COMMUNICATION WITH ELDERLY PATIENTS

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When exploring how I communicate with elderly patients, I found that I have several common assumptions. I speak loudly because my older patients’ hearing may be decreased. I use smaller words and more simple explanations because their education regarding medical care might be outdated. I also find myself thinking that they will not read written material because their eye sight may be bad or they may not even be able to read. I did not realize how, by using these assumptions, I might be impairing instead of improving communication with older adults.

One key point in communicating with elders is to always use their full name or their preferred name. In the short term setting, I believe that ma’am and sir are also respectable. Once, I called an older patient by her first and last name when I walked into her room to verify that I had the right patient. I will call her Jane Smith for the sake of this example. She had no reservations in telling me that I was rude to call her by her first name and that I could address her as “Miss Smith.” Although I was being thorough and my main concern was safety, she saw my approach in a different way. From that point on I have only used my elderly patients’ first names when reading it off their armband so that my verification is not mistaken for disrespect. Elderly patients appreciate being respected and one of the easiest ways I can show this is to address them properly.

Another key point in communicating with elders is to be aware of elderspeak and avoid using it in the work setting. Elderspeak is basically using terms of endearment when communicating with older adults (McGilton et al., 2011). All of my previously mentioned assumptions in communicating with elders fall under the definition of elderspeak. I was speaking slower, louder than normal, and using shorter sentences with simpler explanations. In educating myself and making myself aware of elderspeak, I can decrease my use of it in the clinical setting.

I believe the most important point in communicating with elders in my work setting is to assess their communication needs before assuming them. Williams, Kemper, and Hummert (2004) state that using the basic framework of the nursing process “charges professionals to perform individual assessments of older adult clients’ communication needs, using simplification and clarification strategies only when indicated by communication needs of clients.” Most of the elderly patients that I come across in the clinical setting do not have any cognitive deficits. I first need to assess my elderly patients’ capabilities and strong points, and then use communication to support their strengths.

I now think about communicating with elders in a different light. I believed that making assumptions about my elderly patients showed that I cared for them because I truly wanted to communicate effectively. I did not realize how patronizing or demeaning I may have sounded. I have struggled with the feeling that my elderly patients may not trust me or respect me because of my young age. I can use the key points that I have learned to create a mutual respect and partnership between me and my elderly patients.

References

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