chapter

# 5 Communicating with Older Adults

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## Objectives

1. Identify communication techniques that are effective with older adults.
2. Define *empathetic listening.*
3. Identify the significance of nonverbal communication with older adults.
4. Discuss the verbal communication techniques used when sending and receiving messages.
5. Differentiate between social and therapeutic communication.
6. Discuss ways communication is affected by culture.

## Key Terms

**confrontation** (KŎN-frăn-tā-shŭn) (p. 97)
**empathy** (ĔM-pă-thē) (p. 93)
**proxemics** (prŏk-SĒ-mĭks) (p. 91)
**rapport** (ră-PŌR) (p. 86)
**symbols** (ŠIM-bălš) (p. 90)

Communication is the process of exchanging information (i.e., sending messages back and forth between individuals or groups of people). Problems between individuals, families, or groups, as well as difficulties on the job or in society, are often the result of poor communication. Each of us who participates in communication is a unique individual with our own personal values, beliefs, perceptions, culture, and understanding of how the world operates. This is particularly important to remember when working with older adults. Oldest adults of today formed their opinions, values, and beliefs in a very different society from ours today. Most of today's oldest adults grew up during the Great Depression, when men sold apples on street corners and searched for pieces of coal in railroad yards to survive. They lived through a major world war and witnessed the beginning of the Nuclear Age when the first atomic bomb was dropped. They grew up in a world without many of today's conveniences, including televisions and private telephone lines. The upcoming generation of elderly is very different. The Baby Boomers who came of age during the Vietnam war, grew up in a world challenged by drugs, protests, and "free love." They grew up with stereos, television, and astronauts walking on the moon. Most Baby Boomers have adapted to the use of cell phones and computers. Technology was, and will continue to be, a part of their lives.

Whatever their background, older adults have had time to encounter many situations, both good and bad. It is often difficult for a younger person to understand the experiences that have made older adults whom they are today. The most effective way to bridge the gulf between the generations is good communication (Table 5-1).

Effective communication is not easy, even among people of the same age group and background. Communication among people from different age groups and backgrounds is even more challenging. This is particularly true when one of the parties is elderly; however, effective communication can occur even when people hold significantly different values, beliefs, and perspectives. Effective communication does not mean that we will like or agree with everything that another person says, but rather that we respect the person's right to think and say it. This atmosphere of mutual respect and understanding helps build trust and **rapport**. Conscious, ongoing effort is required to become an effective communicator.

Effective communication requires the following:

1. The need or desire to share information
2. Acceptance that there is value and merit in what the other person has to say, demonstrated by a willingness to treat the other person with genuine dignity and respect
3. Understanding of factors that may interfere with or become barriers to communication
4. Development of the skills and techniques that facilitate effective interchange of information

## INFORMATION SHARING (FRAMING THE MESSAGE)

Verbal communication involves sending and receiving messages by means of words. Some verbal communication is formal, structured, and precise; some is informal, unstructured, and flexible. Formal or therapeutic communications have a specific intent and purpose. Informal or social conversations are less specific and are used for socialization. Both have a place in nursing. Nurses must be effective in both formal and informal

3. **Enlist the help of family, friends, and neighbors to provide reminders.** Reminder phone calls from friends or family are useful for less frequent occasions such as doctor visits. It is wise for the friend or family member to call the person the day before the appointment and then again on the day of the appointment to ensure that he or she has not forgotten. It is even better for a responsible friend or family member to transport the person to the medical appointment. Responsible friends and family members can also provide help in setting up the weekly pillbox and preparing other reminders around the home.
4. **Involve social service agencies in promoting compliance.** If the person is noncompliant because of financial or transportation problems, a social worker or social service agency may be able to provide assistance that enables the person to comply with the care plan.
5. **Use any appropriate interventions that are used in the institutional setting.** (See Nursing Care Plan 4-1.)

## Get Ready for the NCLEX® Examination!

### Key Points

- A large percentage of today's aging population continues to live independently, despite a variety of chronic health problems.
- Health maintenance is an ongoing challenge for these people, their families, and health care providers.
- Careful assessment of the aging person's perception of his or her health, health practices, and knowledge of safety factors is an important part of nursing care in all settings.
- Early detection of problems and early intervention can prevent more serious complications and enable older adults to maintain the highest possible level of wellness and function.
- Home health assistance—both unpaid and paid—can help older adults remain independent for a longer period of time.
- Nurses play an important role in case management and in providing services to older adults in their homes.
- Caution should be used when selecting home care providers for older adults.

### Additional Learning Resources

SG Go to the Study Guide on pp. 379–397 for additional learning activities to help you master the chapter content.

Evolve Go to your Evolve website (http://evolve.elsevier.com/Wold/geriatric) for the following FREE learning resources:

- Animations
- Answer Guidelines for Nursing Care Plan Critical Thinking Questions
- Answers and Rationales for Review Questions for the NCLEX® Examination
- Glossary with pronunciations in English and Spanish
- Video Clips

### Review Questions for the NCLEX® Examination

1. The activity that best promotes health maintenance for the typical senior citizen is:
   1. One hour of low-impact tai chi per week
   2. Thirty-minute walk 3–5 times a week
   3. Twenty minutes of step aerobics 2 times a week
   4. Five to 10 minutes of stationary bike riding done daily
2. The nurse recognizes that regular dental visits are:
   1. Necessary for only those elderly people who still have their natural teeth
   2. Recommended on a yearly basis for all elderly people, even those with dentures
   3. Not necessary if the person brushes and flosses properly three times a day
   4. Desirable, but not necessary unless pain or another problem occurs
3. An older person does not follow through with health recommendations from the physician. The person does not take prescribed medications or keep medical appointments. The nurse formulates a care plan for the nursing diagnosis:
   1. Noncompliance
   2. Knowledge deficit
   3. Disturbed thought processes
   4. Impaired health seeking behavior
4. Immunizations that the elderly need to receive on a yearly basis include the following: (Select all that apply.)
   1. Pneumonia vaccine
   2. Influenza vaccine
   3. Tetanus vaccine
   4. Polio vaccine
   5. Hepatitis B vaccine
5. When attempting to help an elderly person improve his or her health-maintenance practices, the nurse will need to assess which factors? (Select all that apply.)
   1. Physical strength and endurance
   2. Availability of transportation
   3. Cultural beliefs
   4. Cognitive and sensory changes
   5. Socioeconomic status
   6. Religious beliefs
   7. Social support system
   8. Educational level

**Table 5-1 Communication Dos and Don'ts When Working with Older Adults**

| DO | DON'T |
|---|---|
| Identify yourself. | Assume that the person knows who you are. |
| Address the person using the name he or she desires (e.g., Mrs. Smith and Bill). | Use "baby talk" or patronizing names such as "sweetie" or "honey." |
| Speak clearly and slowly in a low tone of voice. | Shout. |
| Get to know the person. | Make generalizations about older people. |
| Listen empathetically. | Pay too much attention to tasks and forget the person. |
| Pay attention to body language—yours and theirs. | Ignore non-verbal messages as insignificant. |
| Use touch appropriately and frequently. | Be afraid to use touch as a method of communication. |

communication and must know how and when to use each type.

Nonverbal communication takes place without words. We are communicating all the time, whether we are aware of it or not. Research has shown that only 7% of communication comes from the actual words we use; the other 93% is nonverbal. Approximately 38% of communication is transmitted by paralinguistic cues (i.e., tone, pitch and volume of voice), and 55% is transmitted by body cues. The importance of understanding nonverbal communication can be summed up in the statement, "What you are saying (nonverbally) is so loud I can't hear you."

## FORMAL OR THERAPEUTIC COMMUNICATION

Therapeutic communication is a conscious and deliberate process used to gather information related to a patient's overall health status (physical, psychosocial, spiritual, etc.) and to respond with verbal and nonverbal approaches that promote the patient's well-being or improve the patient's understanding of ongoing care. This type of communication looks easy and natural when performed by an experienced health professional, but it is a skill that requires time, effort, and practice to develop. Careful use of words and language is an art. Knowledge of the individual's educational background and interests provides nurses with a starting point for conversation. Social discussions often center around past employment, family, or other interests. Increased knowledge of the individual enhances the nurse's ability to respond empathetically. Effective verbal communication requires the ability to use a variety of techniques when sending and receiving messages.

When communicating verbally, whether in a formal or an informal situation, nurses should know as much as possible about the other person involved. A person's age, marital status, cultural or ethnic orientation, educational background, interests, and the ability to hear and see influence the communication techniques used and the words chosen. As nurses, we need to be careful to choose words that the patient can understand—not so simple that we are "talking down" to the patient, but also not so technical or "medical" that the meaning is unclear. Avoid acronyms such as *TURP* or *CBC* unless you are sure that the person understands them. Careful listening to the patient's speech can give clues about the appropriate level of language.

### Cultural Considerations

**Communication Styles**

- Americans tend to be bold and ask direct questions, particularly in a crisis. We expect the answers to be similarly clear and direct.
- Members of other cultures may prefer to proceed less directly and need to establish a relationship through "small talk" before addressing more serious concerns. Although this may seem less productive, the nurse's awareness that the patient and his or her family may be more comfortable with this type of communication can contribute to greater success in the long-term relationship.

Some home health nurses had a good laugh at the office when one nurse recounted the following experience during a home visit:

Her elderly patient reported that he was recently hospitalized. When she explored the reason for this hospitalization, he told her, "I was castrated." She asked whether he knew why this was necessary. He replied, "Because of my prostitute." At this point, she pulled things together in her mind (and restrained the unprofessional urge to break out in laughter), realizing that what her patient meant to say was that he was *catheterized* because of problems with his *prostate* gland. This is an example of medical terminology gone awry.

Also remember that different words can have different meanings to persons of different generations or cultures. *Gay* may mean happy and lighthearted or an alternative lifestyle. *Cool* may be a temperature or something really good. *Bread* may be something you eat or something you spend. Consider the culture, ethnicity, experiences, and perspective of the older patient when choosing your words.

## INFORMAL OR SOCIAL COMMUNICATION

Simple chitchat has a place in nurse-patient communications. If nurses talked only about things related to health treatment, they would know little about their patients. Small talk; pleasantries; and conversations about the weather, a favorite television show, or the latest news can demonstrate that the nurse thinks of the patient as a real person, not just a patient. This also goes the other way. Older patients often like to know something about the nurses who care for them; they may ask about the nurse's family, hobbies, vacations, and so forth. This is particularly true in extended-care facilities because the nursing staff often becomes a new family for the aging person. Do not be afraid to be "human" when communicating with elderly patients.

Be honest with your older patients. When you do not have time to visit, explain why so that patients do not personalize and think they have done something wrong. Do not be afraid to use humor appropriately. It has been said that "laughter is the best medicine," a medicine that is too often in short supply around the elderly. Pick the right time and place. Make sure that the humor is culturally sensitive. Remember that it is okay to laugh at yourself but never at the other person. Aging does not cause people to lose their sense of humor. A humorous story or cartoon may help brighten their day.

## NONVERBAL COMMUNICATION

Because so much of our communication is nonverbal, it is essential that we examine each aspect of nonverbal communication to see its effect on our interactions with the older adult (Figure 5-1).

If two people entered a room—one wearing a white laboratory coat with a stethoscope around her neck and the other wearing a clerical collar and a cross—what message would you receive? Would these people have to say anything for communication to take place? What is being communicated? The items we wear or carry (e.g., clothing, jewelry, stethoscopes, masks, gowns, and gloves) send messages; we use these symbols to communicate something about who we are. Distinctive uniforms are worn to make people identifiable. Police officers, flight attendants, clergy, and nurses wear uniforms so that they can be recognized even in a crowd.

### SYMBOLS

In the health care setting, uniform styles and colors help patients distinguish the various caregivers. Many patients, particularly older adults, were unhappy when nurses stopped wearing caps. The white uniform and cap were **symbols** that helped older adults distinguish nurses from other caregivers. For this reason,

FIGURE 5-1 Nonverbal communication signals that the nurse is interested in the patient and in what he is saying.

nurses in some nursing homes continue to wear white uniforms and caps. In other settings, nurses may not wear any distinguishing uniform, or they may wear scrub suits. Street clothes, such as a navy blue outfit with an identifying name tag, are preferred in some agencies, particularly in home care or public health. This can be confusing to older adults because such clothing is not distinctive enough to identify the individual as a nurse and because many older adults cannot read the small print on name tags. Older adults have been heard to say to caregivers, "Who are you? What are you going to do to me?" Although nurses may not place much importance on wearing a uniform, it does play a role in communication.

### Cultural Considerations

#### Nonverbal Communication

- Culture and nonverbal communication play important roles in patient perceptions. For example, Russian immigrants new to the United States may perceive that they are being treated incompetently and without adequate respect, based on cultural misunderstandings.
- In Russia, illness is viewed as a serious matter, and patients expect to be treated by stern, authoritarian care providers who give directions and do not seek input from the patients. Care providers wear appropriate uniforms, indicating their role and status.
- By contrast, in the United States, the patient is likely to be attended to by smiling, friendly, nonauthoritarian care providers who seek to involve the patient in decision making.
- These caregivers are normally dressed in scrubs or casual clothing that does little to identify their role or status. This contrast can lead to the mistaken interpretation that the caregivers are inexperienced and do not take the patient's concerns seriously.

### TONE OF VOICE

Think of the sound of a whisper, shout, or whine. Try saying, "I don't want to do that," first in a whisper, shout, and whine, and then in a normal speaking voice. Was

your understanding of the message the same in each situation? Probably not. To survive we learn early in life to understand that tone of voice is a fairly reliable way of judging a person's emotions. Because the nonverbal message is so strong, we typically respond to the emotion we perceive from the tone of voice and may not even hear the words. When a person shouts at us, we normally shout back. Shouting is often associated with anger or displeasure, yet many people shout in an attempt to communicate with someone who is hard of hearing. Shouting is not an appropriate way to deal with hearing problems because our tone of voice may lead the hearing-impaired person to think we are angry with him or her when this is not the case. Speaking in a low tone of voice close to the person's good ear is much more effective. Use of other nonverbal methods of communication, such as communication boards or gestures, can also help.

## BODY LANGUAGE

You walk past a room and observe a nurse standing in the doorway, with his or her head sticking into the room and body still in the hallway. The nurse's mouth is saying, "Can I help you?" but the body is saying, "I'm in a hurry. You really don't want anything, do you?" We communicate many things by how we move, stand, sit, and position our bodies. In dealing with all patients, but particularly older adults, it is important that we be aware of what we are communicating through our body language.

In situations in which the words and body language are conveying two different messages, most people respond to the body language. Standing at the door, hurrying down the hallway, sitting behind the nurses' station, and working in the medication or treatment room all communicate that the nurse is busy and does not want to be interrupted. Many older adults and their families are intimidated by this body language and may hesitate to interrupt, even to report serious concerns. Nurses must be careful not to create barriers between themselves and their patients. Going *into* the rooms to talk with patients, sitting down at eye level with residents, and spending time in the lounge with visitors are all ways of nonverbally communicating that you are truly interested and concerned.

Another part of nonverbal communication involves watching for the messages that patients are communicating to us through their body language. For example, patients who slump down or slouch in their chairs may be communicating fatigue or physical weakness, or they may be communicating a lack of interest, sadness, defiance, or a number of other things. Turning away from the nurse could indicate anger, fear, or lack of interest. When body language says something different from the words, believe the body language. Explore the situation using techniques such as reflective or open-ended statements. (These techniques are clarified later in the chapter.)

## SPACE, DISTANCE, AND POSITION

Physical space, distance, and position are other ways we communicate. The study of the use of personal space in communication is referred to as **proxemics**. *Personal space* refers to how close we allow someone to get to us before we feel uncomfortable. The amount of space that separates two individuals when they communicate is significant. In the traditional American culture, most people are comfortable when strangers are 12 feet or more away. This is considered **public space;** at this distance, there is no real positive or negative connection with the other person. Between 4 and 12 feet is considered **social space.** This is a comfortable distance for a casual relationship, in which communication is at an impersonal level. If a nurse stays this far away from his or her patients, the message being communicated is indifference. A distance of 18 inches to 4 feet is considered **personal space.** This is the optimal distance for close interpersonal communication with another person. A nurse who communicates from within this space is usually viewed as concerned and interested. The space within 18 inches of the body is considered intimate space. Most people allow only trusted individuals to get this close. Entering the intimate space without permission is usually perceived as a threat.

A nurse or other caregiver may approach an older adult to provide care or treatment and, without thinking, enter this intimate space too quickly. (Because of the nature of their work, nurses and other caregivers are used to entering a person's intimate space, and they take this for granted.) An older adult who has poor vision or hearing, who has been sleeping, or who is not totally alert may be startled by the nurse's approach. He or she may not be able to recognize the nurse as a trusted person at first and may strike out verbally or physically. This response results from fear of physical attack. It is essential that nurses recognize the importance of personal space and attempt to get the older adult's attention and (if possible) permission before attempting to perform any physical care.

## GESTURES

Gestures are a specific type of nonverbal communication intended to convey ideas. Gestures are highly cultural and generational; those that are acceptable in one culture may be considered offensive in another. Some gestures that are accepted today as commonplace were once considered crude or insulting. Gestures that have a certain meaning in one culture may have a different meaning in another. For example, nodding the head up and down means *yes* in most cultures, but to some Eskimo tribes it means *no*. Before using gestures, it is wise to determine that both parties have the same understanding of just what a particular gesture means.

Gestures are helpful for people who cannot use words. After a stroke, many individuals suffer from a condition called **aphasia.** Because of brain damage, these individuals may not be able to recognize words or to "find" the words they want to use. This inability to communicate wants, needs, and feelings is often frustrating to the affected person, and the use of gestures and other nonverbal forms of communication can be effective.

### Cultural Considerations

#### Preventing Cultural Bias in Caregiving

Culture, language, and communication are closely connected. Failure to recognize the impact of culture on communication can be a barrier to effective health care.

Health care providers, like others, often base their evaluation of a patient's words or behavior on their own culture and ethnic assumptions. To minimize cultural misunderstanding, health care providers need to do the following:

- Recognize their own cultural biases and assumptions.
- Increase their knowledge and understanding of the attitudes, beliefs, and communication styles of cultures other than their own.
- Recruit, retain, and promote health care providers from diverse ethnic and cultural backgrounds.
- Provide skilled interpreters, visual aids, and educational materials for predominant language groups.
- Address complaints or grievances that arise from cross-cultural misunderstandings so that care becomes more culturally sensitive.

## FACIAL EXPRESSIONS

Facial expressions are yet another form of communication. The human face is most expressive, and facial expressions have been shown to communicate across cultural and age barriers. Smiles, frowns, and grimaces appear to have the same meaning whether you are in the outback of Australia or in a boardroom on Wall Street. Humans respond to facial expressions from the time they are born. We tend to mirror the expressions of the person with whom we are communicating: Smiles tend to elicit smiles, and frowns elicit frowns. Fear, anger, joy, and a variety of other emotions can be conveyed by a simple change in facial expression. Nurses need to be aware of this fact and ensure that their expressions communicate what is intended. Too often, nurses are preoccupied while interacting with an older adult. A frown may lead the individual to think that he or she has done something wrong. A wrinkled nose, particularly when cleaning up an episode of incontinence, could be viewed as a lack of acceptance. A smile when listening to serious concerns may make the person wonder whether the nurse really cares about what is being said.

## EYE CONTACT

"Look me in the eye" is a phrase many white Americans have heard. Looking someone in the eye is perceived in our culture and other cultures as a measure of honesty. Yet in some cultures (e.g., African Americans and some groups from Southeast Asia), averting the eyes communicates respect. When dealing with older adults, it is important to be sensitive to the meaning of eye contact for them. Face-to-face, eye-to-eye contact can be helpful when communicating with older adults, providing this does not frighten or intimidate them. Eye contact is often interpreted to be a sign of attentiveness and acceptance. Face-to-face contact also maximizes the chance that an older adult with hearing problems can read lips if necessary. Sitting at the bedside may facilitate eye contact.

## PACE OR SPEED OF COMMUNICATION

Nurses tend to be substantially younger than the aging people they serve. The resulting difference in rate of speech and movement can be overwhelming and frustrating to older adults. Many choose not to respond or interact with younger nurses because they feel they are being hurried. Do not become impatient or uneasy with silence; give the older person enough time to think and organize a response. Provide encouragement and reassurance that they will have all of the time they need. Nurses have too often been observed completing sentences for older adults when they should have the patience to wait for the individuals to organize their thoughts and speak. Many times, nurses complete the communication according to their own way of thinking rather than waiting to hear what the older adult wants to say. This is disrespectful and demoralizing. Patience and active listening are greatly needed skills when working with older adults. "Slower is better" should be the motto impressed in the mind of anyone who chooses to work with older adults.

## TIME AND TIMING

Timing is related to the pace of communication, but it has other distinct implications as well. The amount of time a person must wait after seeking attention is important. Delays in response to a call light or direct request from a person may be interpreted as a lack of concern, even if this is not intended. The response to this perception may manifest in anger, displeasure, anxiety, fear, and many other feelings. Studies have shown that nurses take longer to respond to terminally ill patients. Nurses also tend to give delayed responses to demanding individuals. This can set up a vicious cycle, because the longer a person waits for a response, the greater his or her anger, fear, and anxiety becomes. This only increases the demanding behaviors, which often occur in an attempt to reduce fear. If the older adult's needs are dealt with promptly, the number of

demands tends to decrease not increase. Making older adults wait unnecessarily constitutes a subtle form of abuse.

Many older individuals have an altered sense of time. A message that is communicated too early may lead to either forgetfulness or to repeated questions of "Is it time yet?" A message that is communicated too late may lead to distress and frustration. Older adults often need more preparation time than younger individuals need to get ready for an activity such as going to the bathroom or getting necessary items together. Communicating an exciting message late in the evening (whether it is good or bad news) may disturb older adults to the point that they are unable to sleep. Nurses need to be aware of these issues so that they can choose the proper time to communicate.

### TOUCH

Touch is a form of communication. No words are required, and there is no need for high-level sensory or cognitive functioning. When all else fails, touch is left. Caring touch is a basic need of all humans, and many older adults suffer from touch deprivation. Many older people, particularly those who have lost their spouses and have little contact with children or other family, have no one to meet this need. Research shows that psychotic patients and older adults are touched the least by caregivers. Those who most need physical contact and the comfort provided by touch receive the least.

Use of touch as a method of communication is often difficult and uncomfortable, particularly for young or inexperienced nurses. Touching is a very personal form of communication. Affection, understanding, trust, hope, and concern can be communicated by a hand placed on a shoulder, a stroke of the forehead, or a frail hand held by another stronger one. Touch is a common method of expressing concern and caring. People who are emotionally close hold hands and touch and hug one another. High on the list of things lonely older people say they miss are hugs and touching. Empathetic use of touch is a much-needed skill when working with older adults. When words do not work, touch often does (Figure 5-2). If there is any doubt whether the patient wants to be touched, the nurse can ask or watch how the person responds to the touch. Touching should be done with caution when a person is experiencing pain so as not to cause further discomfort.

Whereas appropriate use of touch is of great benefit to older adults, inappropriate touching can be destructive. Touch is inappropriate when it is used to communicate anger or frustration. Rough handling, slapping, pushing, or otherwise communicating displeasure constitutes patient abuse and is out of place at all times. Cultural beliefs may dictate when, who, and how people may touch. If there is any question regarding the appropriateness of touch, clarification should be obtained beforehand.

**FIGURE 5-2** Comfort and well-being can be promoted with eye contact and gentle touch.

### SILENCE

Saying nothing is also saying something. Being with another person and remaining silent is difficult for many people, including nurses. At times, words can be intrusive; they can interfere with true communication. Many times, older adults require more time to compose their thoughts. Silence permits them to focus on the point of discussion while continuous talking is distracting. At times, no words are necessary. During intense grief, pain, or anxiety, simply *being there* without saying or doing anything may be the most appropriate form of communication nurses can give. The simple presence of another human expresses true concern and can be worth more than all of the words in the world.

## ACCEPTANCE, DIGNITY, AND RESPECT IN COMMUNICATION

**Empathy** is defined as the willingness to attempt to understand the unique world of another person. It is the ability to put oneself in another person's place and to understand what he or she is feeling and thinking in various situations. Empathetic listening involves actively trying to understand the other person, not just knowing many facts about that person.

Effective communication starts with proper introductions. Nurses should determine how each older adult wishes to be addressed. It is presumptuous for nurses to become too familiar with older adults by addressing them by their first names. It is better to start by using the older adult's proper title and name (e.g., Mrs. Quinn and Dr. Jones) and then clarifying which form of address the person prefers. If someone wishes to be called by a first name or a nickname, the person will usually say so. In special situations, such as when a patient has dementia or other alterations in cognition, first names may be most appropriate because that may be the only name the person can remember. Use of the

pronoun *we*—as in "Are we ready to get dressed now?"—is inappropriate and should not be used unless the nurse plans to get dressed along with the patient. Use the term *I* when speaking about yourself and *you* when referring to the patient.

Often younger persons use a sing-song voice or refer to older adults by "baby talk" names such as "sweetie" or "honey," thinking that this conveys affection and caring. This type of speech may be appropriate with young children, but it is patronizing and demeaning to older adults and considered inappropriate in a clinical setting. This type of communication, sometimes called *Elderspeak*, is a form of ageism. It is far too commonly heard in health care settings, which is unfortunate because it has a subtle way of diminishing an older person's self-esteem. Use a normal conversational tone of voice whenever possible. When communicating with older patients, nurses must avoid language that stereotypes or dehumanizes them. Such language may be overheard by the older patient or family members, who may interpret it as disrespectful. It is best to first speak in terms of the *person*; for example, the nurse should refer to "Ms. Todd, who has diabetes"—not the "diabetic in bed 14B." The nurse should also pay attention to the possible negative connotation that words can have to older adults or their family and substitute more positive terms when possible. For example:

- Instead of *diapers*, say *briefs*, *pads*, or use a trade name such as *Depend*.
- Instead of *blind* or *deaf*, say *visually* or *hearing-impaired*.
- Instead of *senile* or *dementia*, say *cognitively challenged*.
- Instead of *nursing home*, say *care facility*.

There is a reason we have two ears and only one mouth. We are supposed to listen twice as much as we talk!

To communicate effectively, we must first learn to listen actively and empathetically. Listening is more than simply hearing. Hearing involves the ability of the ears to detect sound, whereas listening involves interpretation (i.e., figuring out what the sounds mean). We have not really listened until we understand for certain what was intended by the speaker. We cannot simply listen to the words; we must listen for the meaning of the words.

Active listening skills are needed in all areas of nursing, but particularly in dealing with older adults. Empathetic listening requires sensitivity to the strengths and limitations of the aging individual (e.g., hearing changes, vision changes, fatigue and pain). Empathetic listening involves patience when an older adult needs extra time to voice a response, or repeats the same thing many times. It includes a willingness to spend time getting to know the older adult better as a human being—not just as another body in need of skilled physical care. Listening to an older person reminisce about his or her life can help the nurse gain better understanding of the person's values, perceptions, strengths, needs, and concerns (see Chapter 11).

Too often, nurses provide excellent physical care to people they have not taken the time to know. Nurses need to stop talking "over" patients while they do procedures, put away their clipboards, and sit down and really talk with older patients more often. Empathetic listening requires the ability to focus on the aging person, not simply on the tasks at hand. If we do not really listen, our older patients are likely to stop talking and we will all be poorer for the loss.

## BARRIERS TO COMMUNICATION

For effective communication, we must learn to identify the barriers that can interfere with an exchange and the methods that help overcome these barriers. Effective communication is not easy (Figure 5-3). More than just the ability to talk to someone, communication involves all of the ways that we send messages to someone else, including nonverbal ways. Different physical problems require different communication approaches. Communication makes use of all of the senses. Hearing and vision are the senses used most often in communication, but touch, smell, and even taste also play a part in the relay of messages. It is important to remember this when communicating with older adults because their perceptions may be altered by normal physiologic changes that occur with aging. Pain or extreme fatigue may make communication difficult. It is best to limit conversation to essential topics during these times. A variety of disease processes, such as cerebrovascular accidents and dementia, significantly affects

**FIGURE 5-3** Nurses integrate therapeutic communication skills into all aspects of care.

communication processes and requires specific approaches. Diverse social and cultural backgrounds of older adults also make the area of communication a challenge for nurses.

**Coordinated Care**
**Communication Skills**

**Supervision**

When it is necessary to correct a subordinate for unsatisfactory performance, try to avoid "You" messages, such as "You never complete your assignments." Instead use assertive "I" messages—for example, "I am upset and disappointed when patients' needs are not thoroughly met." This is less likely to result in an argument and will more likely lead to problem solving. Also, be sure to praise people in public but correct them in private.

## HEARING IMPAIRMENT

If the person wears a hearing aid, make sure it is clean, that the batteries are working, and that the device is in the correct ear. Try to minimize background noise because this can distort sounds and make hearing more difficult. Many people who are hearing-impaired spontaneously begin to read lips. In addition to the basic strategies, the following actions are likely to be beneficial:

1. Stand in front of the person.
2. Do not eat or drink while you are having a conversation.
3. Keep your hands away from your face when speaking.
4. Try different ways (words) of saying the same thing.
5. Speak more slowly and slightly louder while modulating the voice to a lower pitch.
6. Avoid exaggerated mouth motions during speech.
7. Use visual cues or written materials that support the spoken words.

Box 5-1 provides additional strategies for communicating with impaired older adults.

## APHASIA

Individuals who have had a cerebrovascular accident or other head injuries may experience aphasia, which is a partial or total loss of the ability to use or understand words. It affects the ability to understand and express oneself through words, gestures, and writing but does not necessarily affect intellectual function. Consultation with a speech therapist can help the nurse devise approaches that will optimize function. In addition to the basic strategies, some commonly recommended approaches include the following:

1. Keep messages simple but adult.
2. Use nonverbal modes of communication such as picture boards, gestures, yes/no responses, and facial expressions.
3. Use visual aids to support.
4. Try increasingly specific guesses or questions to determine concerns (e.g., Something's wrong with your meal? The coffee? It's too hot? You want milk?).
5. Praise attempts to speak, and avoid correcting or criticizing errors.
6. Reassure the person that it is okay to be frustrated, but avoid empty platitudes such as "You'll be fine."

**Box 5-1 Basic Strategies for Communicating With Impaired Elderly Adults**

- Try not to startle the person when starting a communication.
- Approach from the front, knock, or announce your presence by calling the person's name.
- Identify yourself.
- Communicate when the person is most alert.
- Eliminate or reduce noise and distractions.
- Make sure you have the person's attention before speaking.
- Focus on abilities, not disabilities.
- Select topics of interest to the person.
- Try to use a variety of words or descriptions until meanings are clear.
- Ask clear, specific questions.
- Ask only one question at a time.
- Pay attention to the emotional context of conversation.
- Use pictures and gestures in addition to words.
- Have the person sit up for conversation whenever possible. Keep messages simple and repeat as needed.
- Be patient and do not interrupt. Slow down the pace of communication.
- Treat the person as normally as possible.

## DEMENTIA

Dementia causes both cognitive and language deficits. The elderly person suffering from dementia has no control over these changes, so the responsibility for effective communication rests with the nurse. Depending on the severity of the dementia, the individual may demonstrate different levels of function. The abilities and limitations of each individual suffering from dementia must be evaluated so that the most effective interactions can be planned. Some characteristics of dementia include a limited attention span, inability to focus on more than one thought at a time, confusion of fact and fantasy, and the inability to follow complex instruction. According to the Alzheimer's Association, "For persons with dementia, behavior is frequently a form of communication." Problems with communication can result in agitation, restlessness, abusive language, or combativeness. Repetitive vocalizations, urgency, and change in tone or pace of speech can indicate an unmet need, even when the sounds are meaningless. Caregivers should try to determine the meaning of the behavior, not ignore it as meaningless.

In addition to the basic strategies, some recommended approaches include the following:

1. Talk about one thing or ask only one question at a time.
2. Limit choices; too many options are confusing.
3. Keep the conversation in the here and now.
4. Ask simple yes/no questions.
5. Try "filling in" or "repairing" thoughts. Rather than letting a person get upset trying to find the right words, you may offer some likely choices. However, be careful not to get in the habit of finishing the thoughts and sentences of patients who are not cognitively impaired.
6. Avoid asking questions that require information, such as "How was your day?"
7. Use gestures or demonstrate an action so that the person can mimic your behavior.
8. Avoid the use of an intercom, which may confuse the person.
9. Avoid arguing if the person does not accept your reality.
10. Redirect the person who is acting out to a more appropriate activity.
11. Share activities such as looking at a magazine, viewing family photos, or listening to music.
12. Avoid trying too hard to communicate. If words do not work, try gentle touch.
13. Watch your tone of voice because patients with dementia are often very sensitive to nonverbal cues and may sense your frustration and become more agitated or upset.

## CULTURAL DIFFERENCES

A Chinese guide in Beijing asked his tour group (in very clear English), "What do you call a person who speaks more than one language?" The group replied, "multilingual." He then asked, "What do you call a person who speaks only one language?" The group was not sure how to reply, so he provided the answer: "Americans." Although this is rather a strong generalization, the majority of Americans still speak only one language—English. We tend to expect everyone else, no matter where we are in the world, to understand us. If others do not speak English, Americans' typical response is to talk more loudly, as if volume will make a difference. Fortunately (or, some would say, unfortunately), most other countries have a significant number of people with some knowledge of English in addition to their native language.

Many community colleges and multicultural centers offer special courses in languages for health care providers. Often, these courses are specifically designed to meet the needs of the local community. This benefits the minority communities as well as the nurses, who have the opportunity to become particularly desirable employees.

Immigrants from many European, Central American, African, and Asian countries bring varied levels of English proficiency, which presents increased challenges to health care providers. To communicate effectively, we need to know what language a person speaks. We also need to know what level the person is most comfortable using because, during times of stress, a person may revert to his or her first language. It is most advantageous if caregivers from similar cultural and ethnic backgrounds are available to act as translators. Many facilities actively try to recruit individuals who are trained and qualified to work with the needs of the dominant cultural groups in a community. In an increasingly diverse world, this is not always possible. In these cases, other interpreters are needed. To be an effective interpreter, a person needs to be proficient in both languages and ideally trained regarding the ethics of the job. Interpreters should also have some understanding of the clinical concepts they will be expected to explain. A study done in a pediatric setting revealed that even official translators made many serious errors that were potentially dangerous. The same problem is likely to hold true when dealing with the elderly. Family and friends of the patient do not have this training and frequently bring personal and emotional connections that may influence the communication or make the patient reluctant to share information. Although family members are not the most appropriate persons to interpret sensitive or technical medical information, they may be helpful in translating simple questions or requests.

Some basic rules to keep in mind when working with an interpreter include the following:

- Ask short questions and provide brief units of information so that the interpreter does not lose the main idea in translation.
- Avoid excessively technical language.
- Avoid slang, idioms, or colloquial expressions.
- Encourage the interpreter to give you the response using the patient's own words, without input or paraphrasing, whenever possible.
- Focus on the patient, not the interpreter.
- Listen for emotional tone and nonverbal clues when the patient responds, even if you do not understand the words.
- Allow enough time.
- Make sure that there is mutuality by encouraging the patient to ask questions of the staff through the interpreter.

In addition to making adaptations for language, the nurse should pay close attention to nonverbal communications. Ignorance of cultural beliefs and practices can lead to mistakes that damage rapport. When in doubt, ask the elderly person or family if there are any special actions or behaviors that should be avoided.

**Critical Thinking**

**Culture, Ethnicity, and Communication**

- Of which cultural or ethnic group(s) do you consider yourself to be part?
- List all of the cultural or ethnic groups with whom you occasionally or regularly have contact.
- Consider the cultural or ethnic group with which you identify:
  - Identify any gestures you consider acceptable.
  - Is direct eye contact typical? Are there times when direct eye contact is not considered appropriate?
  - How close do people stand when talking to each other?
  - Do people touch frequently? Whom do they touch? Where or how do they touch? What type of touch is not allowed? Are there gender differences related to touching?
- Do you live primarily in the "here and now," or do you think it is essential to plan for the future?
- How important is it in your culture to be on time and keep appointments?
- Do you feel comfortable or ill at ease when communicating with individuals from diverse cultures? Does your comfort level change when the interaction is one-on-one or when you are in a group? Does it change if you are the only member of a specific culture or ethnicity in a group dominated by another culture or ethnicity?
- Identify two or three situations in which you felt that a person from another age, cultural, or ethnic group did not understand you or misinterpreted your nonverbal communication.
- Identify two or three situations in which you felt that you did not accurately understand the communication sent by a person from another age, cultural, or ethnic group.
- Can you think of any specific cultural beliefs or practices that you would want a nurse caring for you to understand?

## SKILLS AND TECHNIQUES

### INFORMING

Informing uses direct statements regarding facts. A good information statement is clear, concise, and expressed in words the patient can understand. When the nurse is informing, the nurse is active and the patient is passive. Informing is the least effective form of communication because the patient is not actively involved. When nurses give information, they should ask their patients to restate what they understand using their own words. A message may need to be repeated and rephrased to ensure understanding. This should be done tactfully and with care that the nurse does not show signs of annoyance or frustration.

### DIRECT QUESTIONING

It is best to keep communication conversational and not too aggressive. Too many direct questions can overwhelm an older person and may block rather than expand communication. Direct questioning is helpful when nurses need to obtain specific information or in emergency situations when time is precious. Direct questions tend to include the words *who, what, when, where, do you,* and *don't you*. Direct questioning is appropriate when information must be obtained quickly; however, if it is overused, patients may become defensive. Many students and new nurses approach patient assessment with a list of 50 questions that must be answered. After the first 10 questions, patients begin to feel as though they are on trial and communicate only the bare minimum of information. Direct questions tend to yield brief answers and often a *yes* or *no* only.

### USING OPEN-ENDED TECHNIQUES

Open-ended communication techniques include open-ended questions, reflective statements, clarifying statements, and paraphrasing. These techniques allow the patient more leeway to respond, thus establishing a more empathetic climate. The patient is more likely to feel that the nurse is interested in him or her personally and not just trying to fill out a stack of forms. Examples of open-ended techniques include the following: "And after you moved to the nursing home, what happened?"; "And then?"; "That must have been frightening!"; "What I heard you say is . . ."; "It sounds like you think (feel). . . ." Open-ended techniques allow patients to express more about their feelings and perceptions. They also allow nurses to verify that the information being relayed is accurate.

### CONFRONTING

Confronting is used when there are inconsistencies in information or when verbal and nonverbal messages appear contradictory. **Confrontation** is one of the most difficult communication techniques to use and should be used only after good rapport has been established. It is never advisable to confront a highly agitated or confused person because conflict and a breakdown in communication will result. Confrontation should be used only when there is adequate time to explore the problem and come to some form of resolution.

### COMMUNICATING WITH VISITORS AND FAMILIES

Nurses must be prepared to interact with their patients' friends, families, and other visitors. These people make up the older adult's social network and support system. Families and friends are interested and concerned about what is happening to their loved ones. Not only do they turn to nurses for information and reassurance, but also they can be a good source of information for the nurse.

These *significant others*, as they are often called, can help in many ways if nurses are responsive to them. Many of the older adult's significant others are themselves senior citizens. Nurses must be aware that communication with these individuals may also require special attention and the use of special techniques. It is important to take the time to develop

good rapport with your patients' significant others. Good communication with these important people can do a great deal to facilitate care. Because they have known the patient longer and better than the nursing staff has, they are often able to detect subtle changes before trained nurses can. Many times, nurses need to rely on the significant others to interpret the behaviors and communications of older adults. Listen to what they have to say.

**? Critical Thinking**

**Communication Skills**

- Look at the people on each side of you in class. What is their body language communicating?
- Think of a person (e.g., friend, instructor, TV personality, and politician) you consider to be a good communicator. Next, think of a person you consider to be a poor communicator. Fold a piece of paper in half. Write the name of the effective communicator on one side and the ineffective communicator on the other side. Below each name, list the characteristics that make that communicator effective or ineffective. Compare and contrast your findings.
- Compare your own communication skills to those of the people whose names you wrote down. Are you more like the effective or ineffective communicator? How? What can you do to become more effective in your communication ability?

## DELIVERING BAD NEWS

No one likes to get bad news, and no one likes to be the one who has to tell someone else bad news. Most people try to avoid this daunting task. Ideally, this task should be performed by the most experienced and knowledgeable person, such as the physician, but, occasionally, the nurse must be the one to break bad news to an elderly person. This could be information regarding the patient's health or about someone near and dear to the patient—for instance, the death of a spouse or other loved one. The EPEC Project, funded by the Robert Wood Johnson Foundation, has developed guidelines for physicians that have relevance for nursing practice. Important concepts include the following:

- Prepare yourself. Make sure you have all of the information and that it is accurate.
- Think through what you want to say so that the message is compassionate and culturally sensitive.
- Establish an environment that respects the patient's privacy.
- Determine whether anyone else (chaplain, family members, etc.) should be present when the news is delivered.
- Make sure there is adequate time, free from interruptions, to deal with the expected emotional response.
- Determine what the person already knows and, if possible, how much they want to know.
- Recognize that ethical and cultural variations may influence the way information is delivered.
- Use simple, direct, but sensitive language to begin the message, such as, "I'm afraid I have bad news for you."
- Respond to the person's emotional reaction—for example, "I'll try to help you. Is there anything I can do?" or "Do you want to talk about how you're feeling?"
- Develop a plan for follow-up. Help the older person and significant others with appointments, referrals, transportation, and so forth.
- Communicate significant information to other caregivers as part of a plan of care.

## HAVING DIFFICULT CONVERSATIONS

Emotionally loaded topics are likely to generate strong emotions and often lead to conflict. Conflict is a normal and routine part of human interaction; it can occur between elderly parents and adult children, nurses and elderly patients, nurses and patient families, nurses and other nurses, or nurses and physicians. Difficult conversations may occur in clinical areas or in home settings involving friends and family members.

Some people prefer to avoid conflict entirely and pretend it does not exist, but avoidance just delays solving problems that need to be addressed. The following guidelines are suggestions based on conflict resolution research:

- Pick a place that is private and a time when you will be free from distractions.
- Try to focus on a single topic; do not bring up old grievances that get in the way.
- If a conversation is not going well, take a look at your own feelings and motivations. Are you reacting to this issue or to another issue that was problematic in the past?
- Express your feelings using "I" statements, such as "I get upset when . . . doesn't get done" rather than "You" statements, such as "You always ignore what I ask you to do."
- Respect the right of the other person to agree or disagree.
- Keep a balance between talking and listening. Try not to dominate the conversation.
- View each communication as a new opportunity to learn something about the other person and about his or her unique feelings, beliefs, and perspectives. Listen to the other person and seek clarification as to his or her reasons and feelings.
- Do not prejudge or assume that you already know what the person is going to say. You may be wrong.
- Be aware of your own feelings regarding the issue under discussion. Keep feelings separate from facts. The fact that someone does not do what you want

does not mean that the person does not like you or that he or she is doing it to upset you.
- Avoid blaming the other person. Look for ways to solve disagreements.
- Accept that difficult conversations are part of life and that things do not always go right.
- Learn from both negative and positive interactions, and try to improve the communication next time.
- Try to achieve a win-win solution.

## IMPROVING COMMUNICATION BETWEEN ELDERLY PATIENT AND PHYSICIAN

Clear communication between the elderly patient and their physician is essential. Most physicians are aware of effective communication protocols, but, because of time constraints or other factors, they may not always use these techniques. Ineffective communication can result in frustration for both parties and can contribute to a lack of compliance by the patient. Also, it is not uncommon for an elderly person to become passive, evasive, or tentative when talking with the physician.

The nurse can often help minimize these problems by (1) suggesting that the patient keep a written list of concerns and questions so time is not wasted while the patient tries to remember them, (2) asking the physician to repeat and summarize directions to the patient, (3) identifying printed materials that support the physician recommendation, (4) suggesting that a trusted friend or family member be present to take notes and help the elderly person express his or her concerns, or (5) acting as a patient advocate by asking the physician to clarify questions or concerns the patient has verbalized to you.

## COMMUNICATING WITH PHYSICIANS

The quality of communication between nurses and physicians can have a significant impact on the quality of care elderly patients receive. Communication problems between nurses and physicians can lead to job frustration, blame, and distrust, all of which diminish the level of care provided and increase the risk for problems or errors. Conversely, good communications tend to improve job satisfaction, decrease errors, and promote quality care of the elderly. Physicians and nurses are busy. No one has time to waste on unnecessary or nonproductive interactions. Mutual respect and a willingness to collaborate for the good of the elderly patient can form a strong basis for good interactions. The nurse can use a number of strategies to decrease frustrations and optimize the efficiency and effectiveness of communication (Box 5-2).

When you call a physician, start by identifying who you are (name and title), the patient or patients you are calling about, and the specific reason for the contact. Plan ahead and have a focus for the communication. Know what you want to report or find out. Be organized, clear, precise, and complete. Provide background information. Remember, the physician is not looking at the chart and may see the elderly patient once a month only, or even less frequently in the case of an independent elderly adult. Provide all necessary and relevant information that the physician might need. Identify the patient by name, major diagnoses, and any medications related to currently presenting symptoms or concerns. Be prepared to clarify any data or information that the physician may request.

Keep a list or log of issues to be reported or discussed with each physician so that all issues can be covered in one interaction. This will prevent repetitive interruptions for both the physician and the nurse. Identifying parameters (or guidelines) when the physician wishes to be contacted (e.g., patient's blood sugar over 200 and blood pressure under 120 systolic) can minimize problems related to under or over notification.

Emergency situations need to be handled immediately, but these make up a small portion of nurse-physician interaction. Most communications involve either routine or somewhat urgent information that can be handled in a more methodical, planned manner. It is helpful to determine whether there is a best time and method to use when contacting the physician regarding nonemergency situations. Today there are many ways to transmit information, including standard telephone, cell phone, Fax, e-mail, Blackberry, and others. Planning ahead to identify the best time and methods will optimize communication and enhance care of the patient while minimizing frustration.

### Box 5-2 Additional Tips for Improving Nurse-Physician Communication

- Work at developing professional relationships based on trust and respect.
- At some point, try to meet face to face with physicians you speak with on the phone.
- Assume that you are both on the same team.
- Report good news, not just problems and bad news.
- Be prepared for conflict.

Adapted from Burke M, Boal J, Mitchell R: Communicating for better care: improving nurse-physician communication, *Am J Nurs* 104:40, 2004.

## PATIENT TEACHING

Education plays an important role in promoting and maintaining the health of older adults. Teaching may be a one-on-one session or a group experience. The ability to teach, explain, and motivate is increasingly part of the role of today's nurse. To perform this role successfully, the nurse needs to know basic principles and techniques of adult education and adaptations specific to older adults.

It has been said that "you can't teach an old dog new tricks." Research has shown that this is not true. Elderly people can learn new things. It has been established that

mental abilities such as numeric tasks, word fluency, inductive reasoning, and spatial orientation develop through the first four decades of life and then hold fairly stable until the seventies in most individuals—even longer in others. Although younger individuals tend to do better at learning information that requires memorization, older individuals compensate by using the verbal skills, experience, and judgment they have acquired over time. Learning is maximized when it can draw on the previous experiences of older adults.

Adult learners are oriented toward problem solving, and they view learning as most desirable when it is relevant to their own lives. Teaching will be most effective when the patient recognizes and accepts the importance of learning new information or techniques. Older adults will be more willing to learn when the topic is important to them. For this reason, the nurse should try to determine ahead of time those things the elderly patient thinks are most important. The nurse can prioritize teaching by starting with the area that the *patient* perceives to be most important, then linking that information to the other things the *nurse* thinks are necessary or important. Work in small, discrete blocks of information, proceeding from simple, more familiar concepts to more complex or difficult ones. Remember that success breeds success. When older adults realize that they have mastered one skill or piece of information, they are more likely to have a positive attitude toward additional learning.

It is important to pick the right place and time for teaching. The right place depends on the material the session will cover. Information that is viewed as personal or private is best taught in a quiet space away from others. More general information (such as nutrition teaching, stress reduction, or similar topics) may be best taught in a group, where older adults are free to share personal experiences and solutions with one another. Wherever teaching takes place, the space should be adjusted for the older adult. The temperature should be set appropriately, chairs should be supportive and comfortable, lighting should be adequate and free of glare, and bathrooms should be readily accessible. Snacks and beverages are appreciated by most elderly adults and can make a group learning session a positive social interaction.

When selecting a teaching time, avoid times when the patient is stressed, fatigued, or in pain; all of these situations interfere with the patient's ability to process information accurately. Also, avoid times when older adults may be distracted by things of higher priority to them, such as a favorite television show or anticipated visit from friends or family. When selecting a time for teaching, make sure there is adequate time to discuss the important information. Remember that older individuals will need more time to process information. Avoid trying to teach too much at one time. Break teaching into manageable blocks so that the older adult has time to think about a limited number of concepts. Whenever possible, provide printed materials to supplement and reinforce the content that was covered (Box 5-3). Practical examples or illustrations related to the topic may be more effective than a quick recitation of factual information. If the teaching involves a psychomotor skill, such as drawing up insulin or changing a dressing, the older adult should receive one or more demonstrations of the skill and then be given ample opportunities to practice and perform the skill with supervision. The nurse should be patient and supportive, regardless of the amount of time needed. Remember, the goal is learning, not speed.

**Box 5-3 Modification in Preparing or Selecting Printed Materials for Older Adults**

- Limit the amount of material on a single page.
- Allow enough white space so that material is clear and distinct.
- Use at least a 12-point font for printed materials. Overhead transparencies should use at least a 20- to 24-point font.
- Thicker letters are easier to read than fine print.
- Avoid elaborate fonts; stick with simple, basic lettering.
- Stick to one style of font per document.
- Use a normal mixture of capital and small letters.
- Select paper and ink of strongly contrasting colors.

Modifications may be needed to compensate for common sensory changes experienced with aging. Be sure to face older individuals when speaking. Speak clearly. Try to avoid microphones or amplifiers that might distort sounds or cause interference with hearing aids. Repeat information, and use visual cues or materials to reinforce a verbal message. Support verbal information with printed material and audiovisual aids such as videos. Encourage hands-on practice. Use as many senses as possible, but not necessarily all at once. Too much sensory input may confuse the older adult.

**Clinical Situation**

**Communicating With Older Adults**

A physician and a clergyman happened to arrive in an elderly patient's room at the same time. The patient became very anxious and started to cry. The physician and the clergyman were taken aback because the patient was doing well and was ready for discharge. After much time was spent calming the patient and listening carefully, they realized that the patient responded as she did because she thought the doctor was going to tell her that she was dying and that the clergyman was there to console her.