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Silence is Not Golden

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Hospitalized older adults are at greater risk for impaired communication with nurses and other care providers than their younger adult counterparts. Ten years ago, Ebert¹ reported that 15.9% of patients admitted to a university hospital general medical service had one or more severe disabilities effecting communication; and those with communication disabilities were more likely to be older. Ebert's criteria for determining serious communication disability were simple: (a) vision so poor that patients were unable to read hospital consent forms or patient-education materials, even with corrective lenses, (b) inability to understand loud speech even with hearing aids, (c) inability to produce speech understandable to the medical team, or (d) altered mental status (p 272). Other studies have discussed the prevalence of and need for identifying preexisting cognitive (e.g., dementia) and/or language impairments (e.g., aphasia) of those older patients admitted to the intensive care unit.²

Many of the several million older adults treated in intensive care units (ICU) each year meet Ebert's criteria for severe communication disability due to neurological injury or respiratory tract intubation.³⁻⁶ Communication difficulty is a distressing symptom that is associated with feelings of frustration, panic, anxiety, dehumanization, and sleeplessness among ICU patients.⁷⁻¹² Compounding the problem, corrective lenses and hearing aids are often unavailable to older patients in the ICU.¹³

We maintain that accommodation for acute or chronic communication disabilities is necessary to provide safe, effective care to older adults in the hospital setting. Misinterpretation of an older adult's communication about their medical history, symptoms, and/or needs can be harmful. Barriers to improving communication among hospitalized patients with communication disabilities include a lack of (a) knowledge and skill, (b) appropriate materials and equipment, and (c) specialists in assisted communication strategies.^{1,14} Nurses are not typically trained in these specialized communication assessment skills and behaviors.¹⁴ Consultations with the speech language pathologist (SLP) should not be limited to dysphagia and swallowing evaluations in acute and critical care settings. SLPs are expert in communication disorders and augmentative and alternative communication (AAC) systems. AAC consultation services provided by SLPs to acute and critical care units have been modeled in several centers¹⁵⁻¹⁷ and training for these services is increasing in SLP educational programs throughout the USA. Importantly, these experts can conduct a thorough assessment of a patient's communication ability and match communication strategies and materials to the individual patient's abilities, needs and preferences.

As part of the SLP's growing communication practice in the ICU setting, we have recently witnessed the SLP's assessment and communication plan change an ICU patient's discharge

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destination from long-term skilled nursing facility to acute rehabilitation. Nonspeaking patients who have a withdrawn, flat affect were observed to become brighter and more engaged when enabled to communicate with caregivers and family and to assume some control over communication.

What resources, in addition to SLP collaboration, are available to nurses to facilitate and improve communication for hospitalized older adults with communication disabilities? We recommend a new book, *Augmentative Communication Strategies for Adults with Acute or Chronic Medical Conditions*, edited by a team of speech language pathologists who have expertise in providing assistive and augmentative communication services in the medical setting.¹⁸ The book offers practical “how to” information based on clinical experience and current research and includes a CD containing clinical forms for communication assessments, strategy checklists, and sample communication “boards.” Chapters address specific communication needs and strategies for patients in the ICU, those with brainstem impairment, traumatic brain injury, dementia, Parkinson’s disease, and stroke/aphasia. On-line resources include our list of tips for communicating with intubated older adults at http://www.hartfordign.org/policy/counts/AJNFinal5_06.pdf and the University of Nebraska-Lincoln’s Augmentative and Alternative Communication Centers website at <http://aac.unl.edu/>.

The Study of Patient-nurse Effectiveness with Assisted Communication Strategies (SPEACS) (Happ, 5R01-HD043988) is currently using SLP assessment, individualized communication planning, and role modeling with critical care nurses who have received communication skills training to improve communication with ICU patients who are unable to speak. As part of the interventions currently being tested in the SPEACS study, we supply a “communication cart” in the ICU with “low tech” communication materials such as spiral notebooks, felt tip markers, clip boards, and a variety of communication boards (picture, word, whole phrases, alphabet, and combination). The cart contains hearing aid batteries in various sizes with instruction cards and the audiologist contact number. Clear plastic cases are available for glasses with instructions to mark whether the glasses are used for reading or distance. Nurses participating in SPEACS are taught techniques to assess and facilitate the patient’s comprehension which is an essential element in communication. It is truly unfair to expect seriously ill hospitalized older adults to comprehend what is being said to them only through auditory means. We don’t expect that of school students or most other audiences. Like good teachers, SPEACS nurses are taught to augment their verbal message (questions or instructions) to patients with visuals: eye contact, exaggerated lip movements, written words or phrases, pictures, and gestures, and to adjust pace and pause time. Analysis of the effect of the SPEACS training intervention and the quality of nurse-patient communication performance is in progress.

Finally, electronic communication aids can be used to facilitate communication in the hospital setting. In pilot studies, seriously ill, hospitalized older adults demonstrated the ability to use electronic speech generating devices (SGDs); however, reminders, cueing, and some physical assistance from communication partners were required.¹³ The SPEACS project is further testing the use of SGDs in combination with low technology communication strategies that are selected and matched by the SLP to individual patient needs and abilities. Staff education and specialty support services are necessary to maximize the accessibility and utility of these devices.

Our goal is to build an evidence base for best practice with hospitalized older adults who experience acute or chronic communication disabilities. We encourage nurses and interdisciplinary team members to collaborate in accessing currently available resources to address basic assessment and assisted communication needs of communication impaired older adults during acute-critical illness.

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