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Communication with elderly patients – a key to success in geriatric care

Komunikacja z pacjentami w starszym wieku – klucz do sukcesu w opiece geriatrycznej

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INTRODUCTION

Interpersonal communication is a main way of exchanging information between patients and medical staff and is indispensable for efficient and adequate treatment. In older age, there are multiple factors reducing ability to communicate, including sensory organ deficiency, slower transfer of information and cognitive

S u m m a r y

Communication is a process of exchanging information verbally and non-verbally. It may be analyzed on many levels, including direct and indirect modes of communication. Physiological changes accompanying aging, as well as comorbidities may create communication barriers and significantly impair understanding between older adults and health care workers. Lack of adequate communication skills lead to common errors committed by medical staff and may cause significant problems and negatively affect treatment process. Auditory and visual impairment, as well as cognitive deterioration represent situations requiring special education and vigilance of health professionals. Hospitalized patients, especially those in advanced old age, have special needs for communication, different from the outpatient setting. Comprehensive geriatric assessment may be a useful tool in evaluating the elderly patient and indicating specific individual challenges. Adequate communication not only facilitates exchange of information, but also creates friendly and safe environment for the elderly patients and guarantees quality of health care. Therefore, communication skills training should be an indispensable component of geriatric education, since it is a key to understanding the older patient.

S t r e s z c z e n i e

Komunikacja jest procesem wymiany informacji w sposób werbalny i niewerbalny. Proces ten można analizować na wielu poziomach, z uwzględnieniem komunikatów bezpośrednich i pośrednich. Fizjologiczne zmiany zachodzące w procesie starzenia się organizmu oraz choroby wieku podeszłego mogą sprzyjać powstawaniu barier komunikacyjnych i wpływać negatywnie na możliwość porozumiewania się osoby starszej z pracownikami ochrony zdrowia. Brak odpowiednich umiejętności komunikowania się prowadzi do licznych błędów popełnianych przez personel medyczny i może spowodować poważne problemy, a nawet zakłócenie procesu leczenia. Zaburzenia wzroku i słuchu oraz zaburzenia funkcji poznawczych występujące często u osób w starszym wieku stanowią znaczące wyzwanie, które wymaga specjalnego przygotowania i uważności pracowników ochrony zdrowia. Pacjenci hospitalizowani, szczególnie ci w zaawansowanym wieku, mają inne potrzeby komunikacyjne niż osoby leczone w warunkach ambulatoryjnych. Metodą pomocną w ocenie pacjenta w starszym wieku i jego indywidualnych trudności w komunikacji może być całościowa ocena geriatryczna. Prawidłowa komunikacja nie tylko ułatwia wymianę informacji, ale również sprzyja tworzeniu przyjaznego i bezpiecznego środowiska dla pacjentów w starszym wieku oraz poprawia jakość opieki medycznej. Trening umiejętności komunikowania się powinien zatem stanowić integralną część szkolenia w zakresie geriatry, gdyż efektywne porozumiewanie się jest kluczem do zrozumienia osoby starszej.

impairment. Lack of adequate communication skills of health care workers may affect contact with patients of any age, however it may dramatically impair communication process with older individuals. Addressing patient's caregiver instead of the patient is not only a serious communication error, but might be perceived as a form of neglect and ageism. Understanding the

complex nature and role of communication with older adults, together with critical view of one's communication style are key factors in establishing the optimal model of communication.

DEFINITION AND LEVELS OF COMMUNICATION

The word "communication" comes from the Latin words *communico*, *communicare* meaning making common, uniting, transferring news, debating. Another Latin word *communio* stands for unity and belonging to a community (1). These broad linguistic meanings underline functional role of communication encompassing much wider space than just exchange of information. Levels of communication include intrapersonal or internal and interpersonal or external dimensions. Intrapersonal communication is necessary for gaining insight of one's actions and perceiving the role of self in the process of communicating with others. Deficient internal "talk" may severely affect interpersonal relations. There are also indirect ways of communication, including exchange of information within a group or between groups of people or organizations, as well as transmitting news through the power of mass media. New ways of communication include long distance communication, e.g. via the Internet (1).

COMMUNICATION MODEL

In the process of communication there is a sequence of elements setting up a model of communication. It includes: a sender (Who is speaking?), a message (What is being said?), a channel (How it is being said?), a receiver (To whom it is being said?) and an effect (What is the result?). It is necessary to acknowledge the role of such additional elements as context of communication, environmental factors including noise, as well as feedback. Nonverbal communication may play a crucial role, especially in cases when the usual verbal channel of communication is compromised, e.g. in patients with speech disorders. Nonverbal communication includes such elements as: gestures, posture, body movements and visual contact. Spatial relationships between participants may facilitate or impair exchange of information. Such para-linguistic factors as voice intensity, speech speed, voice modulation, laughter may make interlocutors comfortable or may establish barriers in communication. General appearance, cloths, hair style and jewelry are additional factors influencing effectiveness of communication. Psychological approach to communication points to therapeutic communication and active listening as two skills indispensable for responsible contacts with patients (1).

BENEFITS OF EFFECTIVE COMMUNICATION

Effective communication will likely lead to better patient's compliance and improved health outcomes, as well as lower the risk of medical errors. Role of interpersonal communication reaches far beyond the transfer of information. Adequate communication may

strengthen patient's feeling of belonging to a group or community or "having a place on earth", it may increase security level and make supportive activities towards elderly patients more friendly and acceptable. Proper communication with hospitalized elderly patients strengthens fragile treads linking them with the reality and may prevent development of acute mental disorders such as delirium.

STEREOTYPES ABOUT AGING

There are many pejorative perceptions about old age and the aging process. Many people believe that older people, especially those in advanced age, are extremely different from the representatives of today's society and don't share the same needs or desires. Another misconception about older adults is that elderly people are isolated due to many health problems and have a lot of emotional problems. In spite of the fact that realities of aging seem not to fit the stereotypes, myths and misconceptions are still prevalent (2). Such phenomena should be perceived as ageism, even if they are presented with a face of pseudo-empathy for the elderly. On the other hand, many older adults share negative feelings about the old age and express pejorative thinking about being old. Understanding the above circumstances does not necessarily make the communication process easier, but it may lead to better understanding of challenges and barriers.

HOW NORMAL AGING MAY IMPAIR COMMUNICATION?

Changes due to physiological aging are usually mild and progressing slowly, however in unfavorable circumstances may become serious foes and culprits of treatment failure. Physiological changes in the brain include small decrease of brain mass, impaired regional blood flow, slower conduction of impulses, and deficits in neurotransmitters. These pathophysiological processes may impair attention, working memory, as well as access to long-term memory. The two main concepts of cognitive aging include the theory of impaired information processing and hypothesis of inhibition deficit. Inhibitory mechanisms impaired during aging are responsible for cognitive control, deleting unimportant data and suppression of improper reactions (3). In clinical practice, the above changes may produce talkativeness, circumstantiality and tendency to deviate from the topic. The situation becomes much more complicated in people with cognitive disorders due to pathological changes in the brain such as degenerative disorders, e.g. Alzheimer's disease (AD). Speech disorders are present in most cases of AD and progress with the disease course, from mild cognitive impairment to dementia.

CAUSES OF INEFFECTIVE COMMUNICATION WITH OLDER ADULTS

Reasons of improper communication with elderly patients are often complex and include stereotypic view

of the elderly, communication barriers due to physical, mental and functional disabilities of older adults and lack of proper preparation and engagement of medical staff. Medical and nursing students asked about barriers in communication most often point out features of the patients such as loss of hearing, impaired memory or prejudice towards medical staff, forgetting altogether about barriers created by medical workers (author's data, not published). The situation may become even more complicated with medical staff having long-time experience that never underwent any training of communication skills. In the author's experience as an academic teacher in postgraduate education, it is not uncommon to meet a physician or a nurse with 30 years of practice who does not possess essential skills of communication with cognitively impaired persons.

Common communication barriers and errors

Difficulties and barriers in communication may be due to patient-related and medical staff-related problems (tab. 1 and 2). It is worth stressing that the list of factors related to medical staff is much longer, but rarely acknowledged. Another group of factors influencing the quality of communication are external factors, such as the environment, noise, the presence of other people during the conversation. An important error in communication is connected with spatial relationship with the patient, e.g. bending over the patient, standing over the patient who is sitting or lying in bed, approaching the patient from behind. It automatically creates a feeling of an overwhelming power and gives a "clear" but often unintended message of "Who is ruling here". Such patronizing or infantilizing way of addressing older people, especially those with cognitive decline, is considered "malignant social psychology" (4).

Table 1. Patient-related barriers in communication.

Impaired hearing or/and vision
Cognitive impairment, dementia
Delirium and other states of disordered consciousness
Slowing down of thinking, speech, information processing
Circumstantiality of speech and tendency to deviate from the topic
Parkinson's disease, stroke
Mood disorders, depression, anxiety
Avoiding contact with others
Previous experience of maltreatment and ageism
Over-suspiciousness and misconceptions concerning healthcare

Errors in delivering information on diagnosis and prognosis

Providing information about a diagnosis of a serious disease with poor prognosis, e.g. advanced cancer or Alzheimer's disease is a stressful event for the patient and the caregiver, as well as a great challenge for the physician responsible for the transfer of information. A lot of communication errors may occur in such situations, including misunderstanding, fragmented infor-

Table 2. Medical staff-related barriers in communication.

Way of speaking: too loud, too quickly or very slow
Patronizing tone of voice, lack of partnership with the patient
Lack of ability to formulate precise questions, using complex sentences, using negation and expressions suggesting answers
Lack of active listening skills
Reacting with anxiety and anger to difficult situations, lack of problem solving skills, inadequate ability to control emotions
Using improper forms of address: honey, sweetie, etc. Using non-personal expressions
Using a lot of diminutives
Talking only to the relatives of the patient, neglecting the patient, talking "over the patient's head"
Not concrete or misleading transfer of information
Devoting time to activities related to the patient, but not dedicating enough time to communicate with the patient
Neglecting patients for whom "nothing can be done"
Paying attention to problematic non-compliant patients and neglecting cooperating, compliant patients
Lack of competence to discuss matters related to the times of patient's youth, e.g. lack of basic knowledge on history of the country or general knowledge; lack of cultural competence
Conviction that impaired verbal communication means total lack of possibility to communicate
Trespassing one's competences, patronizing speech and behavior, deciding for the patient
Lack of insight, lack of self-distance

mation resulting in patient's anxiety, addressing only the caregiver and not the patient etc. When delivery of important information is planned, such meeting should be carefully pre-planned and organized in a way providing maximum possible comfort for the patient. A psychologist may help by providing support and facilitating effective communication (5).

EXAMPLES OF COMMUNICATION PATTERNS AND ERRORS

Two cases of communication patterns observed in the past by the author in a nursing home patients and two cases in a hospital setting are presented below.

Case 1

A patient is addressing a nursing assistance dressed in a visibly short coat in the following humorous way: "Your coat is very long, please be careful not to trip over it!". The reaction of the nursing assistance is as follows: she says nothing to the patient, but looks hurt, than she says to her colleague: "Look! They even criticize our work suits!". This type of communication may be described as an open, friendly, humorous and active behavior of the patient and rigid, unpleasant, over-reactive behavior of the nursing assistance. It is worth stressing that the patient had known the nursing assistance for over 10 years of living in the nursing home.

Case 2

A bed-ridden patient with lower limb fracture, and post-stroke hemi-paresis asks a nursing assistance

entering the room: “Could you, please, pour a glass of water from the pot for me?”. The reaction of the nursing assistance: “And maybe you would like a hot cup of tea?”. Several hours after the above conversation the patient described it as “a morning conversation which has made her day shine”. The behavior of the patient is minimalistic, she is asking for the simplest service – a glass of water, while the behavior of the nursing assistance is open, reaching out to the patient, showing understanding of the older person’s needs.

Case 3

An eighty-eight-year old woman with multiple chronic diseases including arterial hypertension, coronary artery disease, COPD, osteoporosis with pathological fractures of the thoracic spine and age-related macular degeneration in both eyes came for a check up visit to a geriatrician assisted by her son. In spite of serious comorbidities, the patient lived by herself, and her functional performance at home was sufficient for partially independent living with frequent support and supervision of family members. Moreover, the patient was cognitively intact and intellectually active maintaining telephone contacts with few elderly friends. During the medical visit, high values of blood pressure were detected (220/120 mmHg), not reacting to repeated doses of an antihypertensive medication. The patient was referred to an emergency room (ER) in a nearby hospital where she was administered complex treatment and was discharged home after 8 hours. Later, during the following visit to the geriatrician the patient was asked to describe her ER experience. She reported that during the 8 hours of stay there, nobody of the ER staff talked to her or asked her any questions beside the initial very short interview. Members of the staff addressed only the patient’s son asking him questions referring to his mother’s health. The patient felt serious back pain due to uncomfortable position in the ER bed, but there was nobody to report the symptom to. Finally, the patient started crying and this event prompted the ER physician to administer a dose of a sedative medication.

This case is a perfect example of unintentional mistreatment of an older adult. The patient was treated as so she was demented and could not express her needs. The patient’s son was addressed as the patient’s representative without asking the patient for permission and without assessing communication skills of the patient herself. Additionally, the improper communication led to an unnecessary use of sedatives, while assessing the patient’s complaint of pain and administering a painkiller would have been much more appropriate and safe procedure.

Case 4

An eighty-two-year old man was admitted to a hospital due to urinary tract infection with suspected sepsis. After initial antibiotic treatment, the symptoms quickly resolved and the patient was discharged from the

hospital on day 10. In the discharge document there was no information on the patient’s cognitive status. One week after hospital discharge the patient was visited by a geriatrician, who performed a comprehensive geriatric assessment including a screening test for cognitive impairment. The results indicated that the patient had considerable cognitive deficits characteristic for dementia. The patient’s wife confirmed that memory problems had lasted for at least two years, and that since that time the patients was not left home alone and required assistance in activities of daily living. The patient’s wife admitted that she was not asked questions relating to functional performance and mental status of the patient during his stay in the hospital.

This case reflects a common attitude of medical staff towards elderly hospitalized patients. The patients are assessed in detail in terms of physical examination and somatic disorders, while their mental and cognitive status remains unknown. This results in under-diagnosis of dementia and over-rating the patient’s independence which in turn may lead to lack of adequate support at home.

ENHANCING COMMUNICATION IN SPECIAL SITUATIONS

Education of health professionals concerning communication skills with older adults should include communicating with patients affected by specific age-related deficits, as well as addressing the older patient’s family. Ability to share adequate amount of information with other staff members and discussion of encountered difficulties may prevent frustration of medical staff. Individualization of care together with active combat against stereotypic view of the elderly facilitates understanding of older patient’s situation and needs and, thus, improves communication. Chosen aspects of age-related factors such as hearing and vision loss and cognitive impairment are discussed below.

Auditory impairment

Hearing loss is prevalent in approximately 50% of older people, however it often remains underestimated by sufferers, as well as by the environment. Additionally, one in five older people have dysphonia which may add to changes in communication skills. In a recent study, more than half of older adults considered their voice to be altered, while in one third of patients pathology was found on foniatric assessment (6). Interestingly, patients recognized vocal and hearing dysfunction, but did not consider it to be a disability. It means that the impact of hearing loss on communication skills was underestimated. Specialist screening consultations should be widely performed to ensure timely choice of appropriate therapy and rehabilitation.

Visual impairment

Physiologic changes in the eye cause impaired accommodation and difficulties with differentiation of similar colors. Moreover, many diseases of the eye

develop slowly over time, making it difficult to notice the change by the patient. It may happen that such diseases as cataract, glaucoma and age-related macular degeneration cause visual impairment with dominant manifestation in one eye. It is not a rare phenomenon that elderly patients do not visit ophthalmologist for regular check-ups and uni-lateral loss of vision is recognized by chance during a comprehensive geriatric assessment.

Cognitive impairment

Age is the major risk factor for cognitive deterioration. Approximately 10% of people over the age of 65 years have dementia, and another 10% present mild cognitive impairment. It is important to note that cognitive impairment is widely under-recognized and screening tests of cognition are not routinely performed. Even in people with slight memory problems, working memory and attention may be compromised, thus making the complex speech easily “forgettable”. Practical clues addressing this problem are to avoid complex sentences, to provide written information and to repeat the most important messages (7).

COMMUNICATION WITH CAREGIVERS OF ELDERLY PATIENTS

Family members or informal caregivers are often present during medical consultation of elderly people. They play an enormous role in the care, supporting everyday functioning, fulfilling the complex needs of the older individual and providing contact with medical and social services. Sometimes, however, caregiver’s presence may be overwhelming and this happens usually in two situations: when a caregiver tries to answer all questions, interrupting the patient and when several members of the patient’s family are present and willing to take active part in the consultation. The author recalls a patient who regularly came for a medical consultation with her wife, son, daughter and granddaughter. All of them performed some important tasks in the care for the patient and all four had observation and questions. Thus, the time of the visit expanded enormously and the patient felt overwhelmed by the caring and loving family members. It is important to ask the patient on the first visit if he/she accepts the presence of a caregiver and obtain a written decision, if possible. During the visit, it is crucial to devote some time to the patient, even though one does not expect any new data or information.

COMMUNICATION BETWEEN PROVIDERS OF CARE FOR THE ELDERLY

A level of communication which does not directly engage the patient, but may to a considerable extent affect quality of care delivered to the patient is communication between different providers of care, especially between long-term care facilities and emergency departments. A typical patient transferred from a nursing home to an emergency room has physical limitations

accompanied by cognitive deficit, and usually is transferred by an ambulance without a caregiver or a family member. There is a communication gap between residential and acute care possibly resulting in delay of adequate treatment and risk of medical errors (8). There are no official guidelines on what information should be provided with a patient transferred from long-term care to the hospital, but most authors agree that it should include:

- reason for transfer to the emergency room,
- past medical history,
- current medication,
- description of patient’s cognitive functions,
- advanced directives,
- contact details.

GUIDELINES FOR COMMUNICATION WITH OLDER ADULTS

In recent years, a number of guidelines published as papers or readily accessible on the Internet have been released. Five of them will be discussed in more detail below, two including general guidelines for clinicians, one on the outpatient setting and two addressing elderly dementia patients in the inpatient setting. These documents give practical tips for addressing older patients.

According to a “**Clinician’s handbook**” edited by the **National Institute of Aging and National Institute of Health in the USA**, there are following rules of communication with an elderly patient (9):

1. Use proper form of address (Mr., Mrs.).
2. Make older patient comfortable.
3. Take a few moments to establish rapport (introduce yourself clearly, explain your role and ask friendly questions to relieve the excessive stress of the patient).
4. Try not to rush.
5. Avoid interrupting (the authors of the guidelines recall a study showing that doctors usually interrupt their patients during less than 20 seconds of the initial interview).
6. Use active listening skills.
7. Demonstrate empathy.
8. Avoid jargon.
9. Reduce barriers to communication (take into account vision and hearing problems).
10. Be careful about language.
11. Ensure understanding (try to make the patient understand: what is the main health problem, what can be done and why it is important to do so).

The guideline gives specific clues to management of patient with hearing or vision loss. Compensating for hearing deficits includes the following recommendations:

1. Make sure the patient can hear you. Ask for a working hearing aid. Remember about excess earwax as a possible cause of hearing problems.
2. Talk slowly and clearly in a normal tone. Speaking in a raised voice, high-pitched voice or shouting may make the speech less understandable.

3. Face the patient directly (eye-contact, lip-reading).
 4. Be aware of the interrupting role of the background noise.
 5. Have a paper ready to write down difficult terms, diagnosis.
 6. Tell the patient when you are changing the subject.
- Compensating for visual deficits includes the following recommendations:

1. Provide adequate lighting, minimize glare.
2. Ask the patient about eyeglasses.
3. Prepare clear handwritten instructions.
4. Prepare easily readable printed materials with large type.
5. Think about other alternatives for patients with more severe visual loss and unable to read.

The Gerontological Society of America set up a list of 29 recommendations for communicating with older adults divided into four categories (10):

- general tips for improving interactions with older adults,
- general tips for improving face-to face communication with older adults,
- tips for optimizing interactions between health care professionals and older patients,
- tips for communicating with older adults with dementia.

The general tips include the following:

1. Avoid patronizing speech.
2. Control your nonverbal behavior.
3. Minimize background noise.
4. Face the patient.
5. Pay attention to sentence structure, ask open-ended questions, use visual aids.

A special attention is paid to rules of verbal communication, including:

1. Face older adults when you speak with them.
2. Pay attention to sentence structure.
3. Stick to a topic.
4. Ask open ended questions.
5. Use direct and concrete language.
6. Verify listener's comprehension.
7. Maintain a positive communicative tone.
8. Keep sentences and questions short.
9. When speaking with older adults with dementia simplify sentences, but avoid speaking slowly.
10. Use repetition or paraphrase sentences to facilitate comprehension.

The authors of the above document stress that: "Providing information to patients is important, but how you give the information to patients may be even more important".

Guidelines for enhancing communication with older patients in an outpatient setting (11) stress three general rules:

1. Establish respect and demonstrate concern (the way of addressing the patient).
2. Ensure the patient is heard and understands (avoid medical jargon, write down simple instructions, schedule older patients earlier in the day).

3. Avoid ageism (get to know the older patient as a person with a defined history and accomplishments).

There are a number of strategies specified in the paper including the following recommendations:

1. Prepare the environment by increasing the lighting and decreasing background noise.
2. Address the patient and family member as "Mr." or "Mrs." and avoid terms such as "sweetie" or "dear".
3. Speak slowly and clearly without shouting, maintain calm, pleasant tone.
4. Use gentle touch.
5. Allow the patient to express his/her concerns.
6. Ask the patient to repeat back important instructions.
7. Provide written instructions in 14-pont type or larger.
8. Remember the importance of psychosocial issues.

The paper provides specific recommendations for patients with sensory deficits (11). Additionally to the issues described in the previous document (9), this guideline does not recommend asking the patient with hearing impairment whether he or she understood the instructions. It is better to ask the patient to repeat the instructions. In the approach to patients with visual impairment, the guideline lists possible resolutions: using two sources of light, e.g. background lighting and a close light, using contrasting colors to make objects visible, e.g. chairs against the floor.

The guideline gives practical suggestions for communication with patient suffering from dementia. Usually the patient is accompanied by a caregiver, in this case a triangle of three chairs should be set up: for the patient, for the caregiver and for the physician. A three-way communication is established with the physician asking questions to the patient and accepting input from the caregiver. Involving the patient in the conversation is considered an important issue (11).

COMMUNICATION DIFFICULTIES IN HOSPITALIZED OLDER ADULTS WITH DEMENTIA

When a patient with dementia is admitted to a hospital, dementia is usually not the main diagnosis, neither the reason for the hospital admission (12). Moreover, hospitalization disrupts communication systems adopted by the patient at home or a place of living. Language deficits are accompanied by other dementia-related symptoms including memory loss, decreased attention span, impaired insight and judgment, reduced visuospatial abilities (13). Dementia may be overlapping with fluctuating delirium and adverse medication reactions may further affect mental status. It is therefore important that medical staff is prepared to deal with in-patients affected by cognitive disorders. The guidelines advise to start with the assessment of receptive and expressive abilities of the patient. Providing answers to the following questions may be helpful (12):

1. Can the patient understand YES or NO questions?
2. Can the patient read simple instructions?
3. Can the patient understand simple verbal instructions?
4. Can the patient understand instructions given with physical cues? Example: Can the patient get dressed if the clothes are set out on a chair near the bed?
5. Can the patient make a choice between two objects or options?
6. Does the patient have difficulty finding correct words or creating sentences?
7. Does the patient use offensive language (e.g. cursing) or exhibit aggressive behaviors?
8. Does the patient avoid verbalization or use meaningless expressions?

The patient's caregiver or a family member may be of help to provide answers to these questions. It is important to use gentle touch reasonably, it may be very useful in getting the patient's attention or guiding the patient to perform certain tasks. However, touching the face and head or approaching the patient from behind should be avoided (12). It is necessary to provide accessory tools used by the patient at home, such as

glasses or hearing aids, since their lack may further impair communication. It is important to remember that in persons with dementia, behavior may be a form of communication, e.g. combative behavior, agitation, and restlessness may be an expression of unmet needs: hunger, pain, the need to use the toilet (13). Understanding challenging behavior of dementia patients will lead to quality care for those who cannot any longer take care for themselves.

CONCLUSIONS

1. Effective communication with an elderly patient and his or her caregiver may improve quality of care and lower the risk of medical errors and treatment failures.
2. It is important to evaluate common causes of communication problems, such as hearing and visual impairment or cognitive decline in the routine assessment of an elderly patient.
3. The best approach to learning communications skills is to adopt simple practical rules, undergo continuous training and remember that health professionals are often responsible for communication errors.

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