Section 9

Communication CAP

Problem

While many conditions can affect how a person expresses and comprehends information, the Communication CAP focuses on the interplay between the person's communication status and his or her cognitive skills for everyday decision making. Normal communication involves two related activities:

- Expressive communication: Making oneself understood to others, usually verbally but also through nonverbal exchange. Typical expressive problems include disruptions in language, speech, and voice production. Specific manifestations include difficulty in finding suitable words, putting a sentence together, or describing objects and events; pronouncing words incorrectly; stuttering; hoarse or distorted voice; and low volume because of poor respiratory status. The percentage of persons with at least some difficulty in making themselves understood ranges from 15% of those living independently in the community, to 25% of those receiving home care, to 40% of persons in long-term care facilities.
- Receptive communication: Comprehending or understanding the verbal or written communication of others. Typical receptive communication problems include changes/difficulties in hearing, speech discrimination, vocabulary comprehension, reading, and interpreting facial expressions. The percentage of persons with at least some difficulty in comprehending the verbal communication of others ranges from 10% for those living in the community, to 25% of persons receiving home care, to 50% of persons in long-term care facilities.

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Overall Goals of Care

- Prevent avoidable loss of communication skills for as long as possible.
- Reverse or improve communication loss.
- Monitor a list of common causal factors and treat as appropriate.
- Work with families and caregivers to ensure effective communication with the person.

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Communication CAP Trigger

The goal of this CAP is twofold: first, to work to improve communication ability whenever possible; and second, to prevent avoidable communication decline. Anyone triggered should receive a specialized communication care plan follow-up.

The key difference between the following two triggered groups is whether the goal of care is improvement or preventing decline.

TRIGGERED TO FACILITATE IMPROVEMENT

This subgroup is defined by the presence of both of two factors:

- Moderate to severe communication shortfalls, which include both communication with others and understanding communication from others; and
- Some ability to engage in everyday decision making (a measure of cognitive reserve).

Given these cognitive abilities, persons in this subgroup are the most likely to experience improvements in communication. Yet, only a minority (about 15%) will improve over the ensuing 90-day period, and the principal focus of care is to increase the likelihood of this happening. Note that this group includes about 11% of persons in long-term care facilities, 8% of persons receiving home care, and less than 1% of older adults living independently in the community.

TRIGGERED TO PREVENT DECLINE

This subgroup is also defined by a person's communication and everyday decision-making ability, but in this instance the person has better baseline communication skills and poorer everyday decision-making capability.

Given the absence of cognitive reserves, this subgroup is the most likely to decline in communication. Yet, only a minority will decline (about 15%), and the principal focus of care is to reduce the likelihood of this happening. Note that this group includes about 25% of persons in long-term care facilities, 10% of persons receiving home care, and less than 1% of older adults living independently in the community.

NOT TRIGGERED

This subgroup includes anyone for whom either functional recovery or functional maintenance to prevent decline is not a clinically realistic care goal. There is a balance between communication skills and cognitive ability (as measured by everyday decision making). There are three such groupings: good communication and good cognition, middle communication and middle cognition, and poor communication and poor cognition.

This subgroup is the least likely to change over time, as communication ability matches cognitive ability. Note that this group includes about 64% of persons in long-term care facilities, 88% of persons receiving home care, and 99% of older adults living independently in the community. Care for persons in this group is limited to monitoring for any unexpected decline in communication levels.

Communication CAP Guidelines

When communication is limited, assessment focuses on reviewing several factors: underlying causes of the deficit, the success of attempted remedial actions, the person's ability to compensate with nonverbal strategies (for example, ability to visually follow nonverbal signs and signals), and the willingness and ability of caregivers to ensure effective communication. In the presence of reduced language skills, both caregivers and the person must expand their nonverbal communication skills — one of the most basic and automatic of human abilities. Touch, facial expression, eye contact, hand movements, tone of voice, and posture are all powerful

means of communicating. Recognizing and using all practical means is the key to effective communication.

Assess the person for confounding problems and address them. [See relevant CAPs.] As these confounding problems lessen or further decline is prevented, the person's communication abilities should be reviewed.

- Decline in cognitive status, especially recent onset of acute confusion (delirium)
- Increased number of mood indicators (for example, an increase on the Depression Rating Scale [DRS])
- Decline in ADL status
- Deterioration in respiratory status in persons with COPD
- Oral motor function — swallowing, clarity of voice production

Assess and correct, where possible, the components of communication. Details of the person's strengths and weaknesses in understanding, hearing, and expression are part of a supportive treatment program.

- Hearing impairment: Check that proper hearing appliance is present, operating correctly (for example, batteries are working), and is being used. Determine if the person is able to understand in particular situations, for example, in a quiet environment or when talking one-on-one where he or she can see the other's lips.
- Communication success: If the person is able to communicate more effectively with certain individuals, then try to determine why this is the case. For example, does the person speak slowly and distinctly, use specific gestures or motions, or communicate in another language? Ensure provision of this effective mode of communication.
- Nonverbal communication: If the person has the capacity to use communication devices or other nonverbal modes of communication, ensure that the staff and/or caregiver is aware of the need to employ such procedures and is trained in their use.
- Recent decline in hearing: Review for potential causes, including presence of ear discharge(s) and cerumen (wax) accumulation.

Review treatment and evaluation history:

- Has the person received an evaluation by an audiologist or Speech-Language Pathologist (SLP)? How recently?
- Has the person's condition worsened since the most recent evaluation?
- If such an evaluation resulted in a plan of care, has it been followed as specified?

Factors to be assessed and addressed for possible relationship to communication problems:

- **Recent onset conditions** (for example, aphasia secondary to stroke). If improvement is possible, consider referral to a SLP.
- **Chronic or recurrent conditions** (for example, Alzheimer's disease or other dementia, aphasia following a stroke, Parkinson's disease, mental health problem). For chronic conditions that are unlikely to improve with

treatment, consider communication interventions that might compensate for losses (for example, for moderately impaired persons with Alzheimer's disease, the use of short, direct phrases and tactile approaches to communication can be effective).

- **Conditions that may display voice production deficits** (for example, asthma, emphysema/COPD, Parkinson's disease, cancer, or poorly fitting dentures). Consider a consultation with a physical therapist for breathing exercises or cardiorespiratory endurance training, physician, or dentist.
- **Transitory conditions** (for example, delirium, infection(s), or an acute illness). Are there acute or transitory conditions, which if successfully resolved might result in an improved ability to communicate? [See Delirium CAP or refer to physician.]
- **Assess the person's drug regimen for conditions that could impair his or her ability to communicate.** Would drug titration or substitution result in an improved ability to communicate? Consult with the physician when the following medications are used:
  - Psychotropic medications such as antidepressent agents and tranquilizing agents (including antipsychotic, anti-anxiety, and sedative agents)
  - Opioid (narcotic) analgesics
  - Antiparkinsonian medications
  - Antibiotics such as gentamycin and tobramycin
  - Aspirin
- **Assess the person's opportunities to communicate where the quality and quantity of communication are equal to apparent ability.** Are opportunities to communicate limited in ways that could be corrected (for example, the availability of others to communicate with or the use of a communication board or computer)?

Additional Resource

Lubinski R, Frattali C, Barth C. 1997. Communication. In Morris JN, Lipsitz LA, Murphy KM, and Belleville-Taylor P, eds. *Quality care in the nursing home*. St. Louis, MO: Mosby. **Note:** This chapter provides an approach assessment of the person with communication deficits, including how to assess and address underlying problems and tips for care planning.

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