facilitated with the use of a straw or children’s “sippy cup.” Provide adequate assistance to ensure the resident has eaten enough. Encourage chewing and swallowing by showing the motion yourself and gently touching the jaw to encourage chewing or stroking the throat to encourage swallowing.

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

Try to emulate the bathing experience that the individual formerly carried out him/herself. Did he or she bathe in the morning or at night, by bath or shower? Did he/she shampoo hair everyday; what kind of soap, shampoo, or powder was used? Try to make it as close to the resident’s bathing routine as possible.

If bathing becomes a struggle, reduce its frequency; dry shampoo can be used to wash the hair if the individual is reluctant to get her/his hair wet. Hair washing can also be done as a separate procedure, in a sink, at a different time. While bathing everyday is not necessary, most institutions require that the resident be bathed about twice a week, at minimum.

If showers or baths become very difficult, a towel bath may be a good alternative, especially if the individual is opposed to immersing him/herself in water. In this alternative, towels or washcloths are dampened with warm water and a no-rinse soap. Special bath blankets can be used to cover the bed, and a large towel is used to keep the resident covered while the dampened towel and washcloths are used to cleanse the body. (For further information, see “Bathing Without a Battle” listed in the bibliography). 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; soaping a part of the person, rinsing with a container of water and towel drying.

As it is conventionally a private and personal activity, ensure modesty is protected by making sure curtains or 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. Have towels and a robe ready when the resident gets out of the shower/bath. Make sure you have everything you’ll need for bathing before you begin, so you don’t have to leave the room to get towels or other supplies. Individuals with dementia should never be left alone in the bath or shower.

Elderly people may be more sensitive to heat and cold, so ensure that water and air temperatures are comfortable. Have the individual test the water temperature before stepping in to make sure it’s acceptable. Fear of falling in the bath or tub is very common, so help the individual 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.

Communication strategies for Alzheimer’s disease and other dementias
Getting ready to communicate
Make sure the individual is prepared to understand you. Does he or she require a hearing aid, dentures or glasses? Has he/she just woken up from a nap or due for one? Trying to speak with someone who is drowsy makes communication more difficult.

Approach the individual from the front, as you may startle him/her if you’re not within their 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 same level so you can look him or her in the eye. You should 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 identify who you are.

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 made more difficult when the resident is confused, sleepy, or medicated. Difficulty communicating may be greater later in the day, as the individual grows more fatigued. Some medications have side effects that make communication more difficult, like drowsiness or lethargy.

Give your complete attention to the resident. Do not attempt to communicate during other activities that require your or the resident’s full attention. Residents with severe dementia will need to focus on what you are saying to understand you. It is best not to ask them to focus on two activities at once. Save unnecessary conversation for safe times when transferring or completing an ADL.

Allow sufficient time for communication; everything needs to be slowed down for the resident with dementia. They are likely to communicate poorly, or without focus, and need additional time. Provide ample time and don’t appear rushed or distracted.

Minimize distractions and noise
Minimize external noise and distractions. This may require closing a curtain, shutting a door, or turning off a radio or TV (always ask first!). Reduce or avoid background noise that can be distracting or drown out what you are saying. 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 like lights and noises.

Keep it short and simple
Communicate simply. Use 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 listener. (Example: “Did your daughter, Susan, visit today?”)

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 what you’re saying, repeat it more slowly using the same words. If there is still no recognition, rephrase what you are saying.

Slow down and use pauses when you speak. Individuals with dementia cannot take in information as quickly. Provide sufficient time for the patient to process information, respond, or ask questions.
Allow the resident to complete his/her own thoughts. In some cases, this means letting them struggle to find a word. Some people in this situation like to have a word supplied; others prefer to struggle. Don’t be too quick to guess what the person is trying to say unless the person doesn’t mind you trying to complete his/her thoughts. Find out what strategy is least frustrating for that individual. If the word is not forthcoming, suggest he/she write it, then try to read it out loud.

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, as this can be confusing or overwhelming to a resident with severe dementia. Break ADLs and other projects into a series of short steps instead of one long process. Tell the resident each step, and let him/her complete it before you move on. Assist and remind as needed.

Develop simple routines and use a small number of key words in critical situations, such as making transfers, or completing other common tasks in a way that ensures resident safety. One strategy, for example, used when transferring an individual with cognitive impairment, is to use as few words as possible to complete this task: “stand,” “pivot” or “turn,” and “sit,” for example, identify what needs to be done at the appropriate time. Using too many words can confuse the resident.

Use behaviors to facilitate communication:
Show: Use pictures or symbols or show the item you’re 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 at getting the point across. See nonverbal communication, in this chapter.
Ask: Ask only one question at a time, and keep it as simple as possible. The best questions can be answered with a yes or no. Don’t give too many choices. “Would you like a banana or an apple for breakfast?” is better than “What kind of fruit do you want?” or “Would you like a banana or an apple with lunch?” It 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, 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 use long instructions, directions, lists, or complicated questions.
- Do not ask questions that rely on short-term memory. Instead, encourage discussion of things that happened long ago in the past, which may seem more vivid than recent memories. Asking what the resident had for breakfast may just be frustrating.
- Do not use medical terminology.
- Do not criticize, hurry, correct, argue or contradict. Individuals with dementia may be confused and prone to agitation. They may confuse reality with imagination, so do not try to argue or convince them they are wrong. Instead, focus on the feelings they are expressing. Respond with verbal and physical reassurance.
- Avoid rushing communication; be patient.
- Avoid crowding the individual. Give him/her “elbow room” and do not stand over him/her.

If you don’t understand:
- Let the person know you do not understand him/her. Do not pretend to understand what the person has said if you don’t. Nod yes only if you understand.
- Maintain eye contact and show that you’re 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 ask if he or she needs to use the toilet.
- Ask the person what might help them communicate (pictures, writing, etc.).
- 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 gentle touch to communicate and reassure when words don’t get through. 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 (nonspoken). People with dementia often find that more words clutter up or confuse their reception of communication. That is why spoken communication should always be as simple as possible, using the fewest number of words. Nonverbal communication can also be nonspoken or nonverbal, which includes writing or communicating with signs or gestures (like a thumbs-up signal communicates good news). Nonverbal communication is sometimes better at communicating a message to people with cognitive impairments. You may want to act out an action or use hand gestures to ask someone to sit up or down. Do not gesture near the individual’s face or stand too close, however. Always keep a respectful distance.

Sometimes your body language is easier to interpret than spoken words, so watch gestures and the way you stand. Sometimes we communicate things we shouldn’t through the way we stand or talk – that we’re in a hurry, for example. While people with dementia have difficulty with spoken words, they are often very perceptive at reading nonverbal cues, like body language. Similarly, one can often interpret a lot by looking carefully at the resident, seeing signs of pain, for example, in the way a person walks or the look on his/her face.

Tone and posture
Even if you get frustrated, try to keep your voice calm and relaxed. If your words and the way you say them don’t match, it may be confusing to the resident. Remember that your nonverbal cues, including the tone of your voice, often send a clearer message than what you actually say. Smile and maintain a positive mood and frame of mind. Keep your tone pleasant, gentle, respectful and caring. Speak slowly, and be reassuring and positive. Use your expression and gentle touch to convey concern or care. Watch the resident’s tone and posture for signs of stress or pain. How are they holding their body? What is their expression? Do they appear to be in discomfort?

Visual cues
Visual cues are very useful nonspoken ways of communicating important information. Use written language or symbols, pictures, or objects to help communicate meaning. In 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’s necessary to assist a resident who soils himself because he forgets where the bathroom is located.

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

Pictogram grids are communication tools that show images, usually black and white, with graphic symbols against a background and text above that gives the meaning of the symbol. The combination of white and black gives optimum contrast to the eye and renders pictograms more user-friendly. Different kinds of pictograms exist for different functions. A similar device can be created by asking the resident to point at pictures that identify what he/she needs. A pictogram replaces written language for those people who are limited in their ability to speak, read and write.

Handling difficult situations and behavior
Problems communicating about ADLs can lead to frustration on the part of both the CNA and the resident. The reason that resistance occurs with daily activities such as bathing and getting ready to go somewhere is because these tasks make the individual feel out of control, rushed, confused by what you say, and frustrated due to their inability to communicate or understand communication easily.
Try to be flexible. Rather than argue with the person, consider changing the environment or your own behavior to adjust and respond to the person’s needs. If the resident wants to sleep in a reclining chair rather than the bed, and there’s no good reason not to, accommodate the new behavior. Sometimes changing your response to the behavior is the best way to change the resident’s behavior, so try to accommodate it whenever possible if safety not an issue.

Because people with dementia have barriers to communication, they may do things we don’t understand, but there is typically a reason for the behavior. Difficult behavior is often triggered by something. Try to determine what triggered the behavior and what the individual is trying to communicate with the behavior. The trigger may be anything – a change in the environment that the resident finds disturbing, or the feeling that he/she is being rushed (because rushing is often a trigger of difficult behavior, you should plan to slow things down or logical. Contradicting or arguing with the resident will not help.

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 project into a series of simple steps, then explaining each step before you do it, as you go, often has a calming effect. Telling the resident what you are going to do gives the individual more sense of control. Always allow enough time.

Consider the words or sentences you are using. Do they sound as if you are telling a child what to do (or what not to do)? Remember that you are with an adult, who may be trying to maintain some sense of control. When you say “You need to…” or “You can’t…” or “I want you to…” it is likely to escalate agitation or anger. Pay attention to the tone of your voice and/or body language. Remember that the dementia damages the person’s ability to be rational or logical. Contradicting or arguing with the person tends to make the situation worse. Don’t allow the difficulty to escalate.

Appear as nonthreatening as possible by staying about three feet away from an angry or agitated person, smiling and keeping a pleasant expression, and using a calm tone of voice.

Some difficult behaviors have medical reasons; see if it is a side effect of medication or can be helped with medication.

**Most important:**

- Keep your sense of humor and don’t 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.
- 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.

**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 clear communication include:

- Respiratory impairment.
- Speech pathology.
- Auditory impairment.
- Laryngeal edema/infection.
- Deafness.
- Inattention to noises or voices.
- Confusion.
- Inability to understand or speak the language.
- Oral deformities.
- Pain.

There may be a number of issues at work that complicate the resident’s speaking, hearing or thinking. Communication can be made more difficult by the normal aging process, which can include sensory loss, memory loss and slower cognitive function. Additionally, as an individual ages, his/her voice may change, becoming harder to understand.

Problems articulating words can be traced to disease (such as lung disease or cancer of the larynx, which controls the voice). A jaw, for example, may move less easily, making certain words more difficult to understand. Dysarthria may affect the muscles of the mouth, face and respiratory system, which become weak and move with difficulty. The individual may have difficulty pronouncing sounds and words due to central and neuromuscular disorders that can act as barriers to clear speech (including neuromuscular flaccidity, spasticity, ataxia, hypokinesia, or hyperkinesias). Barriers to reception include hearing problems, poor understanding of the language being spoken, thinking problems (cognitive), or lack of focus or attention (the person must be prepared to listen/hear/speak). Illness, fever, dehydration, medication, changes in routine or schedule, new personnel or surroundings; all can make communication more difficult. It is best to keep the environment familiar. Don’t introduce changes unnecessarily. Clutter may contribute to a resident’s discomfort; keep rooms and pathways neat and uncluttered. Limit noise, and keep the room bright in the daytime.

Some simple fixes: Check the patient for hearing problems or excessive wax buildup in the ears. Some drugs cause cognitive impairment. If you are trying to communicate, it is best to avoid times when certain drugs, such as sleeping medication or anxiety medication, are most active. Integrate the ADL schedule around the drug regime.

**Strategies for communicating with the visually impaired:**

- Introduce yourself when entering the room and anyone else who is with you.
- Say you are leaving as you go; explain who else is staying if they are not leaving with you.
- Use the name of the person you are speaking to when addressing them.
- Offer to read a menu or other written information when necessary.
- For many individuals with low vision, 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.
- Don’t move anything in the room unless asked to by the resident.

**Strategies for communicating with the hearing impaired:**

- For those who wear hearing aids, ensure that the hearing aid is in the person’s ear, turned on, and has a good battery. If all is OK, and there are still problems, evaluate the individual’s hearing.
- Do not begin speaking until you are in front of the individual, facing him or her, and engage in eye contact.
- Do not smoke, chew gum or have candy or food in your mouth when you talk. It will make you more difficult to understand.
- Keep hands away from your face or covering your mouth.
- 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 must be able to read), use pictures.
- If not understood, try a different way to communicate the same thing.
- Communicate simply, with short sentences, statements, or questions.
- Use body language, gestures, etc, to help communicate.

**ENDNOTES**


**BIBLIOGRAPHY**

- Elite

1. Cognitively impaired people have difficulty with one or more of the basic functions of their brain, such as perception, memory, concentration and reasoning skills.
   True   False

2. The two most common forms of dementia in older people are Alzheimer’s disease and vascular dementia.
   True   False

3. Vascular dementia is also known as mild cognitive impairment (MCI).
   True   False

4. People in the middle stages of Alzheimer’s disease may forget how to do simple tasks like brushing their teeth or combing their hair.
   True   False

5. “Dysarthria” refers to the complete or partial loss of the ability to use or understand words.
   True   False

6. More severe forms of aphasia may be called dysphasia.
   True   False

7. Dementia is often associated with incontinence.
   True   False

8. “Perseveration” is the uncontrollable repetition of a sound or gesture.
   True   False

9. About one out of every four individuals with AD wanders during the course of the disease.
   True   False

10. A critical wanderer can be hard to locate because they act unpredictably, do not call for help, and do not respond when their name is called.
    True   False