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RESEARCH REPORT

Communication support in care homes for older adults: Views and reported practices of speech and language therapists and care home activities staff in the UK

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Abstract

Background: Speech and language therapists (SLTs) and care home activities staff play key roles in managing and supporting the communication needs of older residents in care homes. However, the current practice and perspectives of these two professions in the United Kingdom has not been examined.

Aims: To investigate the practice patterns and views of SLTs and activities staff working in UK care homes for older adults in relation to residents' communication needs.

Methods and Procedures: Two online surveys, with 63 questions (SLT survey) and 46 questions (activities staff survey) in total, were created using the online platform Qualtrics. Participants were asked to consider their routine practice before COVID-19. Results were analysed using descriptive statistics and qualitative content analysis.

Outcomes and Results: A total of 116 valid responses were received from SLTs and 29 valid responses from activities staff. A high level of communication needs in care homes was reported by both participant groups, as was insufficient time and resources and lack of managerial encouragement in this area. SLTs reported that the majority of referrals to their service from care homes was for swallowing needs (70%). Cognitive communication difficulty was the most commonly reported communication need by SLTs (65%). Most SLTs (73%–87%) provided some level of communication intervention and considered management of residents' communication needs to be both part of the SLT role and a good investment of their time. Lack of confidence setting goals and providing direct intervention for communication needs was reported, with 25% feeling stressed at the thought of this. The main themes from free text responses about SLT service improvement were increased staff training, funding (of resources and specialist posts) and changes to service provision (referral

criteria and accessibility/awareness of SLT service). Hearing impairment was the communication need most commonly reported by activities staff (43%). Participants demonstrated relatively high awareness of communication difficulty in residents and reported high levels of knowledge and confidence identifying and supporting residents' communication. Most (79%–89%) considered identifying and supporting the communication needs of residents to be part of their role and expressed interest in receiving further training in communication support. The reported activities staff data set may be positively biased.

Conclusions and Implications: SLTs and activities staff were highly motivated to support the communication needs of care home residents. Increased training, time and resources dedicated to managing the communication needs of residents emerged as opportunities for service improvement across both data sets.

KEYWORDS

older adults, care homes, communication, speech and language therapist, survey

WHAT THIS PAPER ADDS

What is already known on the subject

- There is a high level of communication need amongst older care home residents. Social interaction and relationships are important factors contributing to quality of life in this population and rely on successful communication. Speech and language therapists (SLTs) and activities staff play key roles in managing and supporting the communication needs of this client group, but the current practice and perspectives of these professions in the United Kingdom has not been examined.

What this study adds

- A high level of communication need in care home residents was identified by both SLT and activities staff and both participant groups were motivated to address, identify and manage this need. However, insufficient time and resources, as well as a perceived lack of encouragement from managers to provide communication support/intervention, were reported by both groups. SLT practice was constrained by referral criteria and care pathways, which differed between services. Suggestions for SLT service improvement are reported.

Clinical implications of this study

- Targeted, ongoing staff training is required in care homes to improve the communication environment and develop care home staff capacity to support residents' communication needs. There is also a call for service level improvements to increase the range of SLT practice in care homes, including a greater focus on communication needs and more specialist (e.g., dementia) SLT roles.

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INTRODUCTION

Leisure activities, social interaction and relationships are amongst the most important contributing factors for quality of life in older care home residents (Hall et al., 2011; O'Rourke et al., 2015; Siette et al., 2022), all of which rely on successful communication. However, supporting the communication skills required for social interaction in older care home residents can present challenges. With age, there may be physiological changes in hearing, voice and speech, and changes in cognition and physical health also contribute to altered communication skills (Caruso et al., 1995; Zraick et al., 2006). Ageing can also compromise linguistic skills, such as word-finding (Heller & Dobbs, 1993) and the maintenance of discourse coherence (Marini et al., 2005). As such, facilitation techniques/specialist knowledge and skills may be required to support and accommodate these communication challenges.

Although, as a profession, speech and language therapists (SLTs) have the skill set to deliver activities in care homes that generate language and communication opportunities, they may not have the opportunity to do so on a frequent and regular basis. In contrast, care home staff and volunteers have more opportunity to create meaningful activities but may lack the skills to ensure that these activities also support and optimise successful communication. The delivery of activities to care home residents, often by a member of staff known as an activities coordinator, is an established and familiar practice in UK care homes. In practice this task is performed by a broad range of individuals, including staff employed by the care home, as well as volunteers, who may or may not have a personal connection to the setting. For the purpose of this paper, and in order to reflect the broad range of staff, we will refer to these individuals as *activities staff*. There is evidence showing successful and unsuccessful attempts at implementing staff-led activity including art (Keating et al., 2020) and exercise (Ellard et al., 2014) in care homes. It is unclear whether activities staff in care homes receive appropriate training to support residents' communication needs and optimise communication opportunities in group activities, and this was explored in this current study.

Environmental factors within care home settings impact levels of resident activity and participation and are an important consideration when evaluating the communication needs of this group (Hickson et al., 2005). Using *the International Classification of Functioning, Disability and Health* framework (World Health Organization (WHO), 2001) to evaluate communication and participation in an Australian care home, these authors found that the physical and social environment was not conducive to communication, with limited communication opportunities for residents. Reported barriers included background noise/poor acoustics and visual glare from lighting as well as reduced or inconsistent use of facilitation strategies by staff to support resident communication and encourage decision making. Importantly, there were missed opportunities for social interaction *between* residents, with ineffective seating arrangements during activities, and use of more acoustically suitable *conversation rooms* for interaction with visitors rather than for intra-resident social engagement. These barriers relate to *all* residents, not just those with vision, hearing or cognitive impairment.

The evidence base for communication interventions for older adults is growing, largely with a focus on dementia intervention research. A systematic review by Swan et al. (2018) found a modest level of evidence in support of direct communication interventions (primarily cognitive stimulation, conversation and reminiscence groups but also naming therapy and use of alternative and augmentative communication methods) for people with moderate to severe dementia across a variety of sites including nursing homes. A more recent review of group interventions with language or communication components for older adults in care homes found evidence of positive impact on language, communication and social interaction skills, in those with and without dementia (Davis et al., 2022). The interventions reviewed by Davis et al. were delivered by a range of professionals which included clinicians *and* care home staff, namely SLTs, clinical psychologists, nurses, social workers; nursing and psychology students; recreational therapists; clinicians supported by care home staff as intervention *co-leaders* and members of care home staff trained in a specific intervention approach.

Research exploring the daily reality of speech and language therapy service provision in care homes for older adults in the United Kingdom, however, is limited; with much of the research in this area having been conducted in Australia. For example, a narrative literature review of speech-language therapy service provision in Australian residential aged-care facilities (RACF) by Sewell and Hopf (2020) found SLTs skills and scope of practice (communication and swallowing disorders) were underutilised in these settings. Identified barriers to the provision of SLT best practice in these settings included poor understanding of SLT *scope* of practice in RACFs, limited SLT *roles* in practice, communication access and quality issues (e.g., impoverished communication environments and staff interaction style) and lack of recognition of RACFs as a clinical specialty site for SLTs.

The communication needs of care home residents, as well as the practice patterns and the perspectives of frontline staff, are areas which warrant further inquiry. This is necessary in order to determine current areas of need, and directions of future research, as well as to ensure that clinical training adequately prepares staff for practice.

The purpose of the present study was thus to investigate: (1) the current routine clinical practice of UK SLTs in supporting the communication needs of care home residents; (2) the routine practice of activities staff, including what group interventions or activities are typically being delivered in care homes for older adults; and (3) the perceived skills, knowledge base and confidence of both professional groups in relation to supporting care home residents' communication.

METHODS

This study was conducted as part of a larger research project, developing a novel language intervention for older adults in care homes. An open web-based survey in the Qualtrics platform was used to reach a large cross-section of SLTs and activities staff. The Checklist for Reporting Results of Internet E-Surveys (CHERRIES: Eysenbach, 2004) guidelines have been adhered to in the reporting of our survey procedure. See Appendices A and B for survey questions and supplementary material for CHERRIES checklist.

Participants

Participants for the SLT survey were qualified, Health and Care Professionals Council registered SLTs working in the United Kingdom. At least part of their current clinical role involved working with older adults in residential care settings (or had done within the last 6 months).

Participants for the activities staff survey were 18 years of age or older, currently working in a care home for older adults (or they had been within the last 12 months) in a paid or voluntary position. Their role in the care home included regularly running activities for the residents.

Survey design

Surveys were developed using the web-based platform Qualtrics. All aspects of the survey process were conducted online, including advertisement, recruitment, provision of project information and respondent completion. The survey questions were developed based on similar practitioner surveys in the field (Bennett et al, 2019a; Cruice et al., 2020; Hopper et al, 2007) and contained a variety of question types including multiple choice, Likert scale of agreement, rank order and free text. The SLT survey had 63 questions in total and the activities staff survey had 46 questions in total. The surveys took approximately 20–25 min (SLT survey) and 15–20 min (activities staff survey) to complete.

The SLT survey collected information on the following: (1) participant demographics; (2) caseload characteristics and service delivery practices; (3) referral and assessment; (4) management of communication difficulties; (5) professional development practices; (6) respondent perspectives on supporting the communication needs of care home residents using the Theoretical Domains Framework (TDF; Huijg et al., 2014; Michie et al., 2005); and (7) SLT service provision barriers and areas for improvement. The activities staff survey collected information on the following: (1) participant demographics; (2) routine practice; (3) observed resident communication needs; (4) respondent perspectives on supporting the communication needs of care home residents using the TDF; and (5) professional development practices (communication focused). The TDF (Huijg et al., 2014; Michie et al., 2005) has been used previously to explore clinicians' practices and views (Cruice et al., 2020). In the current study, questions explored perceived levels of knowledge, skills and confidence in supporting or managing resident communication, using rating scales to indicate respondent level of agreement with statements, for example, 'Identifying when residents are having difficulty communicating or are reluctant to communicate is part of my role' (activities staff survey) and 'I am positively encouraged by my service/ workplace to carry out direct intervention for communication needs in this group, as required' (SLT survey).

An open text format question was utilised to ask *both* groups about which communication difficulties they typically see in care homes in order to capture the breadth of clinical presentations in these settings. Responses were collated into basic categories.

Usability and technical functionality of the surveys were tested by the research team prior to the survey being opened.

Recruitment and data collection

Respondents were asked to consider their routine practice *before* COVID-19 related changes when answering survey questions, so results reflect usual care practices prior to March 2020. On reaching the end of the surveys, respondents in both professional groups were also invited to answer questions relating to the impact of COVID-19 on their work practices. Answers relating to the impact of COVID-19 on the practice of both groups are not discussed here.

Survey questions were designed to generate both quantitative and qualitative data. Key stakeholder groups (established in a previous stage of the project) were consulted when creating the surveys and piloted a small

number of questions, providing feedback on terminology and accessibility of the language used in both surveys. Stakeholders did not directly influence survey questions.

Respondents in both surveys were provided with an information sheet and were informed that participation was anonymous and voluntary and they could withdraw at any time up until they submitted their survey. No incentives were offered. Respondents gave informed consent before they were able to open the survey. Ethical approval of the study was granted by the Language & Communication Science Proportionate Review Committee, City, University of London on 3 February 2021.

The surveys were open from 11 March to 25 August 2021. Participants for the SLT survey were targeted through professional networks and Twitter, using the @STARs_CityUni project handle and authors' personal account handles. The project was advertised through the Royal College of Speech and Language Therapists (RCSLT) Clinical Excellence Networks relating to dementia, mental health, aphasia, neurology, brain injury, dysphagia and palliative care. The activities staff survey was advertised via Twitter and through the National Activity Providers Association members emailing list and in their quarterly members' publication.

Data analysis

Quantitative data were analysed using SPSS. Content analysis was conducted on the qualitative data gained through open text questions. Free text responses and free text options (i.e., *Other* responses throughout survey) were copied to Microsoft Word and conventional content analysis (Hsieh & Shannon, 2005) was applied by the first author (L.Da.), that is, words that were felt to capture core concepts were highlighted and these were then coded and sorted into categories to create meaningful themes. Free text responses for Q60 in the SLT survey (Appendix 1) were independently analysed by the first author (L.Da.) and the member of the research team with expertise in qualitative methodology (M.C.).

RESULTS

Participant characteristics

Speech and language therapists

Demographic information relating to SLT respondents ($N = 116$) is reported in Table 1. Not all respondents completed all questions so the denominator is reported for all results. The majority of respondents (67.2%, 78/116) were female. Respondents represented a spread across educational background, years of clinical experience and clinical settings (Table 1). The highest number of respondents was from South East England (19.3%, 22/114), closely followed by Scotland (18.4%, 21/114), and the fewest respondents were from Northern Ireland (2.6%, 3/114); 65.8% (75/114) worked in England. The majority worked in an urban area (60.5%, 69/114). Most respondents were employed on a full-time (60.9%, 64/105), permanent basis (74.3%, 78/105) within the National Health Service (NHS; 76.2%, 80/105) and worked in a community setting for at least part of their role (90.9%, 90/99).

Activities staff

The activities staff survey was completed by 29 respondents (see Table 2). Again, not all respondents completed all questions so the denominator is reported throughout. Respondents were predominantly female (82.7%, 24/29), and employed by care homes (80%, 24/30) on a permanent basis (72.4%, 21/29). The vast majority of respondents worked in England (93.1%, 27/29). The highest number of respondents worked in greater London (48.3%, 14/29) and the fewest respondents worked in Wales (3.5%, 1/29). There were no respondents from Northern Ireland, North East England or Yorkshire and the Humber. More respondents worked in urban areas than rural areas. There was a good range in age, education levels, number of years working in this role and size of care homes at full capacity (see Table 2). The mode age of respondents was between 41 and 50 years (34.5%, 10/29). One fifth (20.7%, 6/29) spoke additional languages.

Current practice of SLTs in care homes

Caseload

Just over half of SLTs (53.1%, 52/98) visited between one and five older care home residents in an average working week (see Figure 1). The mean percentage of caseload composed of older adults *living in care homes* was 40% (SD = 23.47, range = 5–100, count = 98).

Referrals

The vast majority of referrals were for swallowing needs (mean percentage = 71%, SD = 29.06, range = 1–100, count = 93). The mean percentage of referrals received for communication needs was 20% (SD = 18.85, range = 0–100, count = 91). When visiting residents to assess

TABLE 1 SLT survey participant demographic and clinical setting data.

Question	Number	%
Gender	($n = 116$)	
Male	31	26.72%
Female	78	67.24%
Non-binary/third gender	5	4.31%
Prefer not to say	2	1.72%
Age range	($n = 114$)	
20–30 years	40	35.09%
31–40 years	29	25.44%
41–50 years	27	23.68%
51–60 years	12	10.53%
61–64 years	6	5.26%
Ethnicity	($n = 114$)	
White	83	72.81%
Mixed or multiple ethnic groups	4	3.51%
Asian or Asian British	17	14.91%
Black, African, Caribbean or Black British	8	7.02%
Any other ethnic group (please specify)	0	0.00%
Would rather not disclose	2	1.75%
Current work region	($n = 114$)	
Scotland	21	18.42%
Northern Ireland	3	2.63%
Wales	15	13.16%
North West England	9	7.89%
North East England	2	1.75%
Yorkshire and the Humber	16	14.04%
Midlands and East England	7	6.14%
Greater London	10	8.77%
South East England	22	19.30%
South West England	9	7.89%
Is your work region mostly urban or rural?	($n = 114$)	
Urban	69	60.53%
Rural	38	33.33%
Unsure	7	6.14%
Highest level of academic achievement	($N = 106$)	
Bachelor/undergraduate degree	44	41.9%
PG Cert/PG Dip	17	16.2%
Master's degree	43	40%
PhD/DPhil	2	1.9%
Years of clinical experience	($N = 106$)	
up to 2 years	10	9.43%
2–5 years	36	33.96%
6–10 years	19	17.92%
11–15 years	17	16.04%
16–20 years	4	3.77%
Over 20 years	20	18.87%

(Continues)

TABLE 1 (Continued)

Question	Number	%
I currently work	($N = 105$)	
In the NHS	80	76.19%
In a non-NHS setting	22	20.95%
In both NHS and non-NHS settings	3	2.86%
Current work setting (tick yes or no)	Denominator varies	
Acute/subacute	42/80	52.50%
Inpatient rehabilitation	40/83	48.19%
Outpatient rehabilitation	61/87	70.11%
Early supported discharge	26/78	33.33%
Community	90/99	90.91%
Residential care homes	82/94	87.23%
Nursing home	84/99	84.85%
Private practice	9/72	12.50%
Not for profit organisation	21/71	29.58%
University	13/71	18.31%
Other	11/43	25.58%
Other specified	Inpatient mental health (1)	
Other specified	Part time PhD student (1)	
Current work pattern	($n = 105$)	
Full time	64	60.95%
Part time	41	39.05%
Current work	($n = 105$)	
Permanent	78	74.29%
Contract	23	21.90%
Casual/agency	4	3.81%

Abbreviations: NHS, National Health Service; PG Cert, postgraduate certificate; PG Dip, postgraduate diploma; SLT, speech and language therapist.

their swallowing needs, most SLTs (97%, 90/93) also considered cognition, communication and neuropsychiatric symptoms (generally referred to as *behavioural needs*), and 73% (68/93) did this *routinely*, and an additional 24% (22/93) reported that they did *sometimes* depending on the situation (Figure 2).

Assessment

Respondents assessed a wide range of areas when evaluating residents' communication skills. Areas of communicative functioning most commonly observed or assessed by SLTs were cognition (89%, 71/80), receptive language (88%, 69/78), functional language (87%, 68/78), cognitive communication (87%, 67/77), emotional well-being (83%, 63/76), behaviour/neuropsychiatric symptoms of dementia (81%, 62/77) and social communication (80%, 60/75). Other areas of communication assessed included speech sound production and voice. Mental health status was also reported as an area of consideration when assessing older care home residents' communication, but further detail was not given about how this may be characterised. The most commonly used forms of communication assessment were discussion with key staff (87%, 65/75) and family members (81%, 61/75) about areas of need, informal/dynamic assessment (82%, 62/76) and observation in setting or with family (79%, 59/75). SLTs used standardised or formal assessment (64%, 47/73), screens developed for use by SLTs within their department (58%, 42/72), speech samples (54%, 40/74) and self-developed screens used by individual clinicians (43%, 32/75).

Communication needs of residents

The following communication difficulties were observed by SLTs in older care home residents: cognitive communication difficulties secondary to dementia (and to a lesser degree, stroke) 65% (30/46); aphasia/stroke (28%, 13/46); expressive language skills, including word finding difficulties (26%, 12/46); dysarthria or speech impairment,

TABLE 2 Activities staff survey participant demographic and clinical setting data.

Question	Number	%
Role in the care home	($n = 30$)	
Activities coordinator (employed by the care home)	24	80.00%
Volunteer	4	13.33%
Volunteer from community (family member of resident/s)	2	6.67%
Gender	($n = 29$)	
Male	5	17.24%
Female	24	82.76%
Non-binary/third gender	0	0.00%
Prefer not to say	0	0.00%
Age range	($n = 29$)	
18–21 years	0	0.00%
22–30 years	2	6.90%
31–40 years	5	17.24%
41–50 years	10	34.48%
51–60 years	7	24.14%
61–64 years	1	3.45%
65+ years	4	13.79%
Highest level of education of qualification	($n = 29$)	
High school/secondary school	7	24.14%
College	7	24.14%
University undergraduate degree	5	17.24%
Post graduate degree	8	27.59%
Other (please specify)	2	6.90%
Ethnicity	($n = 29$)	
White	25	86.21%
Mixed or multiple ethnic groups (please specify)	1	3.45%
Asian or Asian British	0	0.00%
Black, African, Caribbean or Black British	1	3.45%
Any other ethnic group (please specify)	1	3.45%
Would rather not disclose	1	3.45%
Mixed or multiple ethnic groups (specified)	Mixed white and black Caribbean	
Any other ethnic group (specified)	Jewish	
Other languages spoken, in addition to English	($n = 29$)	
Yes (please specify)	6	20.69%
No	23	79.31%
Other languages spoken (specified)		
Dutch		
German		
Hebrew, French, Russian		
Spanish, French		
Russian, Bulgarian, German		
Mandarin, Italian, French		
Current work region	($n = 29$)	
Scotland	1	3.45%
Northern Ireland	0	0.00%
Wales	1	3.45%

(Continues)

TABLE 2 (Continued)

Question	Number	%
North West England	2	6.90%
North East England	0	0.00%
Yorkshire and the Humber	0	0.00%
Midlands and East England	4	13.79%
Greater London	14	48.28%
South East England	3	10.34%
South West England	4	13.79%
Urban or rural area	($n = 29$)	
Urban	20	68.97%
Rural	7	24.14%
Unsure	2	6.90%
Current work pattern	($n = 29$)	
Full time	14	48.28%
Part time	13	44.83%
Other (please specify)	2	6.90%
Other (specified)	Mix of employed and freelance	
Other (specified)	One day a week volunteering, full time employed	
Permanent	21	72.41%
Contract	3	10.34%
Casual/agency	5	17.24%
How many years working as activities staff	(n=29)	
Up to 1 year	4	13.79%
3–5 years	10	34.48%
6–10 years	4	13.79%
10+ years	5	17.24%
1–2 years	6	20.69%
How many residents live in your care home when it is at full capacity?	($n = 29$)	
0–20 residents	1	3.33%
21–40 residents	7	23.33%
41–60 residents	7	23.33%
61–80 residents	0	0.00%
81–100 residents	5	16.67%
100+ residents	9	30.00%
Does your care home provide different levels of care for residents with different needs (e.g., residential care, nursing care, dementia care)?	($n = 30$)	
Yes	26	86.67%
No	3	10.00%
Unsure	1	3.33%
Which level or type of care do you mostly work in?	($n = 25$)	
Residential care	7	28.00%
Nursing care	0	0.00%
Dementia care	4	16.00%
I work equally across different levels/types of care	14	56.00%

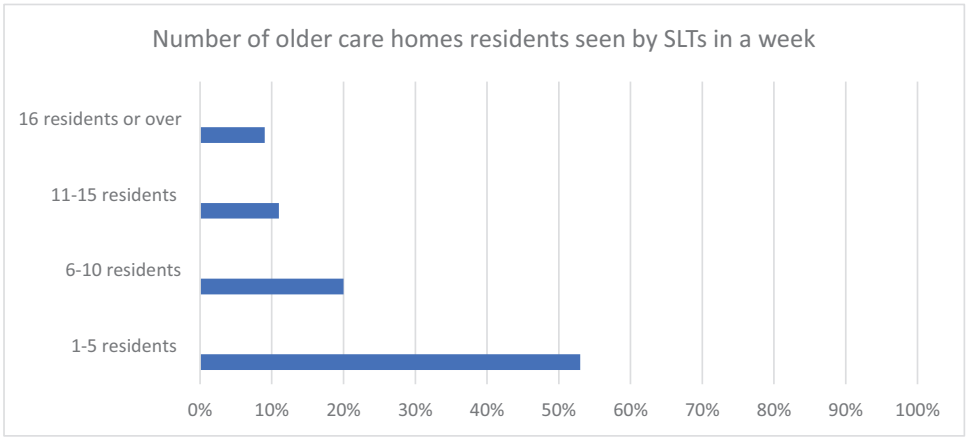

FIGURE 1 The number of older care home residents seen by SLT survey respondents in an average working week. Abbreviation: SLT, speech and language therapist.
[Colour figure can be viewed at wileyonlinelibrary.com]

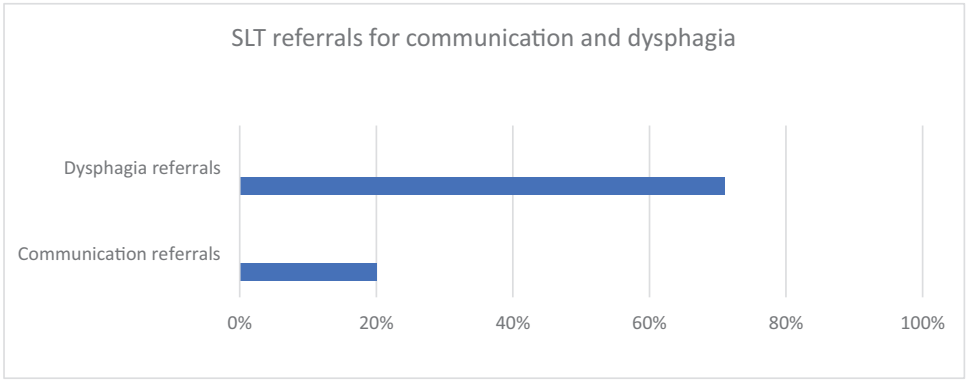

FIGURE 2 Average (mean) proportion of SLT referrals for communication and dysphagia. Abbreviation: SLT, speech and language therapist.
[Colour figure can be viewed at wileyonlinelibrary.com]

for example, secondary to Parkinson's disease or multiple sclerosis (26%, 12/46); problems relating to the communication environment, for example, reduced social interaction and communication opportunities, lack of recognition or response to residents' non-verbal communication and a need for supported conversation strategies (17%, 8/46); behaviour/neuropsychiatric symptoms, usually secondary to dementia and/or the inability to make themselves understood (15%, 7/46); receptive language needs (11%, 5/46) and dysphonia or voice impairment (9%, 4/46) (Figure 3).

Intervention

Most SLTs provided intervention for communication skills (87%, 71/82). Input was most often consultative in nature, rather than providing direct input, but most respondents provided some input at specialist, targeted and universal level (e.g., staff training). Intervention most often took the form of informal advice to staff and/or family members about supporting communication (97%, 67/69); supporting staff and/or family member(s) to create communication books and external communication or memory aids (96%, 65/68); and monitoring of communication needs but no direct intervention (82%, 55/67).The majority of SLTs, however, were also providing some direct, individual speech and language therapy (78%, 52/67) or a targeted programme of activities for staff and/or family members to carry out 1:1 with the resident (71%, 46/65). Formal staff training about identifying and/or supporting communication needs (68%, 44/65) was more common than training staff to provide group activities, for example, reminiscence or cognitive stimulation (39%, 26/66). Other responses included provision of Augmentative and Alternative Communication and life story work.

The most commonly reported form of continuing professional development for SLTs was discussion with

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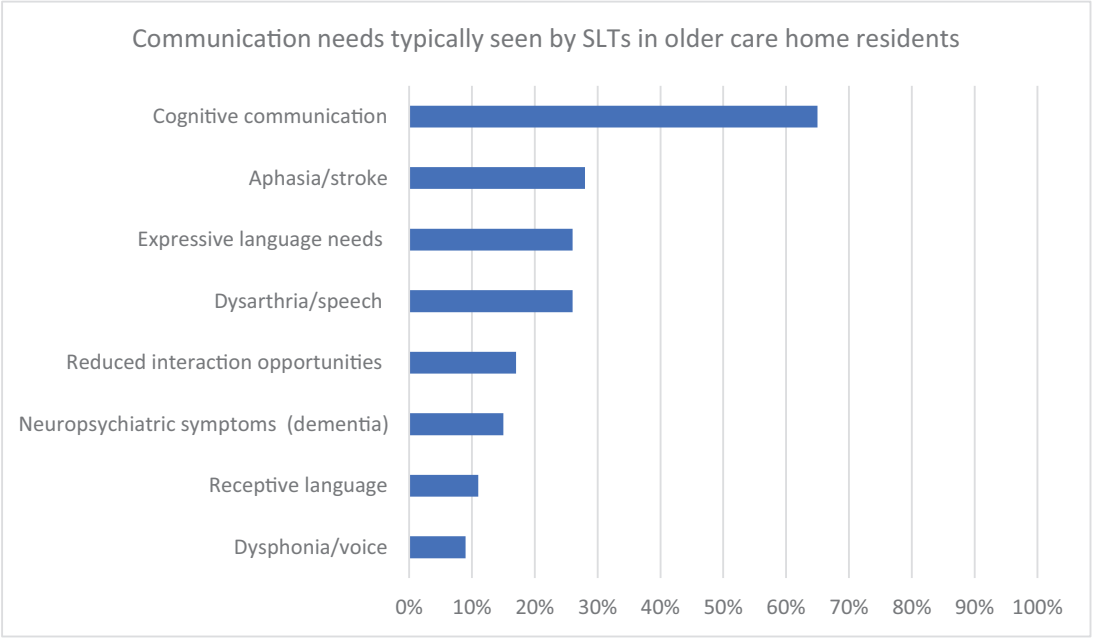

FIGURE 3 Types of communication need typically seen by SLT survey respondents in older care home residents.
Abbreviation: SLT, speech and language therapist.
[Colour figure can be viewed at wileyonlinelibrary.com]

colleagues (92%, 71/77), followed by independent reading (86%, 65/76) and short courses organised through work (81%, 65/80). The majority reported attendance at journal clubs (67%, 51/76), Clinical Excellence Network involvement (65%, 50/77) and self-funded short courses (51%, 39/77).

Current practice of activities staff in care homes

Most respondents (87%, 26/30) worked in care homes which provided different levels of care for residents with different needs (e.g., residential care, nursing care, dementia care). A majority (56%, 14/25) worked equally across different levels/types of care in their role and all of these respondents (100%, 14/14) varied what activities they carried out with different levels/types of need.

A broad range of structured group activities was reported to be delivered regularly in their workplace. The most commonly reported activities were arts and crafts (100%, 28/28), reminiscence activities (96%, 27/28), exercise classes (96%, 26/27), music sessions (93%, 25/27), singing group/choir (87%, 20/23), sensory/*Namaste*[1] groups (84%, 21/25), group crossword or word search activities (81%, 22/27) and current affairs/newspaper review discussion groups (77%, 20/26). Less structured activities that were most commonly reported were birthdays and seasonal parties (96%, 27/28), performances from visitors to the care home, for example, singers or dancers (96%, 26/27), watching TV programmes or films together as a group (93%, 25/27) and coffee mornings (86%, 24/28).

The number of group activities a day/week varied. At least three group activities a week were reported by 14% (4/29) of respondents; at least five group activities a week in 21% (6/29); two group activities per day in 38% (11/29); and two (7%, 2/29) reported that their care home ran eight or more activities per day.

Communication needs of residents

Approximately 28% (8/29) of activities staff considered *many* residents to have difficulty communicating; 21% (6/29) considered *about half* of the residents to have difficulty communicating; 38% (11/29) considered *some* residents to have difficulty communicating; and 14% (4/29) considered *no or few* residents to have communication difficulties.

The communication difficulties observed by activities staff were hearing impairment (43%, 10/23), dementia-related difficulties (22%, 5/23), word finding difficulties (22%, 5/23) and reluctance to interact socially and/or communicate (22%, 5/23) for example, 'shyness', 'purposefully isolating themselves' or feeling self-conscious about physical symptoms of, for example, Parkinson's disease. Speech impairment (13%, 3/23), visual impairment (13%, 3/23), difficulty understanding (13%, 3/23), 'non-verbal' residents (13%, 3/23) and reduced coherence (4%, 1/23), for example,

'sentences not linking together', were also reported. Some, more general, respondent comments indicated an awareness that certain residents were having difficulty accessing activities or communicating but less understanding (or detail) about *why*, for example: 'Sometimes they can't keep up with the pace of the activity' and 'Difficulty verbalising what they want'.

Two thirds of respondents (66%, 19/29) had received specific training in their workplace about supporting the communication of the residents in the care home. The most commonly reported areas of training were techniques to support communication skills (77.8%, 14/18), how to identify communication difficulties in residents (72.2%, 13/18), how to run reminiscence activities (72.2%, 13/18), techniques to support memory difficulties (64,7%, 11/17) and how to run sensory or Namaste groups (55.6%, 10/18).

Additional, individual, open text responses referred to dementia specific training, informal 'training' in the form of advice from other staff and developing skills independently through experience working in a care home setting.

Views of SLTs and activities staff

For the purpose of analysis, the survey questions have been categorised according to three broader constructs (Cane et al., 2012): capability (relating to perceived awareness and skills), motivation (related to associated feelings and the degree to which communication support with this client group is perceived to be part of their professional role) and opportunity (related to support in the workplace, availability of time and resources). For purposes of this paper, 'agree' refers to the combined categories of strongly agree and agree and 'disagree' refers to the combined categories of strongly disagree and disagree.

SLT views

Capability

Most SLTs were aware of communication assessments they could use with this client group (70%, 56/80), agreed they had sufficient skills to carry out communication assessment with this client group (71.6%, 58/81), were aware of indirect and direct communication intervention approaches they could use with this client group (71.8%, 56/78) and agreed they had sufficient skills to provide direct communication intervention approaches with this client group (61.5%, 48/78).

Motivation

Most SLTs considered the assessment of communication needs (81.2%, 65/80) and the provision of advice and/or direct intervention for communication needs in this client group to be part of the SLT role (84.6%, 66/78); and a good investment of their time (73.4%, 58/79). Most SLTs were confident in carrying out assessment of communication needs in this client group (71.6%, 58/81), providing advice to staff and family members about how to support communication needs (74.4%, 58/78) and setting goals and providing direct intervention for communication needs in this client group (77.2%, 61/79). A third of SLTs (31.6%, 25/79) neither agreed nor disagreed with the aforementioned goal setting question.

Whilst just over half of SLTs *did not feel stressed* at the thought of assessing communication needs in this client group (51.3%, 41/80), a minority *did feel stressed* at the thought of this (26.2%, 21/80). Broadly similar findings were noted for treatment with 44.3% (35/79) who *did not feel stressed* by the thought of providing treatment for communication needs, and nearly a third of respondents (30.4%, 24/79) reported they *did feel stressed*.

Opportunity

Questions related to opportunity generated the broadest ranging results. Whilst a fair proportion of SLTs agreed that they were positively encouraged by their service (55.7%, 44/79) and had sufficient resources to both carry out communication assessment (61.3%, 49/80) and provide communication intervention (54.7%, 41/75) with this client group, a minority of respondents did not feel positively encouraged or well-resourced.

Most agreed they had sufficient time in their job to provide advice and support to family members and staff regarding clients' communication needs (59.5%, 47/79), but fewer than half agreed that they had sufficient time to carry out assessment of communication needs (42.5%, 34/80) and provide direct communication intervention with this client group (38.5%, 30/78).

Correlations

Spearman correlation was used to examine the relationship between three areas: (a) confidence setting goals and providing direct communication intervention (one question), (b) perception of sufficient time to provide direct communication interventions to this client group and (c) perception of sufficient resources to carry out

communication interventions. A weak, positive correlation was found between level of confidence setting communication goals and providing direct communication intervention, and perception of sufficient time to provide direct communication to this client group ($r = 0.386$, $p = 0.01$). A moderate, positive correlation was found between the level of SLT confidence setting communication goals and providing direct communication intervention, and perception of sufficient resources to carry out communication interventions ($r = 0.534$, $p = 0.01$). There was also a strong positive correlation between SLT perception of sufficient time to provide direct communication intervention and perception of sufficient resources to provide direct communication intervention to this client group ($r = 0.601$, $p = 0.01$).

Communication support in care homes—barriers and facilitators

The majority of SLTs (84%, 67/80) felt more residents would benefit from communication assessment and management than are currently being referred to their service. These views were informed by their own observation of residents in care homes (47%, 57/122), staff reports (35%, 43/122) and research literature (16%, 20/122). The most commonly reported barriers to the provision of SLT screening/assessment and intervention were other patients with more acute concerns having priority, limited potential (to improve, where appropriate, or maintain skills), poor prognosis (palliative/poor health) and lack of funding.

Most SLTs (89%, 71/80) thought speech and language therapy services could be improved for older adults living in residential care homes. Content analysis was used to evaluate the qualitative data generated by the open text option for this question. This produced six categories: training, funding, SLT service provision, specific suggestions, miscellaneous and uncodable. The first category, training, comprised two subsections: (1) *training* which were generic references to the need for training, typically aimed at care home staff but also SLTs and family members; and (2) specific references to *training in communication*, which almost exclusively referred to care home staff, and on occasion specified dementia communication skills. Within this category, suggestions were made in relation to the *quality* of training: increased, improved and more regular training for example, 'rolling programme of training for care home staff', and more time for SLTs to provide training, both formal and informal, to staff and families; as well as the *content* of training, for example, increasing awareness of the role of SLTs in care homes, the identification of communication needs, the potential for improving communication in this population, and dementia care for example, 'developing dementia communication skills for staff and families'.

Respondent suggestions in the *funding* category related to the need for increased resources for communication interventions; SLT services; and posts, within care homes (e.g., 'to support interventions') and within the UK NHS (e.g., 'investment in dementia specialist SLT posts'). The *SLT provision* category contained suggestions relating to SLT *process* (e.g., changes to referral criteria to allow routine assessment/management of communication as well as swallowing needs) and changes to how SLTs *relate* to care home settings (e.g., 'dedicated speech and language therapists for care homes' as the gold standard, a more 'open access' approach to enable care homes to 'ring to discuss/get advice/strategies from an SLT', and 'SLTs more embedded in care homes').

Participants also provided a broad range of *specific suggestions* about how to improve SLT services. This category comprised four subsections: ideas relating to the introduction or increased frequency of specific communication interventions (namely Reminiscence, Montessori[2] and communication groups); suggested changes to care pathways and management of conditions (e.g., dementia) including 'better linking with community mental health teams for older people to provide communication interventions that could in turn reduce the over-prescription of antipsychotic medication in people with dementia'; improvements to the communication environment; and changes to workforce organisation which included increased or protected time for activities staff and SLTs to support resident communication and the development of student placements in care homes. The miscellaneous category comprised general comments and observations about current practice in care home settings that related to staff–resident interaction or privileging of one aspect of SLT practice over another, for example, dysphagia versus communication. Minimal data was categorised as *uncodable*, defined as statements in which the meaning was not clearly determinable or unrelated to the question.

Care home activities staff views

Capability

Most activities staff agreed they knew how to support and encourage communication between residents when running group activities (88.9%, 24/27), had the skills to support residents' communication during group activities (77.8%, 21/27) and knew who to ask for advice and support about how to support residents' communication (61.5%, 16/26).

Motivation

Most activities staff agreed they were confident in supporting residents' communication during group activities (85.2%, 23/27) and that identifying when residents are having difficulty communicating (88.7%, 24/27) and supporting the communication skills of residents (81.5%, 22/27) were part of their role. A fair proportion of respondents did not agree with the statement 'I feel stressed at the thought of supporting residents' communication' (44%, 12/27), and a third of respondents (33.3% 9/27) neither agreed nor disagreed with the statement.

Opportunity

As with the SLT survey, questions related to opportunity generated the broadest ranging results. Whilst the largest proportion of respondents agreed they were positively encouraged by their manager/workplace to support the communication skills of residents (48%, 13/27) and had sufficient time and resources (41%–52%) in their job to support residents' communication, around one third of respondent did *not* feel encouraged and did *not* agree they had sufficient time or resources.

Most activities staff reported that they would be interested in receiving further training in all proposed areas of communication support, for example, how to *involve* a resident who has communication difficulties or is reluctant to communicate in group activities (89%, 24/27), how to *communicate with* a resident who has communication difficulties or is reluctant to communicate (85%, 22/26), setting up group activities that encourage resident communication (77%, 20/26), identification of communication difficulties (73%, 19/26) and how to encourage communication and conversation between residents (73%, 19/26).

In the open text/*Other* option to this question, one respondent reported interest in training about 'How to become a communication specialist. I'm sure most places don't get visits from SLT so having people who work in a home trained in parts of SLT would be beneficial to all'.

Correlations

Spearman correlation was used to examine the relationship between the length of time respondents had been in an activities staff role and how capable, confident/stressed and encouraged they felt. There were weak positive correlations between length of service and perception of skills supporting communication needs ($r = 0.455$, $p = 0.05$), confidence supporting communication needs ($r = 0.424$, $p = 0.05$), feeling positively encouraged by managers ($r = 0.432$, $p = 0.05$) and feeling sufficiently resourced ($r = 0.423$, $p = 0.05$). There was a negative correlation between length of service and feeling stressed at the thought of supporting residents' communication skills ($r = -0.439$, $p = 0.05$).

DISCUSSION

This paper investigated (1) the current routine clinical practice of UK SLTs in supporting the communication needs of care home residents; (2) the routine practice of activities staff, including what group interventions or activities are typically being delivered in care homes for older adults; and (3) the perceived skills, knowledge base and confidence of both professional groups in relation to supporting care home residents' communication. Beyond our original research questions barriers and opportunities for SLT service improvement emerged as an interesting area of inquiry, and as such this is also discussed later.

Current routine clinical practice of UK SLTs

Most SLTs agreed that more residents would benefit from communication assessment and management than were currently being referred to their service. Our survey findings suggest that these SLTs were providing a holistic service when attending care homes. The primary reason for referral is dysphagia-related concerns, but most SLTs were also assessing cognition and communication and considered the impact of neuropsychiatric symptoms on communication and interaction. SLTs overwhelmingly considered assessment and management of communication needs in this client group to be both part of the SLT role and a good investment of their time. These findings echo previous practitioner surveys in Australia (Bennett et al., 2016), and Canada (Hopper et al., 2007). Whilst questions and samples differed slightly in focus, there appears to be a broad professional agreement that the assessment and treatment of older adults with communication difficulties, regardless of practice setting, and including people with dementia (Hopper et al., 2007) and those receiving end-of-life care (Bennett et al., 2016), is an important part of the SLT role.

Findings indicate that SLTs tended to use informal means (including dynamic assessment) to assess communication in care homes. This finding aligns with Bennett et al. (2019b) who reported more use of informal assessments compared to standardised assessments. Clinicians' rationale for this was the need to balance *best practice*

with *responsible care* of often frail and cognitively impaired clients; time pressures meant quick screening tools for assessment were favoured; and, not least, the fact that many assessment tools and therapy approaches developed for use with adult populations have not been validated with older people with complex needs, potentially limiting their clinical utility.

Current routine practice of UK care home activities staff

It was reported by activities staff that half or more of the residents in their care home have difficulty communicating. A high percentage of activities staff/care homes are delivering structured and unstructured activities. This is encouraging, given the research data about resident inactivity/lack of engagement in activities in care homes over several decades, outlined by Smith et al. (2018).

Activities staff overwhelmingly agreed that both identifying when residents are having difficulty communicating, and supporting the communication skills of residents was part of their professional role which echoed the sentiment of SLTs.

The survey findings revealed some differences between SLTs and activities staff in the identification and definition of communication difficulties they typically see in this client group, but there was also commonality between the professional groups. Cognitive communication difficulty was the communication need most commonly reported by SLTs (65%) and hearing impairment was the communication need most often reported by activities staff (43%). However, both groups indicated that sensory impairment (poor vision and hearing), emotional wellbeing and/or mental health status can impact residents' ability or desire to communicate.

Perceived skills, knowledge base and confidence reported by SLTs and activities staff

Whilst the majority of SLTs self-reported a high/sufficient level of knowledge, skills and confidence to assess and manage older care home residents' communication needs, it is important to consider the substantial proportion of SLTs who did not. Nearly half of SLTs did not *actively agree* that they were confident setting goals and providing direct intervention for communication needs (32% neither agreed nor disagreed and 16% actively disagreed). A further 25% felt stressed by the idea of this aspect of service delivery. Around a third of SLTs did *not* agree that they were encouraged by their managers/team to assess and support the communication needs of care home residents and similarly a third reported they do not have enough time to assess communication assessment or to provide treatment for communication needs. These negative responses were from SLTs with a range of years of clinical experience (from up to 2 years to over 20 years) and those working in both full- and part-time roles indicating a shared experience that seems to transcend years of clinical practice and work patterns.

The associations between confidence delivering communication intervention and sufficient time/resources *could* be interpreted as follows. If SLT departments are well resourced for communication interventions in this client group, then less planning and preparation is required of the clinician to provide this type of input. This could mean increased opportunities for the development of experience and confidence in this area. Or vice versa, if a clinician feels confident setting communication goals and carrying out communication intervention in this clinical area then they may feel better able to adapt resources used with other adult client groups or to create their own resources. It is possible clinicians who feel less time-pressured are more likely to carry out direct communication intervention with this client group, rather than indirect or consultative approaches, and in turn develop experience and confidence in this area. The ideal situation would be that clinicians have enough time to prepare for and carry out communication interventions with this client group, including trialling new approaches, and that their department is well resourced with the tools to do so. Our survey results suggest this is not the case.

It is possible that higher levels of confidence in care home activities staff exist in the context of less technical knowledge of the communication needs of older care home residents. On the other hand, we acknowledge that the respondents to this questionnaire might be those staff who are most interested and knowledgeable in this area. In either case, one implication from our findings is that additional communication training for care home staff would be welcome.

Length of service in the activities staff sample was positively associated with confidence supporting the communication needs of residents and negatively associated with feeling stressed supporting residents in this area. This suggests that high staff turnover in care homes may not just be an inconvenience in terms of staffing but may also impact how confident or stressed staff feel about supporting the communication needs of residents.

The association between length of service in a care home and feeling encouraged by managers to support communication highlights the importance of management providing a clear organisational approach to communication. This echoes a qualitative study by Stanyon et al. (2016) in which identified facilitators of communication between care home staff and people with dementia included staff

knowledge and skills to facilitate communication but also the impact of organisational factors such as culture, leadership and management.

Current barriers and opportunities for service improvement

In the current study, most SLTs agreed that SLT services could be improved for older adults living in care homes. Previous research (Sewell & Hopf, 2020) identified the primary barriers to SLT service delivery in Australian RACFs as poor understanding of SLT scope of practice, limited SLT roles in practice, communication access and quality issues (impoverished communication environments and staff interaction style) and lack of recognition of RACFs as a clinical specialty site for SLTs. Findings from the current study, specifically suggested areas of focus for service development/improvement, support findings from Sewell and Hopf (2020). SLTs reported a desire to increase the range of SLT practice in care homes for older adults, extending the focus of practice from being predominantly dysphagia related to including support of communication needs, and provide individualised care plans/pathways to meet a more diverse range of needs, and for an increased SLT presence, including specialist SLT roles (e.g., dementia specialist), within these settings. Respondents also identified opportunities to improve communication access and quality in care homes, by optimising the communication environment and developing staff capacity (skills and knowledge) to support residents' communication needs, through targeted training.

Previous studies (Bennett et al., 2015) indicated a need for regular targeted, multidisciplinary training in care homes for older adults to prepare and support the workforce. This sentiment was supported by the current study, with a priority area for service improvement identified by SLTs as staff training in communication skills as well as more *joined up* working and liaison with care homes staff, and for SLTs to be more embedded in care home settings. A large proportion of activities staff reported interest in and motivation to support the communication needs of residents and receive further specialist training in how to do this.

Much like those reported by Hopper and colleagues in their 2007 study, the primary barriers to service provision in the current survey results were the prioritisation of other patients with more acute concerns and a lack of funding. Professional guidance from the RCSLT (RCSLT, 2014) recommends 'equal access to intervention for communication and for swallowing disorders' (p. 6) but the current study and previous research discussed in this paper suggest that this is unlikely to be the case in the United Kingdom and other countries in which service provision and SLT clinical perspectives have been surveyed, where staffing and an emphasis on dysphagia are issues (Hopper et al., 2007). Comments from SLTs in the current study indicate a variation in SLT service provision between trusts in referral criteria and which conditions receive communication support versus dysphagia support.

Limitations

There are a number of limitations to the current study. There was minimal representation from certain geographical areas (e.g., SLTs in Northern Ireland and the North East of England), and particularly for the activities staff survey in which 93.1% (27/29) of respondents were working in England and nearly half (48.3%, 14/29) in greater London. The findings of this study pertain only to the United Kingdom. Nevertheless, the surveys showed a spread of participants across age and experience and indicate that the views raised are not limited to a particular minority of professionals.

Both the SLT and activities staff samples were small and self-selecting so unlikely to be representative of the views of members of either profession as a whole. This is notable in the activities staff sample, in which answers relating to motivation and competency were very positive. This suggests a positive bias in the activities staff dataset. Activities staff who are aware of the communication needs of residents and interested in developing their skills in this area may be more or likely to complete a survey on the topic. It is likely, therefore, that the current study does not represent a full range of activities staff views and that the need for training in how to support communication needs may indeed be more widespread than this paper reveals.

Both the SLT and activities staff surveys were relatively long, and in both surveys not all respondents answered all questions. Nevertheless, the use of surveys rather than interviews limited the number and scope of questions asked. As such, no information was gathered about the specific content, length, and delivery of communication training for staff in care homes. Some demographic questions were not replicated across both samples, for example, SLTs were not asked about languages spoken. Multilingualism in care homes and how this may impact the communication of residents and staff was not explored in the current study but warrants further exploration.

We acknowledge that when we looked at the types of communication difficulties reported by SLTs in this population there is some overlap and that these could have been categorised in a number of different ways. However, the categories reported here were felt to best reflect the responses of professionals given existing literature and our clinical experience. There is a high level of comorbidity in this population and the current study

did not explore the extent to which cognitive, sensory (e.g., vision and hearing), physiological and psychological or emotional difficulties co-occur and compound communication difficulties. Further research in this area is warranted.

Respondents were asked to consider their practice *before* the start of the COVID-19 pandemic, which is likely to produce less accurate data than asking about current practice.

The current study focused on the practice of SLTs and activities staff in care homes, but it is important to consider the views of other stakeholders, for example, residents, family members and other professionals in order to gain a more accurate picture. Economic costings for increasing communication support in care homes were beyond the realm of this study and as such have not been considered.

Directions for future research and clinical practice

Further systematic research (e.g., through service audits and observation) is warranted to gain a clearer picture of current SLT clinical practice in care homes, as well as the routine practice of care home staff regarding the identification, documentation and dissemination of information relating to the communication needs of residents. Qualitative research, including in-depth interviews with activities staff could be used to explore barriers and facilitators to supporting residents' communication needs.

Care home staff training is considered a priority area for service development by SLTs and appears to be welcomed by the majority of care home activities staff, with a high proportion expressing interest in further communication training. Importantly, this occurs in the context of a sample who already appear positively biased towards communication support.

The results from the current study might have wider implications for care settings more generally.

CONCLUSION

A high level of communication need in care home residents was identified by both SLT and activities staff in the current study, and both participant groups were motivated to address, identify and manage, this need. Insufficient time and resources, as well as a perceived lack of managerial support, were reported in both groups and consistent opportunities for service improvement emerged across both data sets. These included the development of communication training for care home staff; increased and protected time and resources dedicated to managing the communication needs of residents; and the prioritisation of residents' communication needs, realised through changes to SLT referral criteria and service accessibility.

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DATA AVAILABILITY STATEMENT

Data available on request from the first author.

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ENDNOTES

[1] Namaste care is an approach designed to provide sensory stimulation, emotional connection and physical comfort to people living with advanced dementia in care homes, using activities such as hand massage, calming music and aromatherapy. Originally developed in the United States, Namaste care is widely used in UK care homes (Bray et al., 2021)

[2] Montessori activities have been used widely across care settings in recent decades to support people with dementia (Janssen et al., 2021). Selection and organisation of specialised materials in the environment provide structure to enable independent engagement in naturalistic and purposeful tasks. The type of activity and level of facilitation is based on the interests, abilities and needs of the individual and should be failure free. In a care home setting this may be, for example, a laundry sorting activity (Douglas et al., 2018).

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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