Developed by: The Village Residence, Drogheda Services for Older People.	Date Developed: Revised April 2020, Sept 2023.
Developed By: Nursing Department.	Date Approved: February 2011, March 2014, April 2020, November 2021May 2023, Sept 2023.
Implementation Date: April 2009	Review Date: May 2024
Guideline Reference Number: DSOP	No. of Pages: 11
Status of the Guideline: Final	

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1.0Guideline Statement

Communication and opportunities for conversation are central to how we express who we are. It is through communication that we share our thoughts, feelings, ideas and concerns and so it is the basis upon which we build relationships with others. The consequences of limited opportunities for communication and conversation are the erosion of autonomy and social exclusion. Each resident with or without disability has the right to expect equitable

treatment in law, health care and social service provision and to receive whatever assistance they need to pursue and uphold this. All adults are entitled to manage their own lives and make their own decisions, communication is central to achieving this (Council of Europe, 2005).

2.0Purpose

To facilitate and support communication between residents who may experience specific difficulties in expressing themselves verbally with staff, other residents and visitors. This may include; residents with sensory, physical and intellectual disabilities, residents with specific communication impairments i.e., aphasia, dysarthria and residents with cognitive impairments. The objectives of these guidelines are:

To create an environment that supports residents with communication difficulties to communicate their preferences, views, and concerns so that they can participate in decision making about the assessment of their needs and about their own care.

To explore alternative methods of communication where conventional methods are not possible by harnessing the individual resident's specific abilities.

To alleviate any fears and anxieties residents may have but are unable to express verbally.

To improve residents' quality of life in the unit

3.0 Scope

The scope of these guidelines applies to all employees, volunteers, residents and their significant others working within St Mary's Hospital.

4.0 Glossary of Terms and Definitions

4.1 Aphasia is the loss of ability to verbally express oneself and/or to understand language (Zaretsky,*et al,* 2005).

4.2 Communication involves a minimum of two people and encompasses any means by which individuals relate experiences, ideas, knowledge and feelings. Communication reduces social isolation and improves social connectedness (Mc Intyre and Atwal, 2005).

4.3 Dysarthia is a language disorder in which there is difficulty in articulating words due to a motor speech impairment (Zaretsky, *et al,* 2005).

4.4 Significant others: people other than Health Service Executive employees who have ongoing input into the care and support of a resident, and whom the resident wishes to be involved in decisions about their care and support.

5.0 Roles and Responsibilities:

5.1 Organisation

It is the responsibility of the relevant Ward Manager within The Village Residence to provide the necessary resources for:

The training of staff in communication skills and specifically in techniques to support communication with people with communication disability. These can be encouraged on each Unit.

The provision of aids/equipment necessary for effective communication to take place in conjunction with the relevant multidisciplinary team members.
The arrangement of services for residents to have routine hearing and sight checks.
The provision of speech and language therapy where needed.

5.2 Nurse Management
It is the responsibility of the Clinical Nurse Manager to:
Disseminate these Guidelines to all staff
Maintain a record of all staff who have signed that they have read and understand the Guidelines
Ensure these Guidelines are reviewed at the designated review date. At a minimum this should be done annually from the date of implementation or earlier if national Guidelines strategies or best practice dictate
Remove any outdated versions of these guidelines from circulation.
Ensure that all staff have the relevant training to engage in effective communication with residents. The HSE's Training and Development Department offer training on communication skills. Communication skills are further woven into most programmes offered. Information about the available training and how to access it is available in the HSE's Prospectus.
Audit these Guidelines.

5.3 All Other Staff
All staff including new staff have a responsibility to:
Read these Guidelines and satisfy themselves that they understand their contents and to then sign to that effect in the Guidelines acknowledgement form.
Inform the Clinical Nurse Manager if they do not understand the Guidelines.

6.0 Guidelines
Nursing staff should undertake and record a communication needs assessment as part of the comprehensive assessment of residents (An Bord Altranais, 2002). This assessment should be undertaken on admission, when there is cause for clinical concern and at least three monthly thereafter (HIQA, 2008). Residents' communication needs, their preferred mode of communication and other ways in which communication can be supported should be recorded in the care plan. Residents, family members or carers should be consulted in the development of the plan of care, if at all possible.

6.1 General communication approaches with residents who have communication difficulties
Communicate at the resident's pace.
Allow time for the resident to process what has been said and to formulate a response.
Minimize visual and auditory distractions if necessary.
Seat the resident in a quiet, comfortable area and in private if necessary.
Address the resident as you approach them and introduce yourself.
Communicate with the resident at eye level while respecting his/her personal space.

Make eye contact,
Allow extra time as needed.
Communicate in a clear, calm and reassuring manner.
Where appropriate, use touch as a means of reassurance (NB. note resident's response and adjust behaviour accordingly)
Use clear language and avoid use of jargon.
Stick to one topic at a time.
Listen without interrupting the resident.
Give the resident a chance to ask questions
Summarize the most important points – write down key points if necessary.
Simplify and write down your instructions.
Always ask the resident what they require and do not assume that you know what they need.
Where appropriate use charts, models and pictures to illustrate your message if verbal communication is not possible. Any signs, forms and brochures should be easy to read and accessible to individuals with special needs.
Ensure confidentiality and privacy is maintained and remember that curtains are not a sound barrier.

6.2 Communicating with residents with hearing impairment
Provide/source facilities or services, including speech and language therapy, to facilitate hearing impaired residents on foot of an assessment of needs.
For residents who have hearing aids, make sure their hearing aid is switched on.
Stand directly in front of the resident and have their individual attention before you begin speaking.
Keep your hands away from your face when speaking.
You may need to write things down for some residents.

6.3 Communicating with residents with speech impairment (e.g. dysarthria*)*
Do not rush the resident when talking to them.
Do not pretend you understand if you do not.
Make a referral to speech and language therapy services as appropriate.
Ask the resident to write down their views/answers to questions using the most appropriate method (e.g. pen & paper, Lightwriter, etc.).
Ask questions that require short answers.
Give the resident time to finish his/her sentences.
Use touch to aid in concentration, to establish another route of communication and to offer reassurance and encouragement.
Check with the resident that you have understood correctly what he/she is communicating.
If necessary, consult with family or carers for assistance in interpreting what the resident is saying but confirm that this is correct with the resident.

6.4 Communicating with residents with language impairment (e.g. aphasia)
As in 6.3 but also the following

Communicate by harnessing the resident's abilities.
Be clear – talk about one subject at a time.
Speak in a calm and relaxed manner.
Use pen and paper to support communication by writing key words or drawing. This helps comprehension as well as giving you a means to check and verify.
Encourage person to write or draw if this helps but don't insist on correct spelling or perfect drawings.
Use resources around you (i.e. photos, maps, calendar).
Make signs, forms and brochures easy to read by using clear language, bold font to highlight key words and sensitive use of pictures and images.
Use charts, models and pictures to illustrate your message where appropriate.
Use facial gestures and expression to facilitate meaning.
Check that you and the resident have both understood.

6.5 Communicating with residents with visual impairment
Always tell the resident to whom they are speaking.
If you are entering a room with a resident who is visually impaired describe the room layout, who else is in the room and what is happening.
Tell the resident when you are moving away so that they do not end up talking to an empty space.
Address the resident before using touch.
Allow the resident to touch you.
Leave things in the resident's room where they are unless the resident asks you to move something.
Treat the resident as a sighted person as much as possible.
Ask the resident if they would like written information to be put into another format, if it is available, for example big print, Braille, audio tape/CD.
Remember that if a patient cannot see your body language you will need to say yes and no etc.

6.6 Communicating with people using wheelchairs
Speak directly with the resident, not to the person pushing the wheelchair.
Do not speak over the resident's head; if possible get down to the level of the chair and establish eye contact, e.g. by sitting on a chair.

6.7 Communicating with residents who have learning disabilities and/or cognitive impairment
Involve family and carers in the assessments of resident's communication needs and also in the development of care plans. They will often know the most effective methods of communication to use.
Make signs, forms and brochures easy to read.
Use charts, models and pictures to illustrate your message where appropriate.
If memory is impaired constant repetition may be required.
Use facial gestures and expression to facilitate meaning.

Where appropriate use touch as a means of reassurance. Note resident's response and adjust behaviour accordingly.
Be receptive to changes in mood or behaviour and respond accordingly.
Acknowledge the feelings you observe, providing reassurance and try to engage in an activity that will offer comfort e.g. story telling, singing, going for a walk.
If unable to understand the patient's behaviour, attempt to understand the emotion behind it.

6.8 Communicating with residents whose first language is not English
When residents who do not speak English apply for admission to the unit, an interpreter (through the resident's family, from within the unit or from outside the unit) should be sought to assist in the assessment of need process and also in the development of the resident's care plan. This will ensure that the resident's views are fully represented.

When on-going interpretation services are required, this should be noted in the resident's care plan and the necessary arrangements made for accessing these services.

6.9 Consent and residents with communication disability
Every person has the right to refuse or consent to any intervention or treatment. Therefore as healthcare workers we have the responsibility to create the conditions to ensure that every effort has been made to make information accessible so that the resident is able to communicate his/her informed consent (Office of the Ombudsman, 2006).

With this aim in mind we need to:
Establish the resident's communication abilities.
Identify what helps the resident to understand what is said / written and what helps him/her to communicate his/her decision.
Create the conditions to maximise the opportunity for the resident to reveal their competence at the time the decision is being made

The opinion of a Speech & Language Therapist is important in order to assess the resident's specific communication abilities and to give appropriate guidance on ways in which to support communication.

6.10 Communicating bad news to all residents
The HSE recognises that breaking bad news may be difficult for members of staff. It is important when breaking bad news that where possible it is done in private and that as much relevant information as possible is available so that questions can be answered. It is preferable for a senior member of staff to be involved in breaking bad news and that staff attend a relevant training programme.

7.0 Implementation Plan
This document acts as the minimum communication guideline and should be brought to the attention of all staff with immediate effect from date of implementation

8.0 Evaluation and Audit:
Guidelines will be reviewed at the designated review date. At a minimum this will be done annually from the date of implementation or earlier if national policy strategies or best practice dictate.
The interaction between healthcare professional/carers and residents and their families should be assessed on an ongoing basis, through audits observations and resident consultation.

9.0 References:

An Bord Altranais, (2002) *Recording Clinical Practice Guidance to Nurses and Midwives.* An Bord Altranais. Dublin.

Council of Europe, (2005) Resolution ResAP (2005)1 on safeguarding adults and children with disabilities against abuse. Integration of people with disabilities. Partial Agreement in the Social and Public Health Field, Directorate of Social Affairs and Health, Directorate General III-Social Cohesion, Council of Europe, France.

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Mc Intyre, A. and Atwal, A. (2005) *Occupational Therapy and Older People,* pages 187-192, Blackwell Publishing, Oxford, England.

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Zaretsky, H., Richter, E. and Eisenberg, M. (2005) *Medical Aspects of Disability, 3rd Edition, A Handbook for the Rehabilitation Profession.* Pages 292-293, Springer Publishing, New York.