Inpatient Functional Communication Interview

Screening, Assessment, and Intervention

Robyn O'Halloran, PhD, M. Phil., B. App. Sci.
Linda Worrall, PhD, B. Sp. Therapy
Deborah Toffolo, M. App. Sci., B. App. Sci.
Chris Code, PhD, M.A., LCST

Plural Publishing Inc.

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e-mail: information@pluralpublishing.com
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Foreword

Imagine being in the hospital and being unable to understand what has happened, not able to ask for a blanket, not able to call for help, or not able to comprehend what happens next. The health care environment can be a distressing and even dangerous place for patients who have difficulty communicating. After over 40 years as a speech-language pathologist (SLP) and researcher in health care, I have witnessed shocking medical incidents, avoidable errors, and unnecessary patient distress—all caused by inadequate patient–provider communication. As a daughter I witnessed the serious consequences of failures to effectively communicate with my mother who had suffered a stroke; and as a wife I suffered the indignities visited upon my husband (who had dementia) by health-care providers who failed to recognize that problem behavior often resulted from communication breakdown. Consequently, the thought of being admitted to a hospital and not being able to adequately communicate with those around me is terrifying.

To avoid patient distress and compromised safety, health care should begin with the assessment of the immediate communication needs of patients. But how is this supposed to happen? What are concrete and implementable methods of identifying patient communication needs? How do we effectively share the best communication strategies with hospital staff? The authors of *Inpatient Functional Communication Interview: Screening, Assessment, and Intervention* (IFCI:SAI) have addressed these questions. I am thrilled that this book will provide SLPs with the methods and tools to navigate these assessment and intervention needs within time-pressured inpatient settings. An important dimension of the IFCI:SAI is that it is not disorder specific. So often students (and clinicians) have expressed confusion about where to begin: how do they avoid giving multiple disorder-specific assessments to identify the diagnosis? My usual answer has been to "have a conversation;" but with the IFCI the conversation becomes structured and goal directed. The clinician is able to systematically rule out various communication disorders and identify immediate communication needs following the IFCI guidelines and conversational script. This book should be required reading for students as well as seasoned clinicians. It comprehensively covers theoretical underpinnings, psychometric properties, and descriptions of how to use the tools.

In the text *Supporting Communication for Adults with Acute and Chronic Aphasia*, I argued that "if there is any method, strategy, or resource that might help someone with aphasia to communicate better . . . , it is the ethical responsibility of the SLP to introduce the support or system" (Simmons-Mackie, 2013, p. 14). In other words, effective communication is not only a matter of quality care, but of rights and ethics! The IFCI:SAI was created with the basic right to quality and patient-centered care at the core. The tools are theoretically grounded and well trialed. Recommendations evolve out of the evaluation, ratings scales, and environmental questionnaires and address critical early steps in patient assessment and management. The publication of these practical and experientially tested tools meets a critical need in health care.

I am also delighted to have been asked to write this foreword, because the authors are some of my most respected and favored colleagues. I recall many years ago talking with my dear friend and colleague Linda Worrall about my frustrations with the experiences of people with aphasia in health care settings. Linda said, "Watch for Robyn O'Halloran! She will do something about it." And here I am years later witnessing the truth of this statement. So despite the significant challenges facing individuals with communication disability, I feel optimistic about the future for this vulnerable segment of society. These clever, dedicated, and forward-thinking authors and researchers are tackling the "big issues" associated with hospital admission for people who are communicatively disadvantaged. It is an honor to write this foreword to the IFCI:SAI—a wonderful contribution to the field.

Nina Simmons-Mackie, PhD, BC-ANCDS
Professor Emeritus
Communication Sciences and Disorders
Southeastern Louisiana University
Hammond, Louisiana

Preface

Mrs. Thompson was referred to the speech-language pathology department on a Friday afternoon in the early 1990s. She'd been admitted into the hospital that morning with a diagnosis of stroke and aphasia. One of the authors (R. O'H.) picked up an aphasia screening test, a picture description task, and a tape recorder and went down to the ward to see her.

Mrs. Thompson could not follow complex instructions; she struggled to get words out; and her sentences were short, telegrammatic, and labored. The more she tried, the more worried and distressed she became. Having finished the assessment, the speech-language pathologist (SLP) told Mrs. Thompson that she would see her again on Monday. The SLP told the nurse that Mrs. Thompson had aphasia and couldn't follow complex commands. The nurse looked irritated and replied, "She understands everything I say."

Early Monday morning, the SLP went to the ward as planned with another aphasia test. Mrs. Thompson was sitting in a chair, fully dressed, with bags packed on her bed, ready to go. In the most fluent and grammatical speech she said, "Oh hello. The doctor says I am much better, so I can go home!" "That's great," the SLP responded, but she didn't feel great. She felt completely and utterly despondent, realizing at that moment that as a speech-language pathologist, she had not been useful. She had not been useful to Mrs. Thompson on Friday when she was struggling and needed support, and she had not been useful to Mrs. Thompson's nurse who needed to care for her. What was worse was the nagging feeling that the way she had assessed Mrs. Thompson may have caused her distress, if not harm.

That clinical experience marked the beginning of a long and critical reflection on the role of speech-language pathologists (SLPs) in hospitals. It prompted years of research by Robyn O'Halloran and colleagues Linda Worrall, Louise Hickson, Deborah Toffolo, and Chris Code, and resulted in the publication of the *Inpatient Functional Communication Interview* (IFCI) in 2004. Since then, the authors have continued to use the IFCI in practice, uncover its limitations, create new tools and resources, and conduct further research to improve its use in practice. This work has culminated in the *Inpatient Functional Communication Interview: Screening, Assessment, and Intervention*.

SLPs have a critical role to play in the diagnosis and treatment of communication disorders. However, if we restrict our focus to the diagnosis and treatment of the disorder, we may fail to see the person who has communication needs in the present. People are admitted into hospital every day with lifelong, recently acquired, temporary, and/or permanent communication disorders. They need to communicate about their health care with their health-care providers, and health-care providers need to be able to communicate with them. Speech-language pathologists could play a vital role in supporting hospital patients with communication disorders and their health-care providers to communicate in optimal ways. This would require a broad view of the role of SLPs in hospitals: one that incorporates individual patient–provider interactions as well as the broader communicative environment of the hospital. The *Inpatient Functional Communication Interview: Screening, Assessment, and Intervention* provides SLPs and other health-care professionals with four key resources to explore and develop this emerging, new role.

In Chapter 1, we provide an overview of the resources. In Chapter 2, we describe the rationale for this approach and review the theoretical frameworks that informed the development of the resources. Chapters 3 through 6 provide details on the development, administration, and scoring of each resource. In Chapter 3, we describe a screening test called the Inpatient Functional Communication Interview (IFCI)–Screening Questionnaire. In Chapter 4, we provide a detailed explanation of the SLP assessment called the IFCI. Chapter 5 provides a description of speech, language, and cognitive-communication rating scales. And in Chapter 6, we describe the development of the IFCI–Environment Questionnaires. In Chapter 7, there are three individual case studies with video resources (available on the PluralPlus companion website—see the inside front cover of your book), and two descriptive case studies to demonstrate how to use these resources in practice.

1 Overview

THE INPATIENT FUNCTIONAL COMMUNICATION INTERVIEW: SCREENING, ASSESSMENT, AND INTERVENTION

Health-care professionals need to be highly skilled communicators to provide appropriate and acceptable health care to patients from diverse backgrounds who have different needs, abilities, values, and preferences. Communicating well with different patients is challenging; however, health-care professionals often experience particular difficulty communicating with patients who have communication disability, and this can profoundly impact patients' quality of care and safety in hospitals (Blackstone, Beukelman, & Yorkston, 2015). The Inpatient Functional Communication Interview: Screening, Assessment, and Intervention (IFCI: SAI) is a set of four resources for speech-language pathologists (SLPs) and other health-care professionals working in acute and rehabilitation hospitals. It has been developed so health-care professionals can identify and support patients who have difficulty communicating, with a focus on patients with communication disability. In this chapter, we define key terms used throughout this text and provide a brief orientation to each resource. We describe the purpose of each resource as well as who administers it, with whom, where, and when.

Defining Key Terms

The term *patient* is used throughout this text to refer to a person admitted into hospital who needs health care. The use of the word patient has been criticized because it implies an unequal relationship between the person needing health care and the people providing it (Byng, Cairns, & Duchan, 2002). We acknowledge this and have used the term patient deliberately, because we believe that a person who needs health care is in an unequal relationship with health-care providers. A person who needs health care is often acutely unwell and dependent on health-care providers. In this sense, the word "patient" is a reminder of a person's inherent vulnerability in the hospital system.

Health-care professional and *health-care provider* are terms used interchangeably to describe any person who works in a health-care setting, who has a duty of care toward patients, and communicates with them for the purposes of health care.

Effective communication occurs when people can exchange information (transactional element), and fulfill their social needs (interactional element) (Simmons-Mackie, 2008). We have drawn on this definition and the work of The Joint Commission (2010), who accredits hospitals in the United States to define effective patient–provider communication as the exchange of information that leads to the joint establishment of meaning, where both patient and provider feel listened to, valued, and respected.

Finally, the terms *communication supports* and *communication strategies* are used interchangeably throughout this text. We have defined communication supports broadly to include any modification to the communicative environment that directly or indirectly affects patient–provider communication. Communication supports include physical items, such as communication aids and written information; changes to the physical environment, such as clear signage; and how family members, friends, and health-care providers interact with the patient with communication disability. Communication supports also refer to the various factors that indirectly influence patient–provider communication, including the policies and procedures of the hospital, staff education and training, funding, hospital design, and the political and legislative environment (King, Simmons-Mackie, & Beukelman, 2013; World Health Organization, 2001).

THE IFCI: SAI RESOURCES

The IFCI: SAI includes a resource for nurses to identify patients at risk of difficulty communicating with health-care providers, resources for SLPs to conduct a communicatively supportive interview with patients identified as at risk, and a resource for SLPs and other health-care professionals to enhance patient–provider communication by creating more communicatively accessible hospital systems. They can be used separately or together to enhance patient–provider communication in hospitals. These resources focus on the Body Functions and

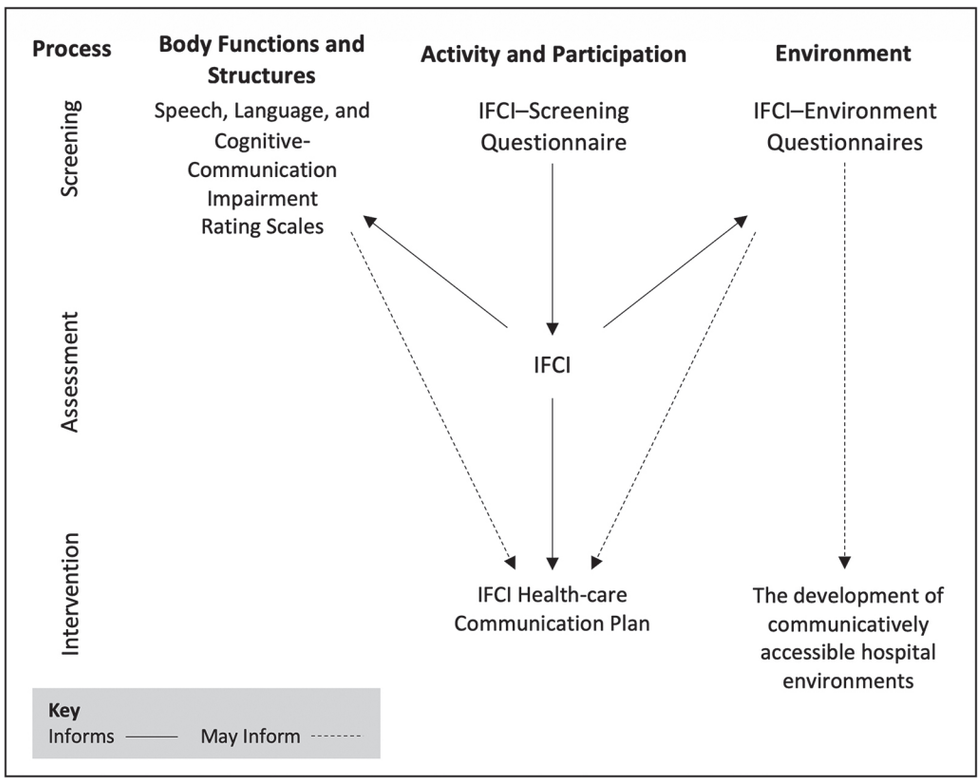

Figure 1–1. The IFCI: SAI resources as they relate to the WHO ICF (WHO, 2001).

Structures, Activity and Participation, and Environmental Factors components of the World Health Organization's International Classification of Functioning, Disability, and Health (ICF, World Health Organization, 2001). How these resources relate to each other and the ICF is depicted in Figure 1–1.

The Inpatient Functional Communication Interview–Screening Questionnaire

The first resource is the Inpatient Functional Communication Interview–Screening Questionnaire (IFCI–Screening Questionnaire) (O'Halloran, Coyle, & Lamont, 2017). The IFCI–Screening Questionnaire is designed to identify patients who have difficulty communicating about their health care and will need support to communicate with health-care providers in hospital.

Patients may have difficulty communicating about their health care because they have a different ethnic and/or language background from their health-care providers, cultural differences, low literacy, low health literacy, and/or because they have communication disability. These groups are depicted in Figure 1–2. Without necessary supports, health-care providers and patients may not be able to communicate effectively, and patient care may be compromised.

Patients who have a different ethnic or language background from their health-care providers encounter many difficulties communicating effectively, without support. Ethnic background refers to a person's place of birth, and may indicate that the person belongs to a social group that shares common cultural traditions (Mendoza & Lopez, 2017). Language background describes the spoken, written, and gestural language(s) that the person uses to communicate. Patients and health-care providers from different ethnic backgrounds may have different understandings about health and illness. Patients and health-care providers from different language backgrounds may not speak the other's language, or may be insufficiently proficient in the other's language to communicate and participate in health-related conversations.

Patients who have a cultural difference from their health-care providers may also experience difficulty communicating about and participating in their health

care (The Joint Commission, 2010). A person's cultural background is defined broadly here to include the person's "habits and beliefs about perceived well-being, as well as his or her political, economic, legal, ethical, and moral practices and values" (Napier et al., 2014, p. 1607). People who have cultural differences from their health-care providers may have difficulty communicating because their beliefs, practices, and values are not understood or accepted (Blackstone, 2015).

People with low functional literacy may also experience difficulty communicating with health-care providers without support. These people are unable to "identify, understand, interpret, create, and communicate, using printed and written materials" (OECD, 2019). Although people with low functional literacy have difficulty accessing written health-care information, they may also experience difficulty communicating and participating in spoken health-care interactions as well. They describe having difficulty understanding complex medical explanations and often feeling reluctant to ask questions or admit to difficulties understanding out of fear of the stigma of having little or no literacy (Easton, Entwistle, & Williams, 2013).

People who have functional literacy skills may not have sufficient health literacy to participate fully in their health care. An individual's health literacy refers to "skills, abilities, motivations and capacities of people to obtain, process and understand health information . . . to make appropriate health decisions" (ACSQHC, 2014, p. 9). People with low health literacy may also experience difficulty communicating with their health-care providers, such as difficulty understanding complex health information and asking questions about their care.

People with communication disability are another key group of patients who experience difficulty communicating with their health-care providers without supports. These people have lifelong or recently-acquired, temporary or permanent impairment(s) of the anatomical structures or the physiological or cognitive functions that support communication. This includes impairments of hearing, vision, speech, language, and/or cognitive-communication. People with communication

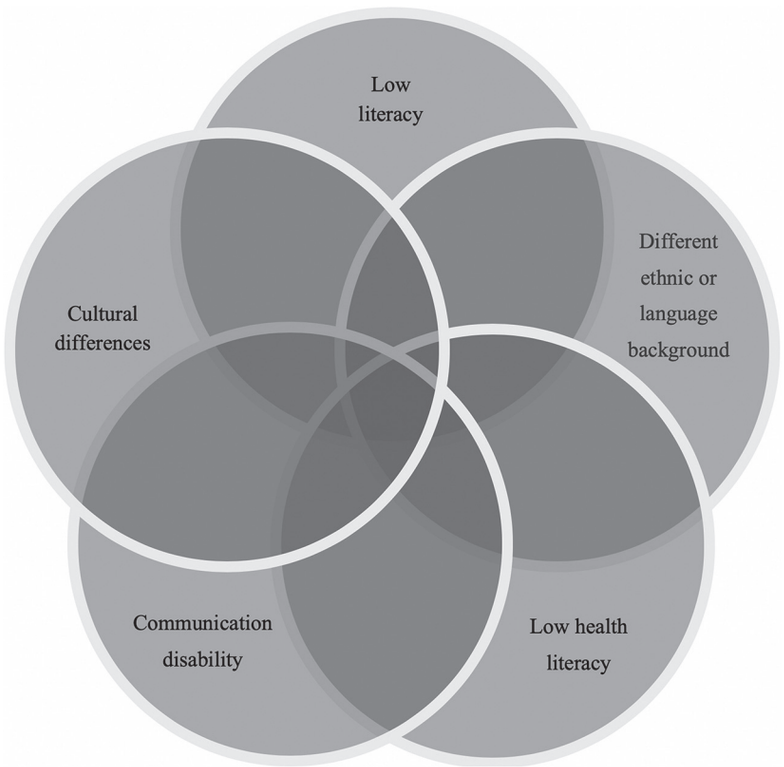

Figure 1–2. Groups of people who may experience difficulty communicating about their health care in hospital without supports.

disabilities have communication-related impairments that may or may not impact communicating in everyday situations such as health-care conversations (World Health Organization, 2001).

The IFCI–Screening Questionnaire is designed to identify patients who have difficulty communicating about their health care regardless of the reason. A nurse who has cared for the patient for an entire shift (approximately eight hr of care) completes the IFCI–Screening Questionnaire by answering 14 simple questions about his or her experience communicating with the patient. The IFCI–Screening Questionnaire takes less than two minutes to complete. The nurse then reviews his or her answers to classify the patient as "has a communication difficulty" or "does not have a communication difficulty." The rationale, development, administration, and scoring of the IFCI–Screening Questionnaire is described in Chapter 3.

Patients who are identified on the IFCI–Screening Questionnaire as having a communication difficulty and who have a different ethnic and/or language background from the nurse will need ethnic and/or language supports to communicate and participate in health-care conversations. These supports might include a cultural broker, who acts as a mediator between the patient and his or her health-care providers (Jezewski & Sotnik, 2001), and/or an interpreter. Effective patient–provider communication often occurs with these supports in place. If patient–provider communication is still difficult, then the patient may need to be referred to an SLP to investigate other potential causes of communication difficulty and identify additional communication supports.

Patients identified on the IFCI–Screening Questionnaire as having a communication difficulty who have the same ethnic and language background as their health-care providers, may need to be referred to an SLP to determine the underlying cause(s) of the communication difficulty and the communication supports they need.

The Inpatient Functional Communication Interview (IFCI)

The IFCI is a semistructured interview that the SLP conducts at the patient's bedside. During the interview, the SLP investigates how well the patient can communicate in everyday health-care communication activities. If the SLP and patient have difficulty communicating, the clinician investigates if any communication supports or strategies could enable successful communication.

By conducting a supportive interview with the patient, the SLP achieves three important objectives. First, the clinician provides the patient with a communicatively accessible conversation about his or her health care early in the admission process. This may help the patient understand and participate in his or her health care. Secondly, the clinician gains insights into any underlying causes of the patient's communication difficulty. Specifically, the clinician has the opportunity to observe if the patient has a communication impairment, such as a hearing, vision, speech, language, and/or cognitive-communication impairment(s) that is affecting health-care communication. Finally, the SLP determines the specific communication supports that would facilitate successful communication. The SLP shares these supports with all members of the health-care team. The IFCI takes between 20 to 35 min to administer, depending on the patient's needs, and approximately 5 min to score. At the completion of the IFCI, the clinician writes up a tailored Health-Care Communication Plan to support communication between the patient and health-care providers. The development, administration, and scoring of the IFCI is described in Chapter 4.

Speech, Language, and Cognitive-Communication Rating Scales

The third resource in the IFCI: SAI is a set of impairment rating scales. These assist SLPs to rate their initial clinical impressions of the patient's speech intelligibility, spoken language, and cognitive-communication function. Each rating scale provides descriptions of speech, language, and cognitive-communication function on a 5-point scale ranging from no impairment to complete impairment. The SLP reflects on the IFCI he or she has conducted with the patient to complete the speech, language, and cognitive-communication rating scales. Each scale takes approximately 1 min to complete. Rating the presence and severity of communication impairments provides the SLP with insights into communication-related impairment(s) that might be contributing to difficulties in health-care communication. This may prompt the SLP to consider other communication strategies that might facilitate successful communication, which could be trialed in subsequent sessions.

Documentation of the patient's speech, language, and cognitive-communication function may also provide the SLP with further guidance regarding formal screening or assessment of speech, language, and/or cognitive-communication function. Patients who have difficulty communicating about their health care on the IFCI, but do not present with speech, language, or cognitive-communication impairment may be experiencing communication difficulty because of hearing or vision impairment, cultural differences, low literacy, and/or low health literacy, which may require further investigation, if indicated. The development, administration,

and scoring of the speech, language, and cognitive-communication rating scales are described in Chapter 5.

The IFCI–Environmental Questionnaires

The final resource is a set of five IFCI–Environmental Questionnaires (EQs). The first IFCI–EQ is the Individual–EQ. The SLP reflects on the completed IFCI to identify the communication supports that helped and did not help patient–provider communication with that individual patient. These are documented in the Individual–EQ. The SLP then consults the second questionnaire called the Overall–EQ to think about how easy or difficult it would be for other members of the health-care team to implement these communication supports. The Overall–EQ lists environmental factors that influence patient–provider communication indirectly at the ward and hospital levels, and at levels external to the hospital. Having consulted the Overall–EQ, the SLP may decide to modify his or her recommendations on the patient's Health-care Communication Plan and include only those recommendations that are feasible in that particular hospital.

The remaining three IFCI–EQs are separate sections of the Overall–EQ: the Ward–EQ, the Hospital–EQ, and the External Agencies–EQ. Each of these questionnaires focuses on a different level of the health-care system. The Ward–EQ lists environmental factors that influence patient–provider communication with patients with communication disability on the ward. The Hospital–EQ details factors that influence patient–provider communication at the level of the hospital or health service. And the External Agencies–EQ lists factors related to outside agencies, such as professional associations, universities, health departments, insurance agencies, and governments that may indirectly influence patient–provider communication. The Ward–, Hospital–, and External Agencies–EQs may assist SLPs and other health-care professionals to "screen" the communicative environment for factors influencing patient–provider communication in their setting. Once the factors that influence patient–provider communication have been identified, SLPs and other health-care professionals may be better informed and more able to systematically address these factors to develop communicatively accessible hospital services. The development of the IFCI–EQs is described in Chapter 6.

SUMMARY

Effective patient–provider communication is essential for the delivery of safe, high-quality health care for all patients. The IFCI: SAI includes four resources for SLPs and other health-care professionals to improve patient–provider communication with patients who have communication difficulty. It includes resources to help nurses identify early in the hospital admission process patients who have difficulty communicating, and resources for SLPs to identify specific communication supports that will enable successful patient–provider communication between the patient and all members of the health-care team. The final set of resources is designed for all health-care providers to address the systemic barriers that prevent effective patient–provider communication, which in turn prevent patients from receiving the best health care possible.

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