

SUPPORTED CONVERSATION FOR ADULTS WITH APHASIA IN SUB-ACUTE REHABILITATION; TARGETING STAFF'S APPROACH

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BACKGROUND AND AIM

People With Aphasia (PWA) have been found to be less involved in their rehabilitation than patients without disorders of communication (1). For that reason, contextual factors such as hospital staff's ability to interact with PWA on their communicative terms are considered important factors for facilitating exchange of information and thereby patient involvement (2). Implementing the "Supported Conversation for Adults with Aphasia" (SCA™) (3) may optimise staff's communication with PWA. This was done at Hammel Neurorehabilitation Centre and University Research Clinic (HNC), which is an inpatient sub-acute multidisciplinary setting. The process was motivated by a wish for optimising the staff's communication with the patients.

The aim of the present study is therefore to examine the perceptions of the staff at HNC regarding their own approach to communication with PWA before and after the implementation of SCA. It is hypothesised that the staff will experience an improved approach to communication.

METHOD

Two wards at HNC were included in the present project. Both wards rehabilitate patients with severe brain injury. 95 multidisciplinary staff members completed a SCA course in two modules.

Communicative Access Measures for Stroke 2 (CAMS-2), Danish translation (2013) (KTA), was chosen to evaluate the perceptions of the staff. KTA was conducted before and after implementation of SCA, 62 staff members fulfilled.

Analysis: Three sub-questions (A-B-C) were formulated to underpin the main question and 24 of the specific KTA-questions were related to these sub-questions. Data were statistically analysed with Stuart-Maxwell's test.

DISCUSSION

The positive changes in the staff's perceptions of being able to meet the communicative needs of the PWA were expressed in a) ability to change the way of giving information, and b) offering alternative ways for PWA to answer questions. Furthermore, the results show that the changes in perceptions of communicative behaviour may be primarily linked to the use of pen, paper and drawings. This raises a question whether the primary gain of the SCA method is the introduction of using pen, paper and drawings to support the communication with PWA. In a wider context, this understanding may be reflected in the positive change of staff's perceptions of having the necessary skills to communicate with PWA as well as having access to relevant communication materials and techniques. Such correlation, however, cannot be supported by the analysis at hand, and the data may therefore be examined for this purpose in a future analysis process.

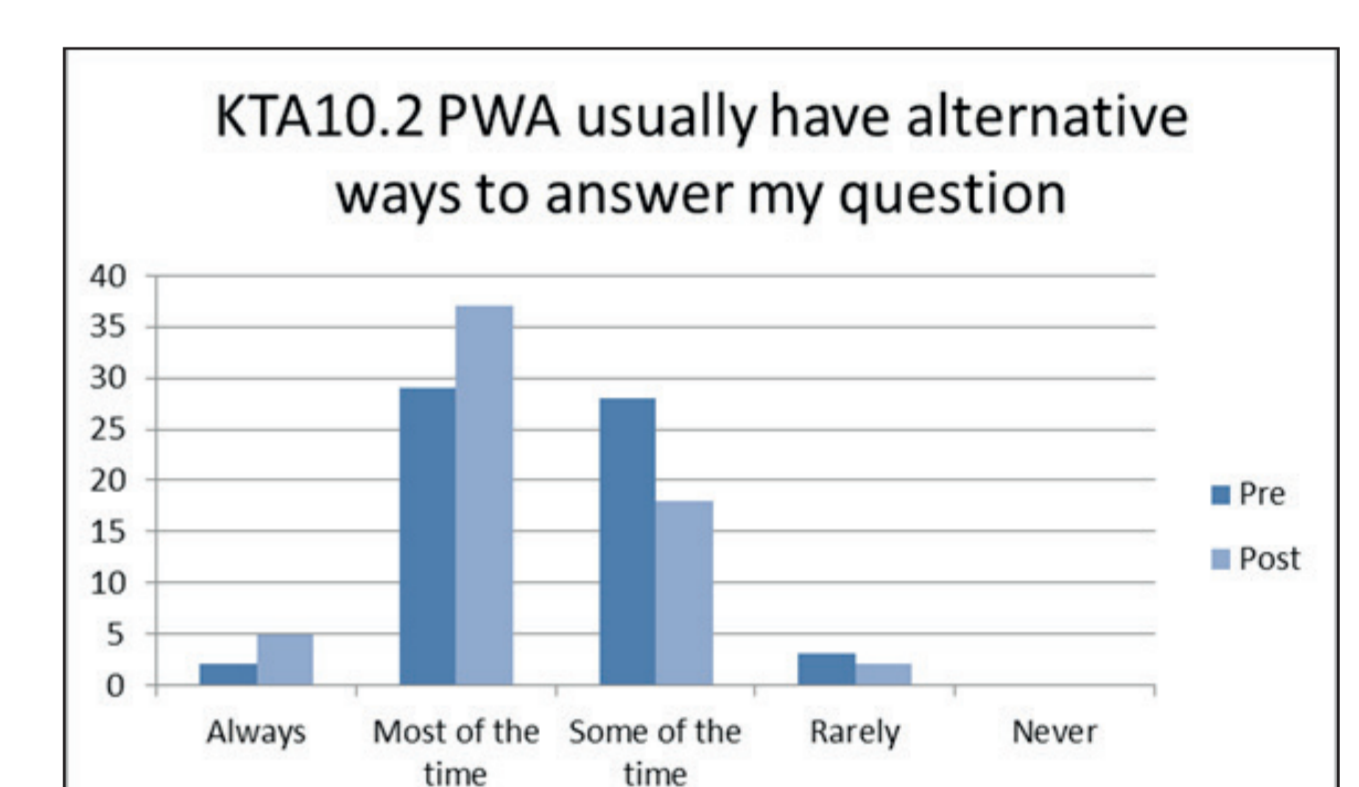
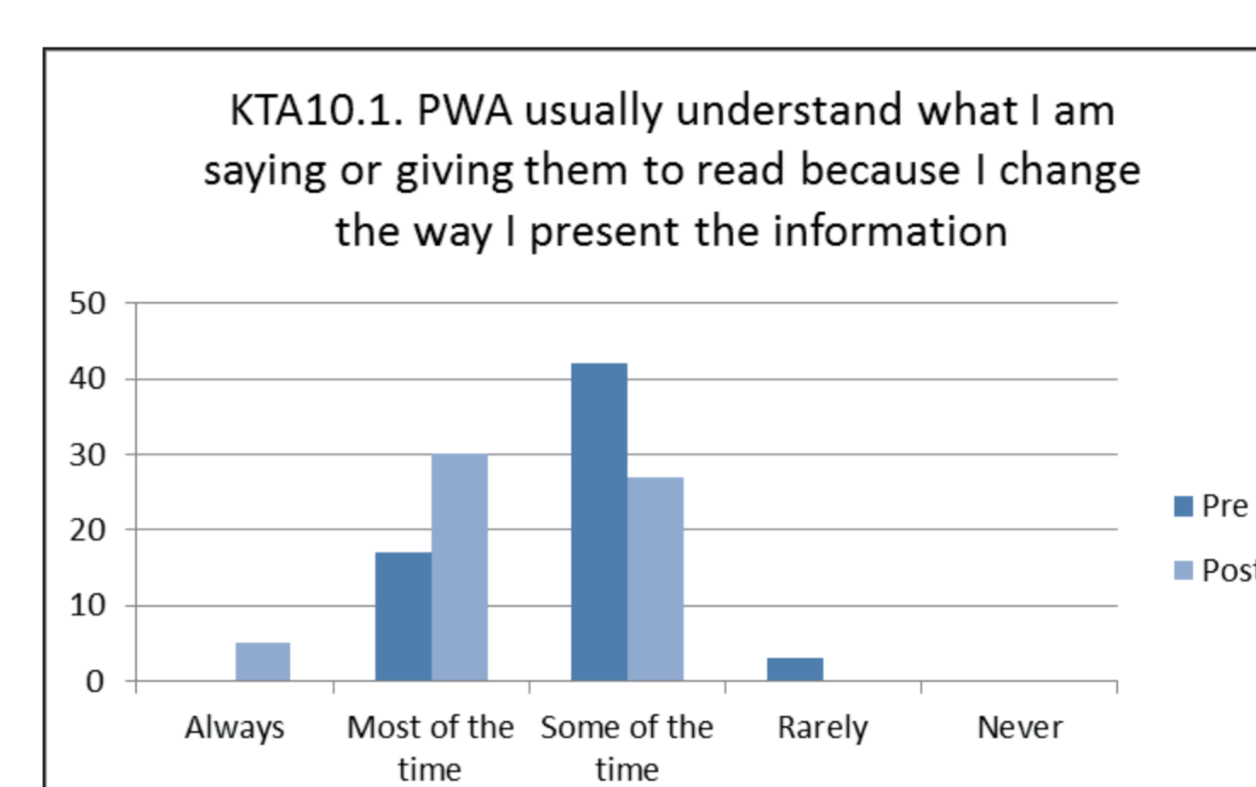
CONCLUSION AND CLINICAL IMPLICATIONS FOR CLINICAL PRACTICE

The immediate clinical implications of the present study may be that staff working with PWA should be introduced to the SCA-method. The purpose of this would be to expand the communicative tool box of the staff for exchanging information with the patients.

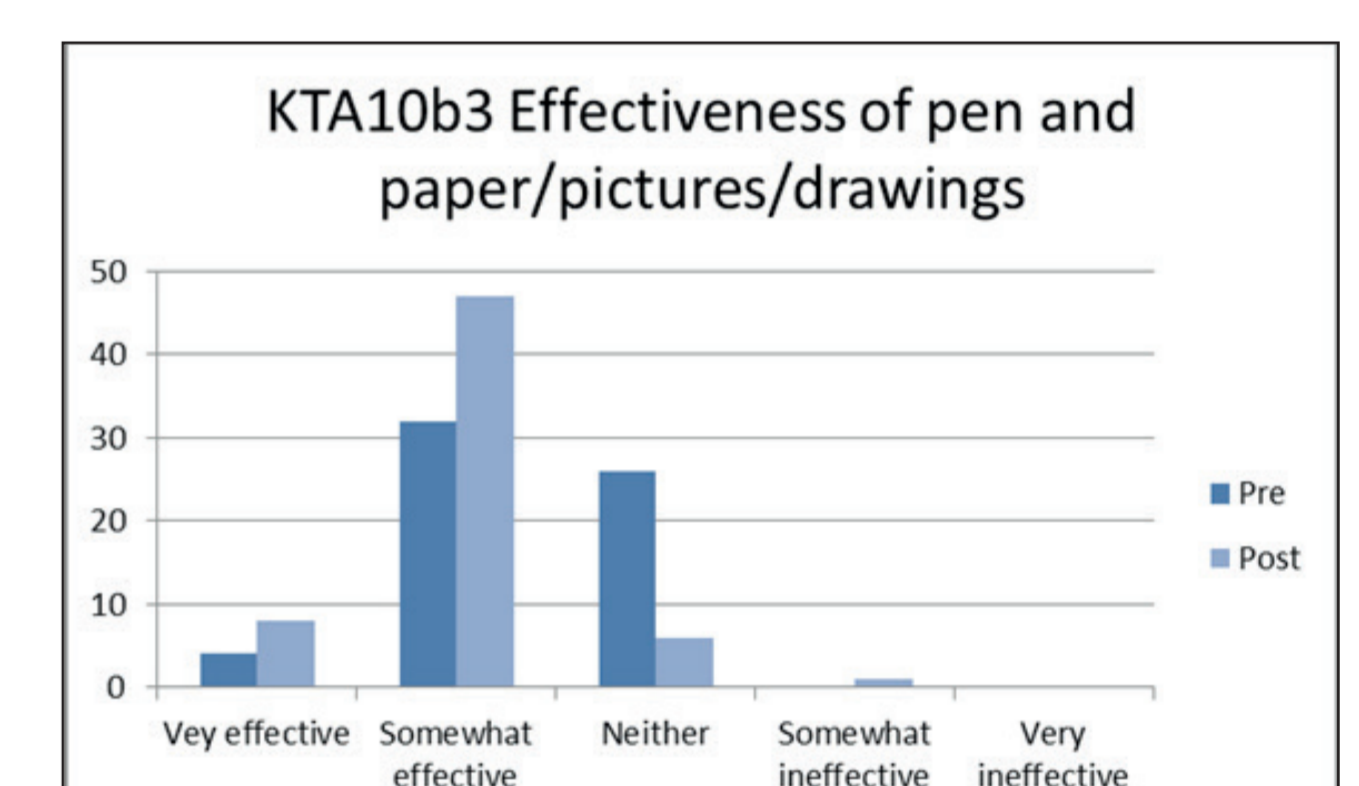
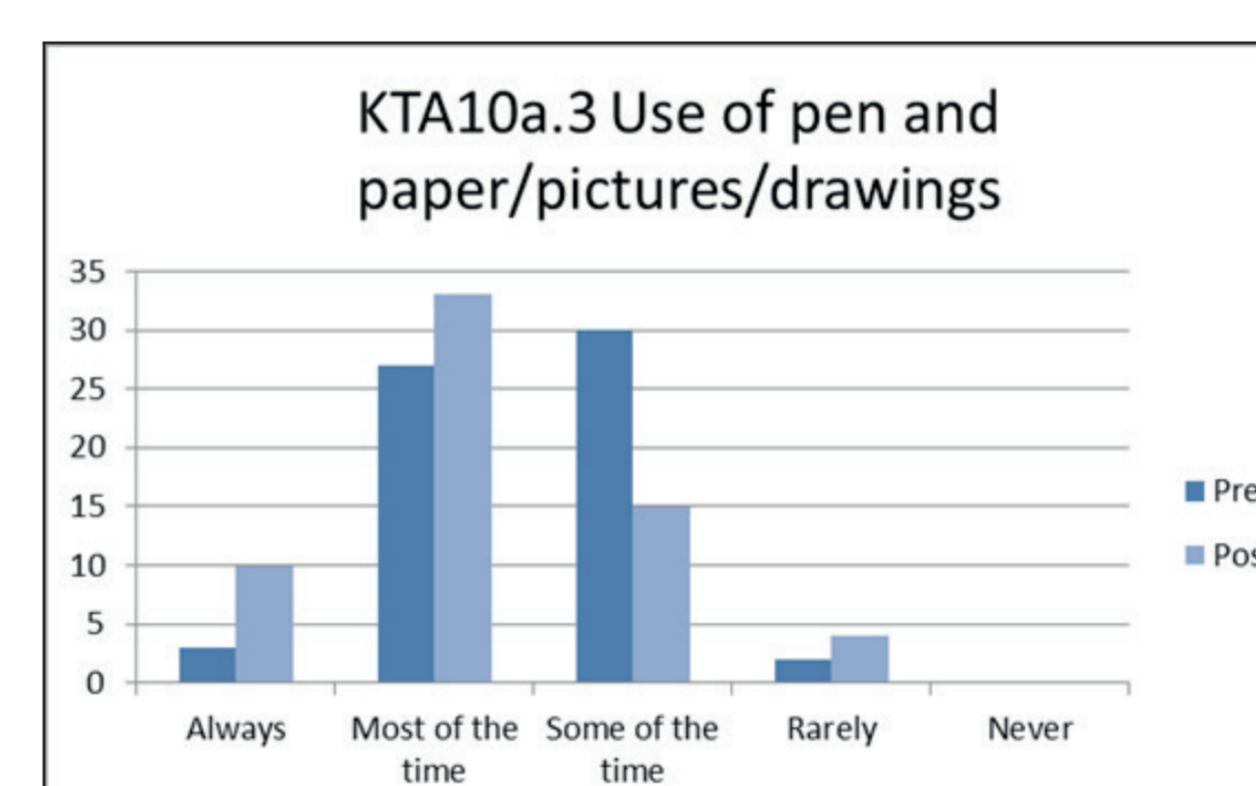
RESULTS

In sub-question A focusing on general contact with PWA, no statistically significant changes in staff's perception were recorded in the related questions.

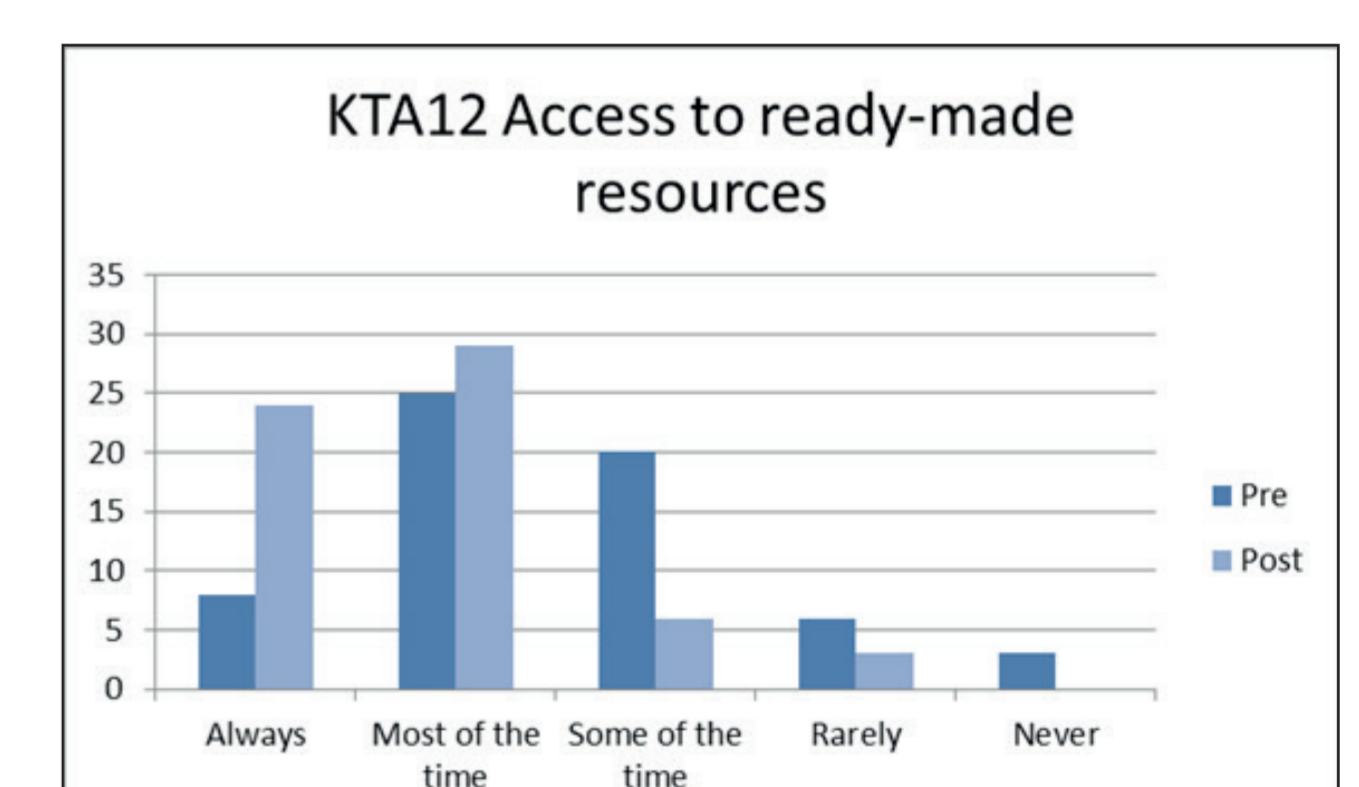
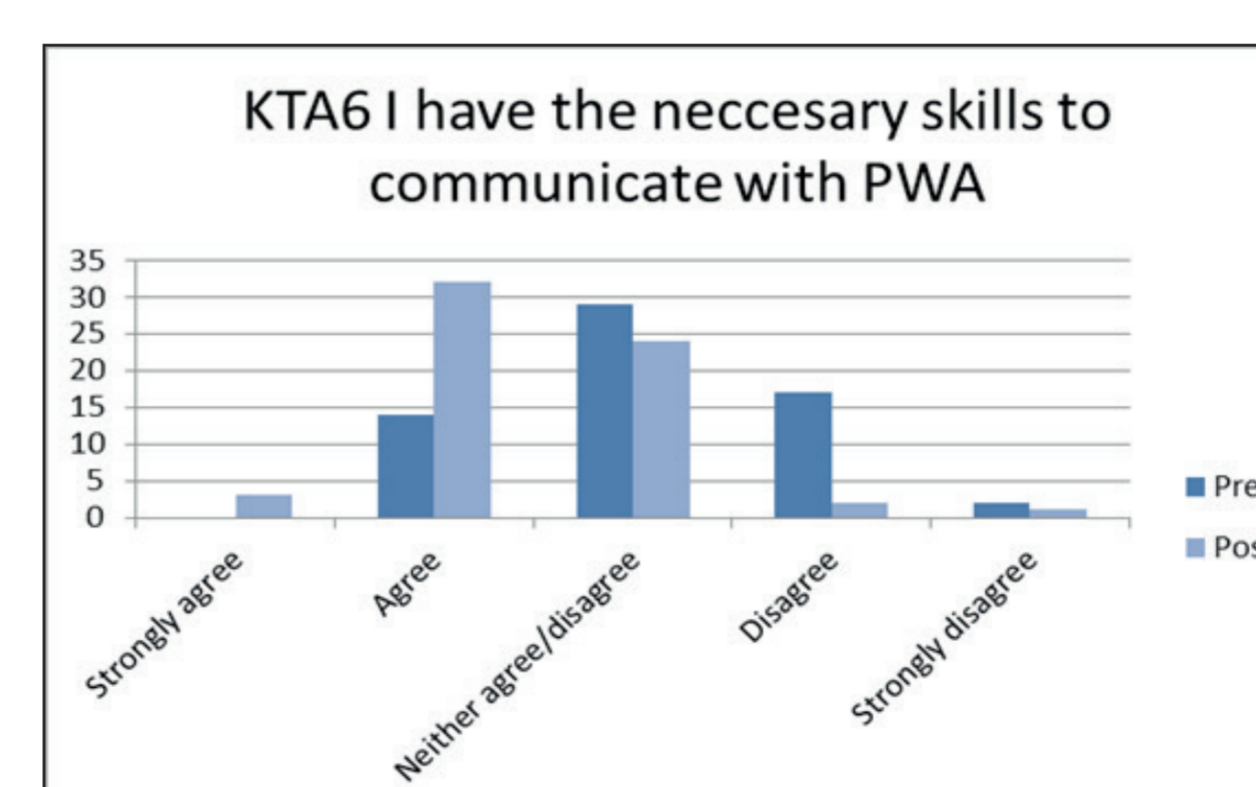
Sub-question B addresses staff's perception of their own communication behaviour in interaction with PWA. Significant changes are present in several of the related KTA-questions. E.g. in KTA 10.1 and in KTA10.2



The results of KTA10a and KTA10b show a consistent pattern. Staff are asked about their perceived use of specific strategies (KTA10a) and about their perceived effectiveness of the communication techniques (KTA10b). Statistically significant changes are seen in the use of pen and paper, while there are no statistically significant changes in the use of the other strategies.



Sub-question C relates to the terms and conditions for the organisational support and educational basis for communication with PWA. Statistically significant changes were found in e.g. KTA6 and KTA12.



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