

KEY WORDS

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STRATEGIES**Rozanne Wilson**

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Formal Caregivers' Perceptions of Effective Communication Strategies while Assisting Residents with Alzheimer's Disease During Activities of Daily Living

Les perceptions formelles des stratégies de communication efficaces qu'ont les soignants lorsqu'ils assistent des résidents atteints de la maladie d'Alzheimer dans le cadre des activités de vie quotidienne

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Abstract

This article describes caregivers' perceptions of communication strategies that are useful in their care practice when assisting individuals with moderate and severe Alzheimer's disease (AD) during the completion of activities of daily living (ADLs). A total of 10 formal caregivers participated in one-hour semi-structured focus group interviews (FGIs) conducted at two different long-term care (LTC) locations (n = 5 at each location). To identify the strategies caregivers perceived to be effective, content analysis was the primary method used to examine the FGI data. Particular attention was given to identifying the frequency and extensiveness in which caregivers made reference to communication strategies during the FGIs. Caregivers discussed a total of 33 strategies that they perceived to be useful when assisting residents with moderate and severe AD during the completion of ADLs. The majority of the communication strategies discussed (64%) were task-focused and the most frequently mentioned strategies included the use of negotiation and explaining one's actions to the resident. Greeting the resident was the most frequently discussed social strategy. In addition, two emergent themes containing a total of 12 strategies were identified, with the most frequently mentioned being establishing eye contact, familiarity with the resident, and postponing the task. Caregivers' perceived use of communication strategies indicates that person-centred dementia care is a central aspect to facilitating the completion of ADLs.

Abrégé

Cet article décrit les perceptions qu'ont les soignants des stratégies de communication utiles dans leur pratique de soins lorsqu'ils assistent des personnes modérément et sévèrement atteintes de la maladie d'Alzheimer au cours des activités de vie quotidienne. Un total de dix soignants a participé à des entrevues semi-structurées de groupes de discussion d'une heure tenues à deux centres de soins de longue durée (n=5 à chaque endroit). Pour identifier les stratégies que les soignants percevaient comme efficaces, on a privilégié l'analyse de contenu pour examiner les données recueillies lors des entrevues. On a porté une attention particulière à l'identification de la fréquence et de l'étendue des références faites par les soignants aux stratégies de communication pendant les entrevues. Les soignants ont discuté un total de 33 stratégies qu'ils percevaient utiles dans leurs interactions avec des résidents modérément et sévèrement atteints de la maladie d'Alzheimer pendant le déroulement d'activités de vie quotidienne. La majorité des stratégies de communication discutées (64 %) ont été soumises aux groupes de discussion et les plus fréquemment mentionnées comprenaient l'utilisation de la négociation et de l'explication des actions posées aux résidents. La salutation adressée au résident était la stratégie sociale la plus fréquemment discutée. En plus, deux thèmes émergents contenant un total de 12 stratégies ont été identifiés ; les plus fréquemment mentionnées sont l'établissement d'un contact visuel, la familiarité avec le résident ou la résidente et la remise de la tâche à plus tard. L'utilisation des stratégies de communication par le soignant indique que les soins axés sur la personne dans les cas de démence sont un aspect central menant au bon déroulement des activités de vie quotidienne.

Alzheimer's disease (AD) is a progressive neurodegenerative disease and is the leading cause of dementia, accounting for 63% of all dementias diagnosed in Canada (Alzheimer Society of Canada, 2010). AD is clinically diagnosed with the criterion of having an insidious onset that leads to the development of multiple cognitive deficits that worsen with disease progression. More specifically, the hallmark clinical symptoms of AD are memory impairment coupled with disturbances in language, executive functioning, and motor activity that significantly impact an individual's social and occupational functioning (Diagnostic and Statistical Manual of Mental Disorders 4th ed., text rev (DSM-IV-TR) (American Psychiatric Association, 2000). Memory and language declines affect the communication abilities of individuals with AD. For instance, semantic problems, including word finding difficulties, reduced verbal fluency, and comprehension impairments are well documented (Appell, Kertesz, & Fisman, 1982; Karantzoulis & Galvin, 2011; Kempler, 2005; Kempler, 1991; Geldmacher, 2009) and these impairments impact the capacity to communicate. In addition to social participation, communication is a fundamental component to completing instrumental activities of daily living (IADLs) (e.g., managing finances or planning activities). Moreover, as AD progresses, managing the completion of basic activities of daily living (ADLs) becomes problematic, creating the need for caregivers to become increasingly involved in supporting individuals during routine daily tasks (e.g., personal hygiene). Unfortunately, given the characteristic cognitive deficits that manifest in AD, communication difficulties inevitably arise and ensuing breakdowns in communication can strain the relationship between caregivers and individuals with AD (Savundranayagam, Hummert, & Montgomery, 2005; Williamson & Schulz, 1993).

At the moderate to severe stages of AD, placement in long-term care (LTC) often becomes necessary to manage the complex care requirements of individuals with declining cognitive and functional abilities. Formal caregivers (e.g., personal support workers [PSW]) are directly responsible for ensuring that the daily care needs of residents with AD are met. Given the declines in memory, language, attention, executive functioning, and visuospatial skills, formal caregivers experience many challenges (e.g., breakdowns during the steps of a task) when assisting individuals with AD in tasks that depend on these capacities. Further, communication is fundamental to fostering co-operative care during the caregiver-AD dyad interaction; however, the declining language skills in residents with AD further complicate the cognitive and functional declines. To help caregivers achieve their care practice goals and

to help residents experience optimal quality of care, several recommended communication strategies have been made available to caregivers as guidance during caregiver-AD resident encounters (e.g., Alzheimer Society of Canada, 2010; Hopper, 2001; Lee, 1991; Ripich, Wykle, & Niles, 1995; Tappen, Williams-Burgess, Edelstein, Touhy, & Fishman, 1997; Zientz et al., 2007). Some typical recommended communication strategies reported in the caregiving literature include the use of short-simple sentences, speaking slowly, asking one question or giving one instruction at time, using yes/no questions or simple-choice questions, using verbatim repetition, giving time to respond, establishing eye contact and eliminating environmental distractors (e.g., Lee, 1991; Sheldon, 1994; Small, Gutman, Makela, & Hillhouse, 2003). Some of these strategies have been individually examined and have been shown to support the caregiver-AD communication dyad. For example, improved sentence comprehension in individuals with AD has been documented when paraphrased or verbatim repetition was provided (Small, Kemper, & Lyons, 1997) and the use of one proposition at a time has been shown to improve comprehension as compared to the use of multiple ideas in a sentence (Rochon, Waters, & Caplan, 1994; Rochon, Waters, & Caplan, 2000). Further, the use of closed-ended questions has been investigated while observing conversations between caregivers and individuals with AD, with findings demonstrating that this strategy supports successful discourse (e.g., Small & Perry, 2005; Tappen et al., 1997). However, to date, few studies have examined effective communication strategies best suited for the procedural discourse (i.e., discourse focused on how to do something) occurring between family caregivers and spouses with AD during the completion of ADLs (Small et al., 2003) and between formal caregivers assisting residents with moderate to severe AD during the completion of ADLs (e.g., Hammar, Emami, Engström, & Götell, 2011; Wilson, Rochon, Mihailidis & Leonard, 2012).

With respect to communication strategies examined in the LTC setting, several communication training programs have been developed and have demonstrated effectiveness (e.g., Burgio et al., 2001; Dijkstra, Bourgeois, Burgio, & Allen, 2002; McCallion, Toseland, Lacey, & Banks, 1999; Ripich et al., 1995); however, these training programs have some limitations. For instance, the training programs contain some communication strategies that have yet to be examined individually for effectiveness. In addition, some of these studies evaluating training programs include residents with dementia without a confirmed diagnosis of probable AD. Importantly, dementia is an umbrella term used to describe acquired cognitive impairment (Weiner, 2009)

and there are several causes of irreversible dementia, each with distinguishable language and cognitive characteristics. For example, in vascular dementia, the second leading cause of dementia (Hebert et al., 2000), less impaired language function with greater executive functioning impairments, and less impaired memory as compared to individuals with AD has been observed (Looi & Sachdev, 1999). Conversely, in semantic dementia, language deficits occur in the absence of significant cognitive impairments and these language impairments are slowly progressing (Maxim & Bryan, 2006). Thus, findings from studies that include residents with dementia may not be applicable to the language and functional impairments typical of individuals with dementia of the AD type. Additionally, the training programs have not been examined in the context of assisting residents with moderate to severe AD specifically during the completion of ADLs.

Research has been done to examine communication between LTC staff (e.g., nurses or PSWs) and residents (e.g., Caris-Verhallen, 1998; Caris-Verhallen, Kerkstra, & Bensing, 1999), with findings indicating that caregivers and residents participate in more task-focused communication as compared to socio-emotional communication, during which they utilize eye contact and affective touch to establish communication interactions. Only a few studies have examined communication between formal caregivers and residents with moderate to severe AD (e.g., Williams & Tappen, 1999; Tappen et al., 1997). For instance, Williams & Tappen (1999) examined conversations between caregivers and residents with moderate to severe AD to explore the possibility for the development of therapeutic relationships in advanced AD. Findings from this study indicated that, despite advanced disease progression, therapeutic relationships were fostered during conversations between caregivers and individuals with AD.

In terms of perception of effective communication strategies, some research has explored the viewpoints of family and formal caregivers' experiences around communicating with individuals with AD (e.g., Richer, Roberto, & Bottenberg, 1995), with findings indicating the importance of individualized interventions. Others have focused on the perceptions of formal caregivers when assisting LTC residents (e.g., Medvene & Lann-Wolcott, 2010) or when communicating with persons with AD (e.g., Beach & Kramer, 1999; Savundranayagam, Ryan, Anas, & Orange, 2007). For example, Medvene and Lann-Wolcott (2010) explored nurses aides' communication behaviours when working with LTC residents by interviewing nurses aides to examine which communication strategies caregivers discussed using in their care practice. Findings indicated that "giving positive regard" was the most frequently discussed

strategy and was used by all participating nurses aides. While this study explored nurses aides' perceptions of effective communication strategies for LTC residents, the discussions were not specific to assisting residents with AD. To our knowledge, no studies have examined caregivers' perceptions of effective communication strategies with a specific focus on assisting residents with moderate and severe AD during the completion of ADLs; and yet, the completion of ADLs comprises the bulk of caregiver-resident interactions in the LTC setting.

The purpose of this research was to describe formal caregivers' perceptions of communication strategies that are effective when assisting individuals with AD residing in LTC, at the moderate and at the severe impairment levels, during the successful completion of ADLs. This research was conducted as part of a larger observational comparison study designed to investigate communication strategies employed by formal caregivers assisting residents with moderate and severe AD during the completion of an activity of daily living (Wilson, Rochon, Mihailidis, & Leonard, manuscript accepted). The data presented in this paper are complementary to the larger observational study and provide the opportunity to help clarify or explain the observational data. The specific aims of this article were: (1) to identify which task-focused communication and social strategies, defined a priori, caregivers consider useful when assisting individuals with AD; and (2) to report any emergent themes, consisting of strategies that caregivers perceive to be effective, that were not included in the previously developed coding scheme.

Method

Research Design

A descriptive study design was employed to examine caregivers' perceptions of the communication strategies that they utilize while assisting residents with moderate and with severe AD during completion of daily tasks. To address the purpose of this research, formal caregivers participated in a one-hour semi-structured focus group interview (FGI). FGI is a useful method to collect qualitative data, which can be quantified, on a topic of interest (McLafferty, 2004). A non-probability criterion-based purposive sampling procedure was implemented to select formal caregiver participants, as this sampling procedure is suitable for the comprehensive study of a phenomenon of interest that is supported by the deliberate choice of participants because of their expert knowledge (Creswell & Plano Clark, 2007; Forman, Creswell, Damschroder, Kowalski, & Krein, 2008; Tongco, 2007). All participating formal caregivers were responsible for the direct care of individuals with moderate to severe AD,

thus were deemed expert care providers of individuals with AD who could contribute to the understanding of effective communication strategies for this client population. All caregivers who participated in an FGI also participated in our larger observational study (Wilson et al., manuscript accepted).

Participants and Setting

A total of 10 formal caregivers (personal support worker (PSW) = 9; registered nurse = 1) from two different LTC settings participated in a single one-hour semi-structured FGI. Five other caregivers had consented to participate in the FGIs; however, four could not attend due to scheduling conflicts and one caregiver had taken a health-related leave of absence after consent was obtained. At each LTC location, five caregivers participated in the FGIs, which is considered an appropriate sample size to generate data (McLafferty, 2004; Rabiee, 2004). Across the two LTC locations, formal caregivers did not significantly differ on age, years of

education, years in current professional title, and years working with residents with AD.

Table 1 summarizes the characteristics of the participants. Nine of the caregivers were female, all caregivers worked the day shift, and all were responsible for the daily care of residents with moderate and severe AD. Further, to be included in this study, caregivers had to speak English comfortably and have worked with individuals with AD for at least one year. All caregivers involved in the FGIs were recruited as participants in a larger project which measured caregivers' actual use of task-focused (verbal and non-verbal) and social-focused communication strategies while assisting individuals with moderate and severe AD during the completion of an ADL -- toothbrushing.

Ethics Approval

Ethics approval was granted by the University of Toronto Research Ethics Board (REB) and by Toronto

Table 1. Characteristics of Formal Caregivers Participating in the Focus Group Interviews (N = 10)

Professional Title	Years in Current Professional Title	Years Working with Individuals with AD	Years of Education	Age (Years)
PSW	2	2	13	30
PSW	5	5	17	37
PSW	25	25	18	62
RN	32	24	13	57
PSW	25	25	15	52
PSW	40	22	12	58
PSW	7	4	16	34
PSW	11	3	15	35
PSW	14	8	15.5	43
PSW	7	7	18	38
Mean (SD) Range	16.82 (12.9) 2 - 40	12.51 (10.1) 2 - 25	14.7 (1.7) 12 - 18	44.6 (11.6) 30 - 62

Note. PSW = Personal support worker. RN = Registered nurse. There was no difference between caregivers on their overall references made to strategies when grouped by years of experience working with individuals with AD: Group 1 = ten years or less experience (n = 6) and Group 2 = 20 years plus experience (n = 4), $U = 10.5$, $z = -.32$, $p = .75$.

Rehabilitation Institute REB, which is affiliated with one of the participating LTC facilities. Oral and written information was provided to caregivers. Written consent was signed by all caregivers in this study. All participants were informed that participation in this study was voluntary and that one could withdraw at any time without any impact on their work status.

Procedure

Data collection. Two one-hour on-site FGIs were conducted with participant caregivers, one FGI at each LTC facility. FGIs were conducted after completion of data collection for our observational study (Wilson et al., manuscript accepted). To ensure consistency, each FGI was led by the same externally hired professional moderator who had experience conducting FGIs in the health care setting (e.g., biotechnology and life sciences research) and each FGI was also attended by the first author to take field notes. The FGIs followed a semi-structured interview format consisting of a pre-determined question guide comprised of open-ended questions and their probes. The question guide was structured to focus caregivers to generate a discussion based on which communication strategies caregivers perceive as useful when assisting individuals with moderate and severe AD during completion of ADLs. The FGIs started with an introduction to the purpose of the discussion and a general knowledge question to begin the discussion: "What comes to mind when you think about your experience communicating with individuals with AD during your daily care routine?" Following the introduction, two main broad questions were posed to participants in each FGI: (1) "Which verbal and non-verbal communication strategies come to mind that you think are useful, or effective, when assisting individuals with AD during daily care tasks?" and (2) "Do you think that there are some communication strategies that may be better suited for individuals with moderate AD and for those individuals with severe AD?" Across both FGIs, the aforementioned broad questions were posed to the caregivers. However, in instances where the moderator felt it necessary, probes were given to explore or clarify participant discussion that was deemed important to the study and if the caregivers requested an example of a daily task, toothbrushing was the ADL suggested as a guide to their discussion. Following the discussion of the guided questions, caregivers were asked to rate the effectiveness of nine communication strategies that were previously found to frequently occur while formal caregivers assisted residents with AD during the successful completion of handwashing (Wilson et al., 2012). Using a 10-point scale, 1 being *the least effective*, 5 being *moderately effective*, and 10 being

very effective, caregivers rated the following strategies for residents with moderate and severe AD: (1) present one idea or instruction at a time, (2) use closed-ended (yes/no) questions, (3) use paraphrased repetition, (4) use the resident's name, (5) use encouraging comments (verbal praise), (6) point to objects relevant to the task, (7) demonstrate the step of the task using gestures, (8) hand objects to the resident (tactile prompt), and (9) use guided touch. The FGIs were video-recorded (but participants' faces were not visible, at their request). Data collection for this research project took place between September 2010 and February 2011.

Data analysis

Transcription and data coding. The FGIs were orthographically transcribed verbatim by a professional transcription service and each transcript was checked for accuracy by the first author. Also, all field notes were typed out for later interpretation. To address the primary aim of this research, directed content analysis was deemed the appropriate method (Hsieh & Shannon, 2005). Hsieh and Shannon (2005) describe this approach to content analysis as having the goal of extending or validating existing research and this approach has been used to explore nurses aides' perceived communication behaviours with nursing home residents (Medvene & Lann-Wolcott, 2010). Following the review of discussions relevant to the research aims, each of the caregiver's statements in these discussions was segmented based on a reference or, in some instances, multiple references made to a communication strategy (units of analysis) in a given discussion. Following unitization of each of the caregiver's comments, a multidimensional observation coding scheme (MOCS) was used to identify communication strategies discussed by the caregivers. MOCS is a comprehensive coding scheme that was developed based on the current empirical literature regarding communication and individuals with AD (e.g., Rochon et al., 2000; Small et al., 1997; Small et al., 2003) and was adapted from a coding scheme used to examine which task-focused communication strategies formal caregivers employ during the completion of an activity of daily living (Wilson et al., 2012; Wilson et al., manuscript accepted). MOCS was also utilized for the quantitative content analysis of the observational data collected as part of the larger study that preceded this research. MOCS consists of three dimensions that contain specific communication strategies that may be utilized during the completion of ADLs: (1) task-focused communication strategies, (2) social communication strategies, and (3) miscellaneous (MISC) categories. The task-focused communication strategies dimension contains a total of 19 communication strategies falling

under one of two sub-categories, verbal and non-verbal body language (e.g., gestures and touch). Six communication strategies were classified as social in nature and four codes were included in the MISC dimension. See Table 2 for a detailed description of the communication strategies included in the MOCS, which were described by caregivers during the discussion stemming from guided questions provided to them. Examples provided in Table 2 relate to the task of toothbrushing and these examples were generated from the larger observational study. All

decisions regarding MOCS codes and code definitions were made a priori.

To summarize, the first step of the analysis involved segmenting the transcripts to include the discussion surrounding caregivers' perceived use of communication strategies while assisting individuals with AD. The next step in the analysis was coding each of the relevant statements with the predetermined codes outlined in the MOCS. Finally, any communication strategy that did not fall under MOCS dimensions was coded as a strategy that fell under emergent themes.

Table 2. Caregivers' Perceived Use of Communication Strategies Included in the Multidimensional Observation Coding Scheme (MOCS)

Communication strategies	Definition	Example: toothbrushing
Dimension 1: Task-focused		
Verbal strategies		
One proposition	Single direction, request, or instruction present in caregiver's utterance to assist resident during steps of the task (e.g., step-by-step instructions)	"Please turn on the water."
Verbatim repetition	Caregiver repeats previous message (all content words or entire utterance) within same utterance or in immediate next utterance (task related)	"Turn the tap on, turn the tap on."
Paraphrased repetition	Caregiver restates previous message for clarification (related to steps of the task)	"Turn the taps on. Turn the taps to get some water."
Introduce task	Caregiver indicates to the resident that they are going to brush his or her teeth (at beginning of the task)	"We are going to brush your teeth now."
Explanation of actions	Caregiver explains what they are going to do with the resident during steps of the task	"I am going to help you turn the water on now."
Use of resident's name	Caregiver addresses residents by their first or last name during steps of the task to gain their attention	"Ms. X, here is the toothbrush"
Negotiation	Dialogue between the caregiver and the resident to reach an agreement or to meet the needs of both individuals during completion of the task	"Okay, after we finish brushing, I will get you a cup of tea."
Encouraging comments	Verbal praise, reassurance, optimism directed toward resident while participating in the task	"You're doing a good job!"
Multiple verbal strategies	Caregiver utilizes more than one verbal communication strategy within an utterance.	"Mr. X, can you turn the water on?"
Combination of verbal and visual strategies	Caregiver utilizes "talk and show" method during steps of the task	"Brush your teeth {caregiver gestures toothbrushing motion at the same time}."

Non-verbal strategies		
Hand object to the resident	Caregiver provides object to resident as a tactile prompt for the resident	Caregiver hands towel to the resident
Guided touch	Caregiver uses physical touch to guide resident through a step of the task	Caregiver guides resident's hand to the toothbrush
Comfort touch	Caregiver uses touch to indicate support or reassurance during a step of the task	Caregiver touches the resident's shoulder
Attention touch	Caregiver uses touch to gain or re-gain the attention of the resident when "off-task"	Caregiver touches the resident's hand to indicate that it is time to begin brushing
Demonstration gesture	Caregiver illustrates, with action, how to perform a step of the task	Caregiver demonstrates how to brush teeth
Pointing	Caregiver visually indicates direction of an object necessary for the step of the task	Caregiver points to the location of the toothpaste
Dimension 2: Social		
Greet resident	Caregiver greets resident upon initial contact	"Hello Ms. X, how are you today."
Compliment resident	Caregiver compliments resident, building rapport or validating resident	"You look nice today."
Caregiver responds to resident	Caregiver acknowledges, agrees, shows empathy or responds to a comment, request, or statement made by the resident	"I know you are looking forward to lunch today."
Dimension 3: MISC		
Full physical assistance	Caregiver uses full physical assistance during the step of the task	Caregiver brushes the resident's teeth
Redirection	Caregiver redirects resident to keep on task	Caregiver guides resident to water instead of towel

Note. The complete set of codes (n = 33) included in the MOCS is reported in Wilson, Rochon, Mihailidis, and Leonard (manuscript accepted). "Quantitative Analysis of Formal Caregivers' Use of Communication Strategies while Assisting Residents with Alzheimer's disease During Oral Care". This Table only includes the codes that were referred to by at least one caregiver during the FGIs.

Transcription and MOCS agreement. As part of the larger study, agreement analysis was performed on all transcripts. The first author independently transcribed a random selection of 20% of the transcripts. Total percent (point-by-point) agreement was computed as follows: $A / (A + D) \times 100$, which is the total number of agreements divided by total number of agreements and total number of disagreements multiplied by 100 (see for review House, House, & Campbell, 1981). Acceptable agreement was demonstrated for words (84.3%) and utterance segmentation (80.0%). After agreement for transcript content was established, the first author and a trained research assistant (clinical speech-language pathology student) independently coded the segments containing caregivers' references

to communication strategies that they use in their care practice. Codes applied to these segments were either the communication strategies defined in the MOCS or those that were novel strategies reported by caregivers. The agreement analysis was performed on half of the total number of segmented units caregivers produced (n = 51 utterances). MOCS codes and strategies categorized within the emergent themes demonstrated an acceptable 88.2 percent occurrence agreement (occurrence agreements/ occurrence agreements + disagreements X 100) between the two coders.

Results

An analysis of the transcripts derived from the FGIs indicated that formal caregivers discussed a variety

of communication strategies that they perceive to use in their care practice. Specifically, caregiver guided interviews generated narratives that were segmented into a total of 102 units (each unit referring to one or more strategy) that contained a total of 137 references made to strategies that caregivers perceived to be useful when assisting residents. Importantly, with respect to our research aims, 83 (60.6%) of the total references made to strategies were contained within MOCS and 54 (39.4%) of the total references made were categorized under one of the two emergent themes: general communication strategies and general care strategies. Moreover, the references caregivers made to strategies were identified by a total of 33 strategy codes, with 64% of these coded strategies ($n = 21$) defined in the MOCS. In the subsequent sections, the results are presented with respect to our research aims. In addition, the findings regarding caregivers' perceived use of strategies as a function of disease severity and caregivers' effectiveness ratings for a set of task-focused communication strategies are presented.

Communication Strategies Defined by MOCS

Of the total segments ($n = 102$ units) that were derived from the FGI narratives, over three-quarters (81.4%) contained at least one strategy that was defined a priori in MOCS. Broken down further, 65.7% of these strategies were identified as falling under the dimension of task-focused communication strategies, 11.8% were categorized as social strategies, and 3.9% were categorized as MISC. With respect to the strategies identified utilizing the MOCS ($n = 83$), the majority of strategies were categorized as verbal task-focused communication strategies (55.4%), while 25.3% were task-focused non-verbal strategies, 14.5% were social strategies, and 4.8% were MISC. The task-focused verbal communication strategies that caregivers most frequently discussed were: (1) using negotiation, (2) explaining their actions to the resident, and (3) using the resident's name to gain their attention. With reference to negotiation, caregivers perceived this strategy to be essential to their care practice and indicated that negotiation is intimately linked to understanding a resident's preferences, needs, and personal history. In addition, supplying residents with their preferred food choices was a common method of negotiation. The most frequently discussed non-verbal task-focused communication strategies were: (1) using visual demonstration, and (2) handing an object to the resident (tactile prompt). Finally, the most frequently used social strategy was greeting the resident. Table 3 provides examples of caregiver narratives pertaining to the most frequently discussed task-focused and social communication strategies identified with the MOCS.

These narrative examples were generated in response to the guided questions presented to the caregivers during the FGIs.

Table 3. Examples of Caregivers' Comments Pertaining to the Most Frequently Discussed Communication Strategies

Communication strategy	Narrative example
Task-focused	
Negotiation	You use it to bargain or negotiate with them. [For example] we tell them "okay brush your teeth and afterward we'll go for coffee and get you some treats."
Explanation of actions	Tell every instruction you will do. [For example] like every instruction you got to do, you just tell them.
Use of resident's name	When you start, just call them by their last name.
Demonstration gestures	What I noticed, working with residents, I find the non-verbal because of the language barrier... that doing demonstration. [For example] wanting them to brush their teeth you do the demonstration and when you put the socks on or whatever, I give a demonstration on myself for what I want them to.
Hand object to the resident I will have to do the brushing of the teeth or I put the brush in the hand and ask them to do it. Right away you know [their severity level].
Social	
Greet resident	We always greet them when we go into their rooms in the morning

In terms of the extensiveness of references made to the communication strategies defined in advance (i.e., the number of individual caregivers that express the use of the same communication strategy), the strategies that exhibited the greatest level of extensiveness during the FGIs were the use of negotiation (90%), the caregiver explaining their actions to the resident (60%), the caregiver demonstrating or gesturing an action to the resident (50%), and the caregiver greeting the resident (60%). In addition to individual references each caregiver made to communication strategies during the FGIs,

there were also instances of group consensus during the FGIs whereby all caregivers agreed that the strategy was useful. The six communication strategies that were identified in this way were: (1) negotiation, (2) use the resident's name, (3) paraphrased repetition, (4) verbatim

repetition, (5) greet the resident, and (6) respond with empathy to the resident's requests, statements, or needs. Table 4 summarizes the findings for the communication strategies formal caregivers commented on that were identified utilizing the MOCS.

Table 4. Frequency and Extensiveness of Formal Caregivers' Perceived Use of Communication Strategies

Communication strategies (n = 21)	Frequency	Relative Frequency (%)	Extensiveness (%)
1. Task-focused			
Verbal			
One proposition	3	3.6	20
Verbatim repetition	2	2.4	10 ⁺
Paraphrased repetition	2	2.4	10 ⁺
Introduce task	2	2.4	20
Explanation of actions	9	10.8	60
Use of resident's name	4	4.8	20 ⁺
Negotiation	17	20.5	90 ⁺
Encouraging comments	2	2.4	20
Multiple verbal strategies	5	6	40
Non-verbal			
Hand object to the resident	4	4.8	20
Guided touch	3	3.6	20
Comfort touch	2	2.4	20
Attention touch	3	3.6	30
Demonstration gesture	5	6	50
Pointing	2	2.4	20
Verbal and visual strategies	2	2.4	20
2. Social			
Greet resident	8	9.6	60 ⁺
Compliment resident	1	1.2	10
Caregiver responds to resident	3	3.6	10 ⁺
3. MISC			
Full physical assistance	3	3.6	10
Redirect resident	1	1.2	10

Note. Relative frequency is the total frequency of a given communication strategy relative to the total number of communication strategies commented on by the formal caregivers included in the MOCS (total = 83). Extensiveness refers to how many of the participating caregivers commented on the use of the same communication strategy in their care practice. ⁺Denotes that a group consensus was expressed regarding the usefulness of a given strategy.

Emergent Themes

Data from the FGIs led to the identification of two main emergent themes, which, combined, contained a total of 12 strategies that caregivers perceived to be useful in their care practice when assisting individuals with moderate to severe AD during the completion of ADLs. The two emergent themes were: (1) general communication strategies, and (2) general care strategies. General communication strategies were classified as communication strategies caregivers discussed that were not included in the MOCS and that were considered to be applicable to all circumstances of communication, thus not necessarily task-driven (e.g., giving time for resident to respond). General care strategies were classified as strategies that caregivers

discussed that were applicable to their general approach to care, which they use across contexts and are not specific to communicating with residents. Further, general care strategies may indirectly support the completion of ADLs (e.g., knowing the resident's preferences). For each strategy, Table 5 provides a definition and an example of a segment of the narrative that made reference to the emergent strategy during the discussion generated when the guided questions were presented to the caregivers. Caregivers made a total of 54 references to these strategies and at least one of these strategies was present in 52.9% of the unitized segments. Of these novel strategies, 20.6% were categorized in the emergent theme of general communication strategies and 32.3% were categorized in the emergent theme of general care strategies.

Table 5. Emergent Themes Caregivers Perceived to be Useful While Assisting Residents with AD during the Completion of ADLs

Strategies (n = 12)	Definition	Narrative example
1. General communication strategies		
Be patient	Provide time for the resident to respond to a request, instruction, or general communication attempt	"Be patient with them and give them time [to respond]."
Focus the resident	Gain the resident's attention and use strategies (e.g., proximity) to help maintain his or her focus during the activity	"The more cognitively impaired the resident is, the harder it is to get their attention, we have to try to put ourselves in front of the resident, get him to look at me and get their attention."
Environmental cues	Use stimulation available in the resident's environment as cues to support participation in the activity	"I'd go in [to the resident's room] and say good morning, good morning, I'd put the light on, just to let him feel like it's the sunshine coming down."
Eye-contact	Establish eye-contact to introduce yourself to the resident, to connect with the resident, and to gain the resident's attention	"They see us on a daily basis and they will remember our face. They don't remember anything else but they'll remember your face. Look at them [eye contact] and as soon as they see you, they say <i>Oh it's you again, okay</i> ."
Para-verbal monitoring	Monitor the tone, pitch and pace of the voice when communicating with the resident	"[Be] calm [and] soft when you talk with them. Be caring and show empathy, so [when] you communicate, you talk to them gently and they [will] cooperate better."
Interpret non-verbal communication	Be aware of a resident's use of non-verbal communication (i.e., body language, such as gestures and facial expression), and help to interpret the message	"They're responding non-verbally and you try to understand and respond verbally but it's up to them, depending on their cognitive ability to get what you're saying and actually respond back."

2. General care strategies		
Familiarity	Being familiar with the resident by knowing their personal preferences and personal history assists in meeting the resident's needs and interpreting his or her behaviour	"This is where their personal history comes in. If the person was never a morning person, why even introduce mornings to this person when they're never a morning person, and then oh this person never has supper, why would you introduce supper, You understand, You're giving them things they don't normally have."
Interpret behaviour	Be aware of a resident's actions to verify that they are compliant and /or understand	"You check their understanding [and] if they are compliant to what you're doing."
Assess mood	At the beginning of each encounter, assess the resident's mood and decide the best action to take following his or her response	"You need to check how their mood is in the morning. [For example] when you greet you will know, when you say good morning, they might say go away or get out of my room."
Assess for restiveness	At the beginning of each encounter, assess for any restive behaviour and consider the management of aggressive responses	"For example, at first you see that a resident is very aggressive, so right away we know you have to tender him."
Request assistance	Ask for assistance from another caregiver because the resident may respond to a different person	"They might say yes to someone else, and then you go back [to finish the task]."
Postpone / repeated attempts	When communication or non-compliance difficulties arise, postpone completing the task and repeat the attempt to complete the task at a later time	"We usually leave them and go somewhere else and come back, and if we have to we'd just leave and postpone again."

The general communication strategy that was most frequently commented on in the FGIs was the use of eye contact, while the most frequently mentioned general care strategies were (1) familiarity and (2) postpone the task/ repeated attempts. Moreover, caregivers indicated that establishing eye contact is always the first strategy they use to communicate with a resident with AD and that residents with cognitive impairments still respond to a familiar face. In terms of familiarity, caregivers expressed that this is an essential component to their care practice, as knowing a resident's preferences helps the caregiver to select the best approach (i.e., implement an effective communication strategy) to support a resident during the completion of ADLs. Caregivers also discussed postponing completion of a task when the resident is non-compliant or indicates that they want to participate at a later time, as a strategy that acknowledges and validates the resident's needs.

With respect to the notion of extensiveness, postponing the task was discussed by 40% of the caregivers. Though not initially expressed by each caregiver as being a strategy that she used, all caregivers agreed that the following three strategies are useful during the completion of ADLs: (1) eye contact, (2) interpret non-verbal communication, and (3) familiarity. Table 6 reports the frequency and extensiveness of the strategies in detail.

Differences in Strategies Used with Moderate and Severe AD

During the FGIs, caregivers were asked to respond to the following question: Do you think that there are some communication strategies that may be better suited for individuals with moderate AD and for those individuals with severe AD? Specific to this guided FGI discussion, 70% of the caregivers provided input. In

Table 6. Frequency and Extensiveness of Formal Caregivers' Perceived Use of Strategies Included in the Emergent Themes

Strategies (n = 12)	Frequency	Relative Frequency (%)	Extensiveness (%)
1. General communication strategies			
Be patient	2	3.7	20
Focus the resident	3	5.6	10
Eye-contact	8	14.8	30 [†]
Environmental cues	2	3.7	10
Para-verbal monitoring	3	5.6	20
Interpret non-verbal communication	3	5.6	30 [†]
2. General care strategies			
Familiarity	11	20.4	30 [†]
Interpret behaviour	1	1.9	10
Asses mood	5	9.3	30
Assess for restiveness	4	7.4	30
Request assistance	3	5.6	30
Postpone task / repeated attempts	9	16.7	40

Note. Relative frequency = total frequency of a given emergent strategy/ total number of strategies (n = 54). [†]Denotes that a group consensus was expressed regarding the usefulness of a given strategy.

general, caregivers commented that they use a variety of strategies, with the selection of verbal or non-verbal strategies being based on each individual's cognitive level, needs, and personal preferences. Caregivers also indicated that, regardless of the cognitive severity level, they utilize the following approach to completing ADLs with residents: (1) greet the resident, (2) introduce the task, (3) explain their actions, and (4) repeat instructions when necessary. However, caregivers did make some distinction between strategies that were considered to be more useful during the completion of ADLs depending on the resident's level of cognitive impairment. With respect to moderate AD, caregivers identified four strategies that they perceive to be best suited for this severity group: (1) familiarity, (2) handing an object to the resident, (3) giving one instruction at time, and (4) using negotiation. Also, caregivers indicated that more challenges can arise (e.g., non-compliance) when assisting these individuals during ADLs because, in some instances, the resident will respond with non-compliance to the caregiver's requests and, in some encounters, there is little to no response to the caregiver's attempts to help with a given task. Interestingly, caregivers indicated that providing closed-

ended questions (yes-no response) is not helpful to their care practice because, when a resident responds "no", they would then have to find alternative ways to encourage the resident to participate in a given task. Caregivers also expressed that negotiation, supported by knowing the person's history and preferences, is a key strategy that is used to complete daily tasks.

Conversely, when assisting individuals with severe AD, postponement of the task (repeated attempts), interpreting non-verbal behaviour, using the resident's name, and employing full assistance were identified as more appropriate strategies. Also, caregivers agreed that they continue to verbalize their actions, greet residents, and talk generally (e.g., social communication) to residents with severe AD even when residents no longer have the capacity to respond. However, caregivers discussed the difficulty in gaining the attention of individuals with severe AD. They indicated that an increased reliance on non-verbal behaviour when interacting with these individuals was important. Such non-verbal behaviours included positioning themselves in front of the resident and establishing eye contact. Caregivers also discussed relying less on negotiation as a strategy of choice as the disease progressed. Instead,

they noted that postponement of the task was the main strategy they used when assisting residents with severe AD, particularly when a resident demonstrated resistive (i.e., non-verbal non-compliance) or aggressive behaviour, which was noted to be most problematic when assisting residents with severe AD. Finally, caregivers indicated that assisting individuals with severe AD is less difficult than assisting those with moderate AD because they generally have to provide full-assistance to these residents and verbalized non-compliance rarely occurs.

Effectiveness Ratings

Formal caregivers were asked to rate, on a scale of 1 to 10 (10 = most effective), the effectiveness of nine task-focused communication strategies (verbal = 5 and non-verbal = 4) that have been previously reported as frequently used when caregivers assist individuals with moderate and severe AD during an ADL (Wilson et al., 2012). Medians are reported in this section, as the median is the more appropriate statistic to report for ordinal scales and for non-parametric tests (Field, 2009). The highest ranked verbal strategies for both severity groups were the use of encouraging comments (moderate: $Mdn = 9.5$, $IQR = 1.0$; severe = $Mdn = 8.5$, $IQR = 2.0$), using the resident's name (moderate: $Mdn = 8$, $IQR = 2.0$; severe = $Mdn = 9.5$, $IQR = 2.3$), and giving one instruction at time (moderate: $Mdn = 8.5$, $IQR = 2.3$; severe: $Mdn = 9$, $IQR = .20$). For the moderate group, the verbal strategy for which caregivers provided the lowest rating was using closed-ended questions ($Mdn = 7$, $IQR = 2.3$) and the lowest rated verbal strategy for the severe group was the use of paraphrased repetition ($Mdn = 7.5$, $IQR = 2.0$).

Overall, caregivers rated the effectiveness of non-verbal strategies lower than verbal strategies. In terms of assisting residents with both moderate and severe AD, caregivers provided the highest rating for the strategy of guided touch (moderate: $Mdn = 7$, $IQR = 2.3$; severe: $Mdn = 5.5$, $IQR = 2.0$). Further, when assisting residents with severe AD, caregivers rated handing an object to the resident ($Mdn = 3$, $IQR = 1.5$), pointing to an object ($Mdn = 4$, $IQR = 4.5$), and demonstrating ($Mdn = 4$, $IQR = 2.3$) as least effective.

In order to examine differences between caregiver ratings for each strategy when assisting those with moderate versus severe AD, a Mann Whitney U test was conducted. There was no significant difference in caregivers' effectiveness ratings for all the verbal strategies. However, significant differences were present for caregivers' ratings of non-verbal strategies. Caregivers rated the following non-verbal strategies as significantly more effective when assisting individuals with moderate AD than when helping those individuals with severe AD during ADLs: (1) pointing ($Mdn = 6.5$,

$IQR = 2.3 > Mdn = 4$, $IQR = 4.5$; $U = 5$, $z = -2.1$, $p = .037$); (2) demonstrating ($Mdn = 6$, $IQR = 2.3 > Mdn = 4$, $IQR = 2.3$; $U = 2$, $z = -2.8$, $p = .013$); and (3) handing an object to the resident ($Mdn = 6.5$, $IQR = 1.5 > Mdn = 3$, $IQR = 1.5$; $U = .5$, $z = -2.8$, $p = .004$).

Discussion

The purpose of this study was to elucidate the perceptions of formal caregivers with respect to which communication strategies they find effective when assisting residents with moderate and severe AD during the completion of ADLs. While previous investigations have focused on examining formal caregivers' use of a selection of communication strategies during conversation with individuals with moderate to severe AD (e.g., Savundranayagam et al., 2007; Tappen et al. 1997), the present study provides a detailed description of formal caregivers' perceived use of a variety of strategies, the majority of which were task-focused, specific to the completion of ADLs. A key finding was that, in addition to task-focused and social communication strategies, caregivers incorporate broader communication and care strategies than originally reported in the literature that has examined caregivers' use of communication strategies when assisting individuals with AD during the completion of ADLs (Small et al., 2003; Wilson et al., 2012). For instance, while the use of a variety of task-focused communication strategies has been previously observed during the communication occurring between caregivers and individuals with AD during the completion of ADLs (e.g., provide one instruction at a time), findings from this study bring added value to this literature, as caregivers highlighted the importance of the broader care context surrounding communication during ADLs (e.g., being familiar with the resident). That is, the strategies that caregivers discussed appear to fall along a continuum, with some of these strategies representing more of a "micro" approach to communication during daily care routines (i.e., strategies specific to completing ADLs) and some of the strategies representing more of a "macro" approach to communication and care (i.e., general communication strategies (e.g., eye-contact) and general care strategies (e.g., postponement)). These two approaches appear to be intimately connected in the sense that strategies that caregivers report using in their general care practice provide underlying support for the implementation of individual communication strategies. A striking illustration of this finding is caregivers' reference to the general care strategy of familiarity, or knowing the resident's preference and personal history, and the selection of strategies individualized to the resident's needs. Negotiation was the most frequently discussed task-focused strategy and being familiar with

the resident and understanding their needs is essential to employing this particular strategy effectively.

The results indicated that caregivers perceive that they use numerous task-focused communication strategies, some of which have been previously reported in the empirical literature. For example, formal caregivers ranked highly the use of one proposition (i.e., one instruction or idea) at a time with residents with moderate and with severe AD. They also indicated with a consensus that paraphrased repetition and verbatim repetition were useful strategies when assisting residents with AD during the completion of ADLs. Of note, while paraphrased repetition was the lowest ranked verbal strategy for individuals with severe AD, the ranking of this strategy was still moderately high ($Mdn = 7.5$). Importantly, reduced number of propositions (Rochon et al., 1994) and repetition (Small et al., 1997) have been shown empirically to increase comprehension in individuals with AD). In addition, the most frequently mentioned non-verbal strategy was the use of demonstrating gestures to support the verbal message. The use of gestures was investigated by Pashek and DiVenere (2006), who showed that gestures enhance comprehension of verbal messages in individuals with mild to moderate AD. During the FGIs, the most common strategies that formal caregivers discussed as being useful when assisting residents with AD included: (1) negotiation; (2) familiarity; (3) explaining their actions to the resident; (4) postponing completing the task when difficulties arise; (5) greeting the resident; and (6) establishing eye contact with the resident. These findings indicate that caregivers perceive that a combination of task-focused, general communication strategies, and general care strategies is an effective approach to assisting residents with moderate and severe AD during the completion of ADLs.

Negotiation was the strategy that caregivers most frequently discussed and was often commented on in relation to being familiar with the resident. This notion appears to incorporate the idea of coaxing in order to achieve a mutually satisfactory solution (see also Small & Montoro-Rodriguez, 2006). Beach and Kramer (1999) also reported that caregivers perceived compliance gaining strategies, which included negotiation and understanding the resident's preferences, as a core communication strategy useful when interacting with residents with AD. Further, being familiar with a resident's personal history and preferences, and acknowledging their individual needs have been shown to be essential components to enhancing relationships between care providers and residents in LTC (McGilton, 2002; McGilton et al., 2003; Richter et al., 1995). Furthermore, therapeutic relationships with residents

with moderate to severe AD can be created (Williams & Tappen, 1999), which has the potential to improve residents' quality of care (Anderson, Taha, & Hosier, 2009; Bowers, Esmond, & Jacobson, 2000; Nakrem, Vinsnes, & Seim, 2011), and improve job satisfaction for LTC staff assisting individuals with dementia (Moyle, Murfield, Griffiths, & Venturato, 2011).

Another communication strategy that may reinforce interpersonal relationships is the use of positive feedback during caregiver-resident interactions. Caregivers in this study referred to the use of encouraging comments and providing sufficient time for residents to respond. Indeed, Medvene and Lann-Wolcott (2010) explored experienced nurses aids' perceived communication behaviours in the LTC setting and reported the key finding that giving what they call "positive regard" to residents was the most frequently utilized strategy. Furthermore, investigations into the effects of caregiver communication training intervention on conversation content in the LTC setting supports caregivers' use of positive statements, providing simple instructions, and making conversational content personally relevant to the resident (e.g., Bourgeois, Dijkstra, Burgio, & Allen, 2004; Burgio et al., 2001; Dijkstra et al., 2002; McGilton et al., 2009) as effective strategies when communicating with residents with AD. For example, Dijkstra and colleagues (2002) reported that caregivers' use of one instruction at a time, positive feedback, giving sufficient time for the residents to respond, and individualizing the content of the conversation benefited individuals with moderate and severe AD. Together, reported findings on the use of communication strategies during conversation support key findings in this current study, indicating that there may be a similarity between communication strategies used during the completion of ADLs (i.e., task-driven communication) and those used during conversation.

When assisting residents with moderate as compared to severe AD, formal caregivers in this study indicated a perceived distinction between the effectiveness of a sub-set of the strategies. Interestingly, the distinction may reflect caregivers' knowledge and experience with the declining cognitive and functional abilities that are apparent with the progression of AD (see Appell et al., 1982; Bayles & Tomoeda, 1994; Bayles, Tomoeda, & Trosset, 1992; Bayles & Tomoeda, 1991). In terms of interacting with residents with moderate AD, caregivers commented on a larger selection of strategies that are useful in their care practice, including task-focused verbal strategies (e.g., using negotiation and providing one instruction at a time), task-focused non-verbal strategies (e.g., handing an object to the resident) and general care strategies (e.g., familiarity). Conversely, although caregivers

agreed that verbalizing with residents should continue when assisting individuals with severe AD, caregivers discussed the usefulness of only a few strategies when assisting residents with severe AD, outside of full assistance. Specifically, the general care strategy of postponing the task and repeating at a later time, the general communication strategy of interpreting the resident's non-verbal behaviour, and the task-focused verbal strategy of using the resident's name were discussed.

Caregivers' effectiveness ratings for task-focused non-verbal communication strategies indicated that the strategies of demonstrating or gesturing an action, pointing to an object, and handing an object to the resident were better suited for individuals with moderate AD, whereas full assistance for individuals with severe AD was the more typical approach discussed during the guided interviews. Taken together, caregivers' ratings of effective communication strategies imply a perceived shift from non-verbal strategies that act as a prompt to complete the step (i.e., assume resident can participate with the assistance of the strategy) to full assistance and no independent participation of the resident. Of note, the fact that there were no significant differences found among the verbal strategies that were rated highly by the caregivers may be attributed to a ceiling effect. On the other hand, it must be noted that the strategies selected for rating were chosen from among those found to be frequently used in our previous work (Wilson et al., 2012), and thus a high rating for all these strategies was not unexpected. Finally, it is important to note that, while the frequency data and the effectiveness ratings appear to display divergent findings for the use of encouraging comments, providing one instruction at a time, and guided touch, it is possible that this finding reflects the nature in which the data were generated. That is, the frequency data were produced in response to open-ended questions, included in the semi-structured FGI, which allowed for a broad range of responses from the caregivers. In this scenario, the aforementioned communication strategies may not have readily come to the minds of the caregivers when they reflected on their care practices. Conversely, the effectiveness ratings placed caregivers in a situation where they were directly asked about a given strategy and had to reflect on their use of that specific strategy in their care practice. Thus, it may be possible that a limitation associated with self-report data (e.g., failure to recall) during the semi-structured interview process, generated different information but not necessarily divergent findings.

Across all strategies coded, the most frequently discussed strategies suggest formal caregivers

incorporate a person-centred approach to dementia care (Kitwood, 1997) when assisting residents with AD during the completion of ADLs (see also Brooker, 2004). According to Kitwood's theory of dementia care (1992; 1993; 1997), while individuals with AD exhibit declining cognitive abilities, they are also more than cognitive beings in that they maintain aspects of their emotional being and are apt to participate socially in relationships; thus, dementia care should emphasize recognition of personhood, (e.g., uniqueness of a person's history and their need for relationships) during the cooperative reciprocal exchanges occurring during their care. Kitwood (1997) identifies five principle components of positive interactions in person-centred dementia care that has implications for communication: (1) recognizing the person as a unique individual; (2) negotiating by consulting an individual on preferences and choices; (3) validating an individual by acknowledging their emotions and responding with empathy; (4) collaborating by aligning oneself with an individual to engage in a task; and (5) facilitating by enabling the use of remaining abilities (see also Ryan, Bryne, Spykerman, & Orange, 2005). Interestingly, caregivers in this study employed strategies that support each of the key positive interactions identified in person-centred dementia care. With respect to recognition, caregivers identified that they always greet the resident and use the resident's name at the beginning of every encounter. Caregivers also indicated that using eye contact and positioning themselves in front of the resident are an essential communication strategy in their care practices. Negotiation is another positive interaction approach in person-centred dementia care and caregivers in this study reported using the strategy of negotiation during ADLs the most frequently. Further, being familiar with the resident's needs and preferences maximizes the potential for successful negotiation. Caregivers' use of postponing the task supports the positive interaction of validation. By postponing the task, typically in response to non-compliance or resistive behaviours, caregivers acknowledge the desires or needs of the residents with AD. Facilitation and collaboration are features of positive interactions in person-centred dementia care that are closely linked to the completion of ADLs. Caregivers commented on the use of a variety of task-focused (verbal and non-verbal) communication strategies that support residents' participation in their own self care. For example, caregivers frequently reported that they explain the steps of the task to residents, even in circumstances where residents do not have the cognitive capacity to respond, which supports their participation in the task. Caregivers also discussed the use of demonstration in conjunction with instructions as a useful strategy to help residents

during the task, which is a strategy that supports the resident by assuming that they can use this strategy to initiate autonomous participation in the step of the task. Interestingly, caregivers' overall effectiveness ratings for verbal task-focused communication strategies were higher than the effectiveness ratings provided for non-verbal strategies. This finding suggests caregivers still perceive verbal communication strategies as more effective, or necessary, in their care practice regardless of disease severity. This may relate to the person-centred approach to care, as caregivers' continued use of verbal communication may indicate they understand the importance of treating the persons with AD as individuals and as social beings who interact with others primarily by means of verbal communication. Thus, relational communication is essential to the quality of care and quality of life for individuals with AD.

Additionally, caregivers' perceived use of strategies appears to coincide with the framework outlined by the Communication Enhancement Model (Ryan, Meredith, MacLean, & Orange 1995; Orange, Ryan, Meredith, & MacLean, 1995). The Communication Enhancement Model provides a framework for a comprehensive approach to communicating with older adults with speech, language, or hearing impairments and has been applied as an intervention to enhance communication in individuals with AD (Orange & Colton-Hudson, 1998). This model emphasizes the importance of individuals' interactions in their environment and how these interactions are important determinants of health care, health promotion and well-being. Further, the framework for this model, which includes offering a supportive environment (physical and social), meeting individual needs of the person with AD, and employing appropriate communication accommodations by avoiding over-accommodation (e.g., elderspeak, (Williams, Kemper, & Hummert, 2003; Williams, 2006; Williams, Herman, Gajewski, & Wilson, 2009)) has been used as part of a communication enhancement and training intervention for individuals with AD and their clinicians (e.g., Orange & Colton-Hudson, 1998). Caregivers in the current study commented on a variety of strategies (i.e., task-focused communication strategies, general care strategies, and general communication strategies) that they use to support communication with individuals with AD during the completion of ADLs. Moreover, as outlined by the Communication Enhancement Model framework, caregivers expressed the importance of being familiar with residents in order to understand their needs, which in turn helps caregivers to select strategies that are best suited to the individual needs of the residents. Finally, caregivers indicated that they distinguish between their use of

communication strategies as a function of disease severity, indicating that they may be attempting to appropriately match communication accommodations to the individual's cognitive status.

Before concluding, it must be acknowledged that possible limitations to the study exist, concerning the use of FGI data. Firstly, although a major advantage of self-report data is that participants can describe their own experiences rather than relying on inferences made from observational data alone, a disadvantage of self-report data is that participants may fail to recall (e.g., possibly under report the frequency of strategies used). Another disadvantage of self-report data is that social desirability effects may create the possibility that caregivers discuss particular strategies because they are more socially acceptable. Thirdly, it is recognized that this method of collecting data can be influenced by the dynamics of the group, such as individuals who tend to dominate a discussion and those who may be less inclined to speak in a group setting. In addition, although the caregivers were a homogeneous sample and the number of individuals per focus group (i.e., 5) that was used is considered an appropriate sample size to generate data, a total of three focus groups is preferable (McLafferty, 2004; Rabiee, 2004). Finally, we acknowledge that we could not examine whether different professional caregivers might have differed in their self-reported use of strategies because the group was small and included only one nurse in comparison to nine PSWs. Future research could investigate this factor.

Clinical Implications

The results of this study provide further support for the importance and the use of targeted and individualized strategies that enhance communication between formal caregivers and individuals with AD. The results add to existing findings in that caregivers endorsed the use of previously reported strategies in the literature, many of which would be recommended by speech-language pathologists. Furthermore, other strategies that were previously unidentified in the literature emerged. Taken together the results provide direction for speech-language pathologists to educate caregivers on how to optimize communication with individuals with AD during ADLs.

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