Identification of hearing loss among residents with dementia: Perceptions of health care aides

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Effective communication can be difficult when working with individuals with dementia and hearing loss. Given the high prevalence of both dementia and hearing loss among individuals in long term care, direct care providers in this setting will almost certainly confront frequent communication challenges. To understand health care aide perspectives of caring for residents with dementia and hearing loss, 12 health care aides from five nursing homes participated in audio-recorded, semi-structured interviews. Transcripts were coded and themes were identified. Health care aides reported the difficulties in distinguishing the relative contributions of hearing loss and dementia to communication breakdowns. They reported that familiarity with residents helped them differentiate between sensory versus cognitive impairments in conversations with residents. Although able to identify strategies to support communication, communication difficulty complicated both their provision of care and support of quality of life for residents with dementia and hearing loss. Suggestions for practice and education are provided.

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Introduction

Communication is an essential component of patient-caregiver relationships. In health care situations, communication involves both instrumental and affective interactions. Instrumental communication involves the assessment and management of health-related problems such as giving explanations or providing cues during physical care activities, whereas affective communication involves the establishment or maintenance of a relationship with the patient. In nursing homes both aspects of communication are necessary to provide quality, individualized care based on respect, compassion, promotion of self-determination, as well as optimal comfort and contentment.

Effective communication is challenging when working with individuals with dementia and hearing loss and the challenges are exacerbated when dementia and hearing loss co-occur. The incidence of dementia has been associated with the severity of hearing loss, and among nursing home residents hearing loss and dementia both have a high prevalence: the prevalence of hearing loss has been estimated at approximately 90% and the prevalence of dementia has been estimated at approximately 60%. Difficulties with communication increase with the progression of dementia and are manifested as word-finding problems, repetitiveness, difficulty initiating and maintaining a conversational topic and, ultimately, significantly restricted verbal output. Dementia also impairs one’s ability to understand spoken language, likely because the individual forgets what has been said or experiences difficulty encoding information.

The added negative effects of hearing loss superimposed on the negative effects of dementia have been referred to as excess disability. The communication challenges stemming from both hearing loss and dementia are associated with negative mood and affect, reduced ability to perform activities of daily living, resistance to care, and social isolation. Although severe-to-profound hearing loss is unmistakable, mild-to-moderate hearing loss also interferes with communication but may mistakenly be assumed to be a normal, unavoidable part of aging, or part of the communication difficulties associated with dementia.

When dementia and hearing loss co-exist there are important implications that can go unrecognized. When people cannot hear normally, their confusion associated with hearing loss may be mistakenly attributed to dementia because many of the behaviors caused by hearing loss (e.g., often asking people to repeat what they say or not staying on topic) are also behaviors caused by...
dementia. As such, it can be difficult to identify hearing loss in people with dementia, which leads to a missed opportunity to address hearing issues that may be remediable. Hearing loss can be an important target for treatment if it is identified by caregivers. A range of interventions can be useful to facilitate communication including the manner of speaking, removal of cerumen from the ear canal, environmental approaches and assistive technology.

Given the high prevalence of dementia and hearing loss in the nursing home population, health care aides who are the direct care providers in nursing homes will almost certainly confront these challenges on a daily basis. Therefore, health care aides require the knowledge, skills and attitudes to effectively communicate with these ‘communication vulnerable’ nursing home residents. Entry-to-practice training in communication is available for health care aides but it tends to be limited in scope and varies across jurisdictions. For example, Canadian health care aide certification programs, ranging from 16 to 29 weeks, include a module on communication. The commonly used textbook, Mosby’s Canadian Textbook for the Support Worker, has chapters dedicated to ‘interpersonal communication,’ ‘hearing and vision problems’ and ‘confusion, delirium and dementia,’ yet the information provided does not refer directly to how to manage the combination of hearing loss and dementia. Although numerous in-service training programs have been developed to enhance the communication of nursing home staff with residents who have dementia, in two recent systematic reviews of such training programs only one of the 22 included articles highlighted the important impact of hearing loss on communication.

Because health care aides communicate with nursing home residents more often than other health care providers, they are in a unique position to potentially reduce the effects of excess disability caused by hearing loss among nursing home residents with dementia. After searching the professional caregiving literature the authors were unsuccessful in locating any previous research in which health care aides provided their perspectives on hearing loss and dementia related to the care or quality of life of residents. To address the gap in knowledge and assist in understanding of how to better meet the needs of nursing home residents, this study involved examination of the following research questions: 1) What are health care aides’ perceptions of hearing loss in nursing home residents with dementia? and, more specifically, 2) What are health care aides’ perceptions of the relevance of residents’ hearing loss for day-to-day care and participation in social activities?

Methods

The study reported here was part of a larger mixed methods study to determine the contribution of hearing loss to excess disability in residents with dementia living in nursing homes. In the quantitative component of the study, the hearing and cognitive-communication abilities of residents with mild-to-moderate hearing loss were measured, while in the qualitative component, health care aides’ perceptions of issues associated with combined hearing loss and dementia were explored. This study was carried out in accordance with The Code of Ethics of the World Medical Association (Declaration of Helsinki) for experiments involving humans. All participants provided informed written consent and the study received ethical approval from the Health Research Ethics Board at the University of Alberta.

Sample

The researchers used purposive sampling in the current study. Health care aides were eligible to participate if they met the following inclusion criteria: knew and worked regularly (a minimum of three weeks) with nursing home residents with dementia who had mild-to-moderate hearing loss (as previously assessed by an audiologist), and were permanent staff members for at least six months, to ensure they had a sufficient understanding of how the unit environment might affect the residents’ quality of care and quality of life.

Procedures

Recruitment

From March 2011 to April 2012 the lead investigators (SES, TH) met with nursing home administrators to obtain administrative approval for the study. Then the research assistant (CI) approached health care aides during meetings scheduled by nursing unit managers, provided them with study information, and obtained their informed written consent to participate in the study. The majority of health care aides in the participating facilities met the inclusion criteria. The first 12 health care aides who were approached agreed to participate in the study. No one refused to participate.

Interviews

Using a semi-structured interview guide, the third author (CI) conducted interviews with as many health care aides as necessary to achieve saturation. Saturation was assessed through concurrent data collection and data analysis. Recruitment stopped when the content of the interviews did not include new information. Interviews were conducted in a quiet room in the nursing home during the health care aides’ regularly scheduled day or evening shifts. Replacement health care aides were available to provide resident care during the time that the research participants were occupied in interviews. Administrators were compensated for these staff replacement costs.

The research assistant recorded fieldnotes following each interview to describe the context of the data-gathering episode, and included reflective memos about her observations and impressions of the interview. The interview was organized into questions that were not resident specific (e.g., How do you know when a resident with dementia has trouble hearing?) and questions that were specific to particular resident participants (in the quantitative study) who were assessed to have mild-to-moderate hearing loss (e.g., How does Mrs. X’s hearing problem affect your ability to provide her care?). Topics included perceptions/ recognition of hearing loss, awareness of interventions for hearing loss, the relevance of communication for providing care, and implications of hearing loss for resident well-being. Health care aides completed demographic information sheets immediately prior to the interview.

Data analysis

Interviews with staff members were transcribed verbatim, checked for accuracy, and imported into ATLAS.ti to facilitate data management. Data were analyzed based on principles of interpretive description. Interpretive description is intended for “smaller scale qualitative investigation of a clinical phenomenon... for the purpose of capturing themes and patterns within subjective perceptions and generating an interpretive description capable of informing clinical understanding.” In contrast to traditional methodologies (e.g., grounded theory, phenomenology, ethnography) interpretive description does not have a specific set of analytic techniques that must be adhered to at all times. We followed the recommendations of Thorne et al to use techniques that facilitate repeated immersion in the data prior to beginning coding, classifying, and creating linkages. Codes were inductively derived
Table 1
Health care aide characteristics (n = 12).

<table>
<thead>
<tr>
<th>Continuous characteristics</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years worked as HCA</td>
<td>19 (9.7)</td>
</tr>
<tr>
<td>Years worked on unit</td>
<td>8.3 (5.2)</td>
</tr>
<tr>
<td>Categorical characteristics</td>
<td>n (5)</td>
</tr>
<tr>
<td>Female</td>
<td>12 (100)</td>
</tr>
<tr>
<td>English as second language</td>
<td>6 (50)</td>
</tr>
<tr>
<td>Completed high school</td>
<td>8 (66.7)</td>
</tr>
<tr>
<td>Completed health care aide</td>
<td>11 (91.7)</td>
</tr>
<tr>
<td>certificate</td>
<td></td>
</tr>
<tr>
<td>Employed full-time</td>
<td>10 (83.3)</td>
</tr>
<tr>
<td>Age 36–55 years</td>
<td>10 (83.3)</td>
</tr>
<tr>
<td>Age &gt; 55 years</td>
<td>2 (16.7)</td>
</tr>
</tbody>
</table>

from the interview transcripts and subsequently organized into categories. One of the investigators (SES) coded 100% of the interviews and, to assess the dependability of the coding, a trained research assistant (DFE) coded 30% of the interviews.

Results

The average duration of the health care aide interviews was 20.6 min (SD = 7.8 min). The themes derived from the data are explained below using direct quotes from the interview transcripts. Table 1 summarizes the characteristics of the twelve participating health care aides in five facilities. In brief, all participants were female and over the age of 35. Fifty percent spoke English as a second language and all but one had a health care aide certification. The five urban nursing homes where the health care aides worked were publicly owned, operated and funded; ranged in size from 36 to 275 beds; and included a range of three to ten nursing units. One of the nursing homes was exclusively dedicated to dementia care. The number of health care aide participants working in the five facilities ranged from one to five.

Recognizing hearing loss in residents with dementia

Recognizing hearing loss in residents with dementia sometimes posed problems for the health care providers in our study. For example, a participant explained that “Sometimes I think they [the residents] cannot understand, may be they have hearing problem, dementia sometimes, we don’t know.” Two other health care aides also discussed the trouble they had differentiating between hearing loss and dementia: “Is it because he cannot hear me or is it because of the dementia? I’m not sure”; “if she [a resident] don’t respond you – you know either hearing aid not working, or either Alzheimer kick in, or both.”

After caring for residents over an extended period of time, one health care aide stated that she could differentiate between the impact of hearing loss and dementia on communication: “You don’t know unless you know the resident well enough because of a lot of times it can be the dementia you know it’s, they just don’t understand what you’re asking them to do and until you know the resident that it is in fact it’s their hearing and not the dementia.” A health care aide from a different facility talked about the positive effects on communication of knowing about the resident’s dementia and hearing loss: “It’s hard but compared to some staff they don’t really pay attention on the hearing aid so they have a hard time communicating with him, but I know... I have to put hearing aid right away.” Knowing the resident naturally facilitates communication, because, as one health care aide stated: “you have to understand... in their part, what they think, and how they react.”

When attempting to distinguish between communication breakdowns due to hearing loss versus dementia, health care aides used two approaches. They identified hearing loss as the primary basis of communication difficulties when the residents did not respond to them: “they will sort of almost ignore you, a lot of times it’s like they’ll ignore you and they go about their business”; “she just look at me like I’m not talking to her.” The health care aides explained that those residents who did not respond when an aide was speaking behind them likely had hearing loss: “when you’re talking behind her or something, she doesn’t know that you’re talking to her, so you have to go in front of her”; “you can even uh make a noise from behind and they don’t hear anything.”

Health care aides identified dementia as the major contributor to communication difficulties when residents seemed to hear what was said but misunderstood the message. The following anecdote provides an example of a confused resident who has a hearing aid to compensate for his hearing loss:

It happens more often to Bob ‘cause I had him for the past five, this is my fifth day that I was looking after him for this week and he was incontinent three times. So even though it’s not his shower day I have to explain it to him that I have to give you a shower but he doesn’t understand. And no, no, no, I’m going home he says. So I have to convince him really good and I put [in] his hearing aid and so he will agree and then sometimes he will not go to the shower room and I keep explaining it to him and then after a while he says oh thank you for giving me a shower.

In this situation, the health care aide realized that, although the hearing aid will not ensure his understanding of the situation, improving his ability to hear will increase the likelihood that effective communication can occur.

The health care aides recognized that residents have difficulty communicating because they have both hearing loss and dementia: “It’s both dementia and hearing.” In the following excerpt from the interview transcripts a health care aide explains how she tried to compensate for the resident’s hearing loss but was confronted by the resident’s cognitive-communication difficulties.

HCA: He hears a little bit loud, louder.
Interviewer: Like he needs to hear things louder you mean?
HCA: Yeah, like when you talk to him, but he’s, he’s confused too.

The health care aide spoke louder to the resident only to realize that the resident was “confused too.” For example, another health care aide shared the following: “I’ll say, ‘John it’s not night yet, it’s just 3 o’clock or 2:30’ and he’ll say, ‘no, it’s night’ and um, we redirect him, and then you go back out and he’ll ring again and we’ll say, ‘John I just told you’ and he’ll say, ‘I didn’t hear you.’”

Strategies to improve communication

Health care aides described a number of strategies for communicating with residents with dementia experiencing the excess communication disability due to hearing loss. The most frequently cited communication strategies that they used included repeating, speaking face-to-face, using body language, speaking slower and speaking louder. The health care aides almost always qualified their comments about speaking louder by cautioning not to speak too loud so as to avoid agitating the residents. These strategies, illustrated with direct quotations from the health care aides, are summarized in Table 2.

Communication helps to avoid aggression

Our participants pointed out that providing care for residents living with dementia can lead to safety issues for health care aides getting close to communicate face-to-face with confused and agitated residents: “when you have to speak directly to someone and when he starts getting resistive, I mean you’ve got the fists and that going, you can’t always get as close as you’d like to someone to be right sort of face on face to communicate with them.” Another
Table 2
Health care aide communication strategies.

<table>
<thead>
<tr>
<th>Communication strategy</th>
<th>Description</th>
<th>Health care aide quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeat</td>
<td>Restating or rephrasing the message may improve communication. Verbatim repetition may help refresh the message for residents with memory impairments; rephrasing may improve communication if certain words or phrases are difficult to hear or comprehend.</td>
<td>“I end up repeating myself over and over.” “But you see it so closely being with both hearing and also dementia that you have to repeat yourself a lot.”</td>
</tr>
<tr>
<td>Speak face-to-face</td>
<td>Approaching the person from the front and establishing eye contact can prepare the resident for verbal communication. When residents can see the health worker first, they can focus their attention on understanding verbal communication, and can also benefit from non-verbal communication such as body posture and facial expression to properly interpret the messages.</td>
<td>“Look right directly at them [residents] when you’re speaking.” “And you make sure you’re facing them when you’re talking to them.”</td>
</tr>
<tr>
<td>Use body language</td>
<td>Using gestures to direct a resident's movement or behavior, or demonstrating a desired action, can reduce the load on hearing and improve resident understanding. Some residents respond better to visual rather than auditory requests.</td>
<td>“Not only the sound you have to have, like the body language go together.” “She [a resident] can see my, you know, body language.”</td>
</tr>
<tr>
<td>Speak slower</td>
<td>Slowing the rate of pronouncing words when speaking may help to improve clarity of messages. This is particularly true if English is not the speaker's first language. Speaking slower also gives residents time to comprehend the message.</td>
<td>“Talk slowly with them [residents], you know, they [residents] understand you better.” “Their hearing is not 100% like us and so you still have to go slow.”</td>
</tr>
<tr>
<td>Speak louder</td>
<td>Increasing the volume of the voice slightly can improve the likelihood of a resident hearing a message. This strategy can be helpful if there is competing noises in the environment. Speaking loudly should be employed with caution, as speaking too loudly, or shouting, can agitate residents.</td>
<td>“I know a lot of times she [a resident] doesn’t hear you so of course you say it again louder.” “I do have to raise a little bit, just so they can hear me, um, not to the level that they will be annoyed, but so they can hear me, it works for me too.”</td>
</tr>
</tbody>
</table>

Table 2 Health care aide communication strategies.

Health care aide noted that “sometimes they resist care ‘cause sometimes they don’t understand what you’re doing to them. You have to explain what you’re gonna do to him first.” Residents living with both dementia and hearing loss may be surprised and/or agitated when health care aides approach them to provide care: the residents “get a little aggressive with you, because they don’t know why you’re doing what you’re doing.”

These quotations highlight two potential problems that can arise when hearing loss and dementia co-exist. Firstly, if a resident is already agitated, with “fists going,” then safety concerns preclude health care aides from employing communication techniques with the resident such as speaking face-to-face. Secondly, the health care aide may unintentionally startle the resident with hearing loss, thus contributing to the agitation experienced by the resident with dementia during care activities.

Communication influences quality of care

The health care aides explained why it was challenging to provide care to residents with both hearing loss and dementia: “everything we do, we talk about it before I do it, I tell them [the residents] what we’re doing (laugh), so if they can’t hear they can’t follow… yes, it’s [hearing] very, very, very important.” Another health care aide agreed: “very important. Yah, otherwise, you know, you can’t do their ADL care, like they won’t let you.”

A health care aide also highlights the importance of a resident’s ability to hear when trying to identify if he or she is in pain:

For example yeah, asking if someone is in pain if they can’t hear you. You know ‘cause sometimes people get irritable and you don’t know why and if they can’t express that they’re, don’t understand you and you ask them are you in pain and they don’t hear you, you know. I mean that’s very important because they could be missing… a PRN pain killer.

Communication influences quality of life

Some of the health care aides we interviewed also explained that the residents’ quality of life was also affected by communication challenges. “Very, very, very important, because we like, I like to communicate with them while I’m doing the care, so if they’re not going to hear what I’m saying that tells me that you know I don’t have to talk to them, so that cannot, that, that affects me, that I’m not going to be able to connect with them, you know.” Two health care aides articulated a sense of empathy for their residents living with hearing loss in the context of care provision: “As a human you have to tell them what you are going to do, right? Even though a — you cannot force me to just take off my clothes… so you have to tell them until they will hear”; “if you want to have them undress and you try talking, all they see you is the mouth moving and hands moving they can’t hear a word what you’re saying and the next thing you know you go strip them you can imagine that feeling, right.” The ability of the health care aide to provide care with respect and to protect the dignity of the resident with dementia was hindered when residents could not hear them.

The participant health care aides were also aware of how communication problems such as hearing loss affect residents’ quality of life in social contexts. Some of them described how hearing loss resulted in their residents experiencing alienation and social isolation. For instance, one health care aide observed that “[those residents] that are really hard of hearing kinda get left out of the conversation of things.” In another example, a health care aide recounted how hearing loss impeded a resident’s ability to participate in a game of bingo: “when they’re playing bingo for example because then if she doesn’t hear and the caller has to say a few time(s) what the number is and you’ve got somebody else hollering ‘we’ve already heard that number three times’ yeah, then people get agitated.”

In the following quotation, a health care aide identified a resident’s hearing loss and encouraged him to participate in an activity:

“We try to tell him, explain to him that like sometimes there are some activities that he can join, exercises like that and he likes it as long as he has his hearing aid in he will feel good.” Health care aide respondents also noted that some of residents withdrew because of their hearing loss: “she goes back to bed and sleeps, and she says I’m going to sleep, I can’t understand what you’re talking about.”

Discussion

The findings from this study provide insight into health care aides’ perspectives regarding their identification and management
of communication challenges associated with hearing loss combined with dementia. Using numerous examples, they explained the central role of communication in providing care for, and contributing to the quality of life of these residents.

Despite the high prevalence of hearing impairment among nursing home residents it has been reported that hearing impairment is undetected in over half of nursing home residents. In the current study health care aides expressed difficulty in recognizing mild-to-moderate hearing loss in residents with dementia, however a few described simple and practical strategies that helped. For example, in the absence of any response from the resident, the health care aides determined the need to use strategies focused on hearing loss such as speaking a bit louder or trying to find the resident’s hearing aid. Meanwhile if the resident seemed to hear what was said but misunderstood the message, or seemed confused, then the health care aides concluded that the communication breakdown was due to dementia and they used different strategies such as repetition.

The health care aides also emphasized the importance of getting to know the resident with both dementia and hearing loss, as a key component to effective communication. In particular, when they knew the resident they were better able to identify the relative contributions of hearing loss and dementia to communication challenges and which strategies to use to prevent or repair these breakdowns. By identifying the presence, type, and severity of hearing loss, communication challenges may be mitigated through direct treatments such as removing cerumen from the ear canal and effectively employing hearing aids and other assistive listening devices. By identifying and reporting hearing loss to the nurse in charge, health care aides can play an important role in supporting and even enhancing residents’ communication abilities.

Participants in a study in which researchers explored the experiences of communication vulnerable clients also emphasized the importance of knowing the client personally to facilitate communication. The need to know the resident has important implications for how care is organized in nursing home settings. Residents benefit when care is organized to provide a consistent assignment of health care aides to residents, thereby facilitating the development of relationships.

The health care aides identified the difficulties in communicating with these residents but were also able to articulate the strategies that they used to try to overcome these difficulties. For example, repetition was frequently cited by participants as a communication strategy although they did not specify whether they used verbatim or paraphrased repetition. Others have demonstrated the effectiveness of repetition when assisting individuals with mild-to-moderate dementia and moderate-to-severe dementia in activities of daily living.

The value of “body language” was reported by several of the health care aide participants, which is consistent with evidence in the literature. For example, in a study identifying the strategies used by direct care providers to successfully guide residents to complete a simple handwashing activity, care providers used guided touch, pointing, handing an object to the resident and demonstrating an action. Likewise, in another study, community dwelling older adults with Alzheimer Disease were able to more effectively comprehend the commands of a researcher when the commands were accompanied by gestures.

The participating health care aides described how they intentionally slowed their rate of speech to enhance communication. Although others have observed similar behavior among formal caregivers in a long term care facility, and have suggested speaking slowly as communication strategy, there is evidence to suggest that speaking slowly is not associated with effective communication. In fact it is thought that slow speech may aggravate the ability of people with dementia to understand due to deficits in working memory. There is an important distinction to be made between communication strategies that are clinically recommended and those that are evidence-based.

Other communication strategies which were not mentioned by the health care aides in this study but strategies that have evidence to support their effectiveness in enhancing the comprehension of people with dementia include: eliminating distractions, using short and simple sentences, using ‘yes/no’ versus open-ended questions, using gestures, using residents’ names to gain their attention and repetition.

The findings from this study could support the development of health care aide training programs. Further research is needed to develop training programs for health care aides to facilitate identifying and managing hearing loss in the context of dementia. Explicit training may be supplemented through the mentoring of junior health care aides by more experienced health care aides to recognize the signs and symptoms of hearing loss among residents with dementia.

There is a considerable literature about communication with older adults living either with dementia or hearing loss, however there is a dearth of literature that deals with communication challenges for those with both hearing loss and dementia, and how to identify and manage hearing loss in the context of dementia. As supported by the findings of the current study, the either/or tendency that characterizes how to address communication problems is limited when it comes to assisting older adults living with both dementia and hearing loss (excess disability). The current findings highlight the need for more research that emphasizes the dual nature of excess communication disability related to the comorbidities of hearing loss and dementia.

The health care aides’ comments and techniques could inform how we frame future training opportunities and research, with a focus on how both dementia and hearing loss contribute to the ‘communication vulnerability’ of nursing home residents. The health care aides have articulated a starting point. Future research should reflect this complexity instead of simplifying a composite challenge into two separate categories.

Limitations

As with all research, there are limitations to this study. Given the homogeneity of participating facilities by operator model and urban location, the findings may not transfer to for-profit or rural nursing homes. Additionally, the variation in health care aide certification programs across jurisdictions makes it difficult to compare the health care aides’ level and extent of training and knowledge regarding communication with residents who have both dementia and hearing loss. The health care aides in our sample may have received training that differs from the training received by health care aides located in other jurisdictions. Finally, given the automatic nature of many communication strategies, some health care aides found it difficult to reflect on and explicitly describe their interactions with residents. Further, the health care aide participants described their experiences with communication but this study did not include objective verification of the effectiveness of their communication with the residents. Therefore, the communication strategies reported here may not be a complete description of how health care aides actually navigate the difficult task of communicating with residents who have both hearing loss and dementia. Direct observation of resident-care aide interactions would help to verify the reported approaches to communication and possibly identify other communication strategies not described by our participants.
Conclusions

Findings from the qualitative interviews reveal that it can be challenging for health care aides to recognize mild-to-moderate hearing loss in residents with dementia. Nevertheless the health care aides described approaches to identify the presence of hearing loss in residents with dementia. The health care aide participants employed a variety of verbal and non-verbal strategies to support their communication with residents with dementia and hearing loss. The participants appreciated the impact of communication disability on both the provision of care and the residents’ quality of life. Attention to establishing relationships between residents and health care aides intersects with the broader literature on person-centred care. The results of this study begin to address the literature gap on health care aide identification and management of excess communication disability associated with hearing loss in nursing home residents with dementia. It is important to develop entry-to-practice and in-service training programs for health care aides that focus on the complex communication challenges of individuals with both dementia and hearing impairment and facilitative strategies to meet their needs.

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References

40. Castle NG. The influence of consistent assignment on nursing home de
44. Castle NG. The influence of consistent assignment on nursing home de


