Many older adults living in long-term care facilities speak English as a second language or may not be able to speak English at all. Bilingual residents are often reported to return to speaking their native language in advanced stages of dementia, even if they had not used it recently (Yeo, 1993). Data from the 1990 U.S. Census indicate that 12% of persons 65 years old and over speak a language other than English, with over 47% of these individuals speaking English “less than well,” which translates into more than 1.5 million older adults who have difficulty speaking English. Immigration of older adults from the former Soviet Union, Eastern Europe, and the Far East in recent years is likely to increase this number.

For example, at Menorah Park Center for the Aging in Cleveland, approximately 8% of the residents throughout our 350-bed long-term care facility speak Russian. This poses a challenge for caregivers, and dementia compounds the problem. Although encouraged to explain what they are doing or will do to a resident, staff cannot do this effectively if they cannot speak the resident's language. The confusion and agitation associated with dementia further complicate these interactions, and may lead to combative behavior toward staff.

Staff in long-term care have attempted to deal with this issue in a number of ways. At a nearby facility, with a similar percentage of Russian-speaking residents, pages of Russian words printed in Cyrillic (with corresponding English words printed next to them) are located in residents' rooms. Residents can point to words on the page and staff can understand residents' requests or questions. The use of words or symbols which can be pointed to as a means of facilitating communication is an example of a more generic intervention for communication problems—communication boards.

Communication boards and other devices to augment communication have been used with a wide variety of populations, including children and adults with mental retardation (Villalba, 1992), individuals with neuromuscular disease (Kazandjian, Dikeman, & Bach, 1995), aphasics (Johnsen, 1992), and long-term care residents (Buckwalter, Cusack, Kruecker, & Shoemaker, 1991). However, this approach places the burden of communicating primarily on the individual who has difficulty with language. When cognitive impairment is also present, learning the use of a communication board is a further challenge. Where dementia may be involved, remembering how to use a communication board adds another level of complexity to this problem.

An alternative approach is to encourage staff to use the language of the resident. For example, at Menorah Park, pages of Russian words and corresponding English pronunciations have been printed and put into folders kept at nursing stations for staff to use in delivering care. In this approach, staff were attempting to overcome the language barrier, which was preventing the most effective delivery of care to residents. However, we found that staff were not utilizing these folders. Reasons include a lack of follow-up in servicing the pronunciation of words, lack of knowledge of the existence of the folders (especially after staff turnover), and the fact that holding folders prevented free use of hands for care delivery.

Burant and Camp (1996) presented a case study detailing an intervention designed to deal with an
especially challenging situation regarding a non-English speaking resident. The case involved a 65-year-old woman diagnosed with advanced Alzheimer’s disease (AD) who was legally blind, spoke only Russian, and had a variety of other debilitating conditions. She was unable to feed herself, and often became both agitated and combative toward staff when being fed. An intervention was developed using a prototype of The InterpreCare System™ (ICS) on which English words were phonetically translated into Russian (e.g., “thank you” translates into “spah-see-bah”). The intervention device needed to be lightweight, portable, and adaptable so that its contents could be changed to accommodate each meal’s menu. Russian translators were called upon to provide phonetic spellings of Russian phrases and names of foods used at specific meals. These Russian phrases and their English word counterparts were put onto cards, which were then placed on the ICS.

The ICS was placed behind the chair and table where the resident was being fed. Line staff were trained for approximately five minutes before each meal in the pronunciation of the Russian phrases. The intervention produced a substantial reduction in both verbal and physical aggression from the resident, and greatly humanized the interactions between staff and the resident. Time spent feeding the resident increased. Staff would name a food item, ask if she would want to eat it (or eat more of it), offer alternatives if she refused a food item, thank her for eating, ask if a food item was good, etc. This in turn increased her willingness to sit through a meal and increased the number of positive interactions between staff and the resident during meals.

Since our initial intervention we have improved our techniques for manufacturing ICSs, so that they are both versatile and durable. Requests for ICSs have been received from three other nursing units, our Rehabilitation Department, and our Adult Day Care facility. A brief description of the ICS will be presented next, using our experience with Russian phrases as an example. Then we will describe training procedures used to facilitate the use of ICSs when they are put into residents’ environments. Finally, we will present some preliminary data describing how line staff have begun to learn Russian phrases since ICSs (augmented by in-service training) have been implemented at various locations within our facility.

Materials Used in Creating an ICS

The physical materials needed to manufacture language boards were designed to offer a “low-tech,” flexible, easily accessible means of utilizing foreign language vocabulary by line staff in the course of delivery care and interacting with residents. The ICS itself consists of a display board which has durable surfaces and a foam core center. It is light and easily mounted on walls. Cards with the transliterated words or phrases are mounted on the boards, but can be removed or replaced within seconds. Different pastel shades of color are used to give good contrast to the lettering. Also, different colors allow critical phrases to be found readily when looking at an entire board filled with phrases.

A full-sized board is approximately 48 x 30 inches, has four columns for placement of words or phrases, and can accommodate approximately 30 separate words or phrases at a time. Smaller-sized boards are used in areas where space is limited, such as a bathroom, and are effective where a limited or specialized vocabulary will suffice. These smaller boards are also portable, and can therefore be taken by therapists to residents’ rooms. We use a very small “Word of the Week” board to highlight a specific word or phrase each week to gradually increase the foreign language vocabulary of staff.

A list of vocabulary terms was developed for the ICS based on requests from staff on various units. These involve a series of core phrases such as “Please,” “Thank you,” “Hello,” “Goodbye,” “Are you in pain?” etc., as well as specialized vocabulary, e.g., “Repeat ten times” for physical therapists or “Don’t pinch” for a nursing care unit. An example of some of these terms is shown in Figure 1. Letters for words used in the ICS are about 1 inch high, and the words can be read from a distance of 30 feet or more.

Putting ICSs into the Environment

After presenting an ICS to staff and an initial in-service meeting to describe its function, we demonstrate pronunciation rules for the phonetic Russian phrases. For example, we say that “ie” will always be pronounced like the word “eye” when appearing on an ICS. In-service meetings for additional training
are generally held on a monthly basis unless staff request that they occur more frequently, as has sometimes been the case. These in-services give staff practice pronouncing Russian phrases, allow requests for additional words or phrases, and enable researchers to determine which Russian vocabulary terms have been learned by staff up to that point.

**Learning Russian Phrases**

Burant and Camp (1996) noted an interesting effect after staff began using an ICS while feeding a resident — the automatic and unconscious learning of Russian phrases after two or three meals. Repetitive use of the ICS enabled staff to speak and understand frequently used phrases without having to refer to the ICS. Members of the staff became enthusiastic about the intervention, and asked for new phrases for purposes other than feeding (e.g., dressing, bathing, etc.). As reported earlier, a number of units and departments at Menorah Park now have requested ICSs. We have begun to gather preliminary data on the learning of Russian phrases after installing this intervention.

In our Rehabilitation Department, a survey was taken at an initial in-service meeting to determine which of 42 target Russian phrases were being used by staff before installation of ICSs. The total number of phrases reported as familiar to staff in different areas of the department were: Occupational Therapy — 0 total phrases for 3 staff members; Physical Therapy — 2 total phrases for 6 staff; Speech Therapy — 14 total phrases for 3 staff; Secretarial — 0 phrases for 1 staff. One month after installing ICSs, the following data were obtained: Occupational Therapy — 0 total phrases; Physical Therapy — 18 total phrases; Speech Therapy — 31 total phrases; Secretarial — 0 total phrases. Both the secretarial staff and the staff in Occupational Therapy reported that they had not been dealing with Russian-speaking residents during this time, unlike their colleagues in other areas. Thus, staff who were using ICSs reported increases in the number of Russian phrases they knew. In addition, they requested additional phrases they felt would be useful. A similar pattern of results was obtained from staff on a resident/nursing unit. All of the five staff surveyed at baseline and at a follow-up service meeting reported increases in the number of Russian phrases they had learned, with the increases ranging from 2 to 4 phrases.

**Discussion**

We have noted some additional benefits from this intervention as well. For example, Russian-speaking employees (numbering approximately 20 out of a staff of over 700) suddenly became experts to other staff, who began to seek their advice on correct pronunciation, how to speak new phrases, etc. This elevated the status of foreign-born staffers and increased socialization between them and other staff. Also, when other staff began to deliver care using Russian phrases with Russian-speaking residents, the foreign-born staffer was no longer constantly being asked to speak to or translate for these residents. In addition, we have observed that residents are tolerant of a staff member’s limited foreign vocabulary when that staffer can state that they only know a small amount of the foreign language. Residents appreciate attempted communications and the increased opportunities for expressing their desires that the intervention creates.

Burant and Camp (1996) were able to use direct behavioral observation to measure the effects of an ICS at the time it was being used. Our future plans include using such direct observation measures as a means of increasing the effectiveness of ICS utilization on different units. In addition, we are exploring ways to provide recorded pronunciation of phrases posted on the ICS so that staff can get feedback and practice on a more flexible schedule. We are also planning to create ICSs in a variety of other languages to meet the needs of our nursing home and others in this geographic area (Hungarian; Slovenian; etc.). Of course, the same technology could be applied to other languages such as Korean, Spanish, etc.

We are also interested in creating words and phrases printed in Cyrillic so that both staff and Russian-speaking residents can use ICSs to pronounce English phrases. This could benefit foreign-born staff by allowing them to communicate more effectively with English-speaking residents. It may also increase socialization opportunities for residents.

We are not claiming that the use of ICSs enable staff to speak a foreign language. However, this intervention can enable staff to use foreign phrases effectively in delivering care to residents. We have observed that hearing even a few phrases in their own language often has a dramatic, positive emotional impact on residents. It creates possibilities for communication, a basic human need (e.g., Buckwalter et al., 1991).

We feel that this straightforward approach to the problem of language barriers in long-term care facilities has great potential. It does not require that staff spend time or energy attempting to memorize phrases, carrying folders or sheets of paper, or being asked to learn information (e.g., grammar) or vocabulary which is not considered useful. In addition, staff can expand their functional vocabulary in areas and at a speed which they consider most appropriate.

**References**


Received December 8, 1995
Accepted April 15, 1996
Choosing Medical Care in Old Age
What Kind, How Much, When to Stop

MURIEL R. GILLICK

WINNER OF THE 1995 WILL SOLIMENE AWARD OF THE AMERICAN MEDICAL WRITERS ASSOCIATION

"Gillick's personal and compassionate approach to medical decision making in old age is bound to spark controversy about patients' autonomy, proxy rights, rationing, and standards of care...I hope this book will be widely read, not only by clinicians but also by ethicists, policy makers, and the general public and that it will stimulate the conversations that will ultimately lead to the social consensus Gillick feels is missing today when we choose medical care in old age."

—Katherine A. Hesse, M.D., M.S.W., NEW ENGLAND JOURNAL OF MEDICINE

"A unique and fertile source of impressions from a seasoned clinician, grappling with the tensions between patients and policy."

—Sheldon M. Retchin, M.D., JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

"Gillick, professor of medicine and director of the geriatrics fellowship program at Harvard Medical School, reviews cases from her own practice in which older patients and their families were faced with critical medical decisions. Based on the outcomes of these cases, she develops an approach to medical decision-making that combines the patient's wishes with an assessment of his or her physical condition...A thoughtful, clearly written look at one of medicine's most challenging questions."

—Karen McNally Bensing, LIBRARY JOURNAL

Harvard University Press
800 448 2242
www.hup.harvard.edu