


# Communicative and Supportive Strategies: A Qualitative Study Investigating Nursing Staff's Communicative Practice With Patients With Aphasia in Stroke Care

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## Kommunikative og støttende samtalestrategier – en kvalitativ undersøgelse af sygeplejepersonalets kommunikative praksis i interaktionen med patienter med afasi efter stroke

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### Abstract

This study aimed to provide detailed descriptions of the influences on the nursing staff's communicative practices with patients with aphasia in the context of usual stroke care interactions, and secondly to explore the nursing staff's use or non-use of supportive techniques, including the SCA<sup>TM</sup> method. A qualitative design was chosen, combining field observations and semi-structured interviews. Inductive and deductive qualitative content analysis was used. The results showed that the nursing staff's interactions with patients with aphasia were influenced by organizational and environmental influences, nurses' roles and functions and supporting patients with aphasia in communication. The role of the nursing staff in caring for the psychosocial well-being of patients is deprioritised in favor of other tasks. If there is no time or culture for prioritizing time for conversing with patients and supporting their psychosocial well-being, communication-partner training like SCA<sup>TM</sup> is likely hindered.

### Keywords

nursing, qualitative research, content analysis, supported conversation, adults with aphasia, stroke care, Denmark

### Abstrakt

Dette studie havde til formål at undersøge sygeplejepersonalets kommunikative praksis i interaktionen med patienter med afasi og deres anvendelse eller manglende anvendelse af kommunikative og støttende samtalestrategier, herunder SCA<sup>TM</sup>-metoden. I det vi ønskede at opnå detaljerede beskrivelser af den daglige kommunikative praksis, valgte vi et kvalitativt design, som kombinerede feltobservationer og semistrukturerede interviews. I analysefasen anvendtes induktiv og deduktiv kvalitativ indholdsanalyse. Vores fund antyder, at sygeplejepersonalets kommunikative praksis i interaktioner med patienter med afasi er påvirket af organisatoriske og miljømæssige omstændigheder, sygeplejerskernes roller og funktioner og anvendelse eller manglende anvendelse af kommunikative og støttende samtalestrategier. Varetagelsen af patienternes psykosociale trivsel bliver ofte nedprioriteret til fordel for andre sygeplejeopgaver. Implementeringen af samtalestøtte i klinisk praksis kan dermed blive udfordret af tidspres og tilstedeværelsen af en kultur, der ikke i tilstrækkelig grad prioriterer at samtale med patienter og understøtte deres psykosociale velbefindende.

### Nøgleord

Sygepleje, Kvalitativ forskning, Indholdsanalyse, Samtalestøtte, Voksne med afasi, Strokebehandling, Danmark

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### Background

Stroke is the second leading cause of death and a leading cause of disability globally (Katan & Luft, 2018). Any brain injury can cause physical, emotional, behavioral, and/or

cognitive difficulties; furthermore, studies of stroke patients' communication have stated that up to 88% of inpatients in acute stroke-care departments have some form of new or pre-existing communication difficulty at admission (O'Halloran et al., 2009, 2012). Communication difficulties include



hearing and visual impairments and developmental and acquired difficulties, such as aphasia, dysarthria, or cognitive communication difficulties (O'Halloran et al., 2009, 2012).

Aphasia affects 34% of adults who suffer a stroke (Flowers et al., 2016). Although other cognitive and social skills may be preserved, aphasia interferes with a person's ability to comprehend and express spoken or written information (O'Halloran et al., 2012). We know from research that patients with aphasia (PWA) and health care professionals (HCP) both recognize that successful communication is a pivotal part of effective stroke rehabilitation (Clancy et al., 2020) and that PWA experience poorer rehabilitation outcomes and more prolonged admissions (Gialanella & Prometti, 2009; Gialanella et al., 2011) while facing impaired patient safety (Worrall et al., 2011) with three times higher risk of adverse events (Bartlett et al., 2008; Hemsley et al., 2013). From the perspective of the HCP, communicating with PWA can be perceived as frustrating, leading to feeling impatient and eventually dismissing the patient while feeling guilty for not providing adequate care (Hur & Kang, 2022).

The communicative challenges mean that PWA often cannot share information with staff or fully participate in decision-making concerning their treatment, care, and rehabilitation (O'Halloran et al., 2012). The inability to participate fully in communication is a severe challenge for PWA and HCPs and their ability to inform and involve patients. Being the second most frequent communication partner, only exceeded by family, the nursing staff play a vital role in the communicative rehabilitation post-stroke (D'Souza et al., 2021).

Interpersonal communication and therapeutic relationships are inevitably linked. When developing a relation with nursing staff, PWAs value the same essential characteristics as in everyday social interactions, such as connectedness, humor and small talk, and in addition, some extent of self-revelation (Bright & Reeves, 2020). Yet, Gordon et al. (2009) suggest that stroke care settings lack enabling and therapeutic dialog, which leads to unequal circumstances, as patients without communication difficulties can impact the conversation in the desired direction, while PWA depend entirely on the nurses to surpass the medical settings and communicationally dive into what they consider essential topics, such as how the stroke has impacted their lives (Gordon et al., 2009). Hersh et al. (2016) reveals how PWAs risk being communicatively "closed down" or restricted to a limited option during hospitalization and thus lose motivation for language use over time. This risk is also described by Loft et al. (2019), stating how this could lead to dehumanizing and exclusionary practices during rehabilitation because patients lack contact and communication with nursing staff.

The experience of aphasia as a communication disability is mediated by environmental factors. Communication partner training is said to be one way to change the communicative environment and provide communication access while minimizing the limitations in activity and participation. Linguistic research regarding natural interaction has underscored the collaboration required to establish understanding in natural conversation (Clark, 1996), and speech-language therapists (SLT) have developed methods for supporting the successful exchange of information and active participation of PWA in communicative interaction (Kagan, 1998; Kagan et al., 2001). Using imagery from another area of disability, trained communication partners can make the conversation more accessible for PWA, just as ramps make buildings accessible for people in wheelchairs (Kagan, 1998). A systematic review (Simmons-Mackie et al., 2016) found that this type of intervention was promising and concluded that the Supported Conversation for Adults with Aphasia™ (SCA™), a common and recommended method, was successful. The SCA™ method focuses not only on communicative transactions but also on interaction as a way of establishing and maintaining relationships and co-constructing identities. Accordingly, it seems to be an essential foundation for good nursing care for PWA as communication can be considered a prerequisite for good nursing practice. The Fundamentals of Care Framework, which aims to raise awareness of the essence and complexity of nursing in changing contexts, describes relationships as the core of exchanges between patients and nurses. Other vital elements are skills and knowledge, communicative abilities, and understanding of the environment and the environment's influence on relationships. According to this understanding, the goal of nursing is to provide situation-oriented and person-centered nursing that meets patients' needs in a competent, respectful, personal, and empathetic way (Kitson et al., 2013). However, caring for patients with communication difficulties increases nursing challenges because communication—especially dialog—is difficult and may result in dehumanizing practices (Pound & Jensen, 2018).

Over the last few years, research within the field of communication experience from the perspective of both PWA and HCP has expanded considerable (Barnard et al., 2021; Bright & Reeves, 2020; Carragher et al., 2021; Heard et al., 2022; Hur & Kang, 2022; van Rijssen et al., 2021). The communication between PWA and HCP is complex and challenging. Despite the recent increase in research, we still lack knowledge on the facilitators and barriers to communication with PWA and the use of communication strategies in nursing practice (Hansen et al., 2020; Heard et al., 2022; Rijssen

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et al., 2021). Also, the long term perspective of implementing supporting strategies is yet to be thoroughly investigated (Armour et al., 2021). However, when effectuating communicative support for PWA, the partnership between SLT and nurses is crucial. This collaboration can be challenged as the SLT often needs to disturb the nurse's workflow when passing on relevant information. Organizational circumstances such as time and workflow are said to increasingly affect interaction and care with PWA and SLT's experience that nurses prioritize daily practical tasks (like swallowing) over communication (Barnard et al., 2021) even though the communication can be seen as therapeutic in its own right (Gordon et al., 2009).

In the Stroke Unit at Rigshospitalet in Copenhagen, the SCA<sup>TM</sup> method was implemented during 2011 to 2015 to support the communication and active participation of PWA (Jensen et al., 2015). All staff members participated in interdisciplinary 1-day courses in the SCA<sup>TM</sup> method; supportive illustrative materials were provided, including pocket-sized materials for different staff groups; and a "conversation book" for writing down keywords and similar helpful notes, phrases, and symbols was offered to all PWA (Jensen et al., 2015). Biannual SCA<sup>TM</sup> courses followed the implementation for new staff members and maintenance by an SLT of supportive materials in collaboration with superusers from different staff groups. The Superusers were trained through two 3-hour workshops and expected to be super-users of the SCA techniques and provide assistance to colleagues from their unit and profession. However, clinical observations and practical experience in a stroke unit suggested that implementing the SCA<sup>TM</sup> method was less successful for nurses than other staff members, such as physiotherapists and occupational therapists.

This study is motivated by clinical observations and experiences from clinical practice suggesting that nursing staff had not integrated the SCA<sup>TM</sup> method into their nursing practices (Loft et al., 2019; Pound & Jensen, 2018) and that the communicative practice between nursing staff and PWA was complex and challenging despite previous implementation initiatives and attempt. This is in line with other recent research emphasizing the challenges of implementing communicational support techniques in clinical practice (Heard et al., 2022; Rijssen et al., 2021; van Rijssen et al., 2021). Since nurses and nurse assistants have more frequent daily contact with PWA than other staff groups and communication with patients is crucial for providing adequate nursing care, this is highly problematic (D'Souza, 2021). Barnard further stresses the need for lifting both knowledge and skills to improve the communicative experience of patients and states how future research would benefit from being conducted in a collaboration between SLT and nurse researchers (Barnard et al., 2021). Hence, the specific aim of this interdisciplinary study was to understand in greater depth the influences on the nursing staff's communicative practices with PWA in the context of usual stroke care interactions, and secondly, to explore the nursing staff's use or non-use of supportive techniques, including the SCA<sup>TM</sup> method.

The study is part of a larger study aiming at developing a re-implementation strategy for improving the nursing staff's use of the SCA<sup>TM</sup> method with PWA in stroke units to strengthen the communicative practice.

## Materials and Methods

### Method

*Design.* We used a qualitative descriptive design (Sandelowski, 2010) to examine data from both field observations and individual interviews with nurses and nurse assistants working in a university hospital stroke unit. The descriptive design recognizes and allows subjective aspects of the phenomenon of interest to appear (Bradshaw et al., 2017). Qualitative descriptive research lies within the naturalistic approach and hence is well-chosen when aiming to understand the phenomenon. In this study, an understanding of the communicative practice between nursing staff and PWA was sought by accessing the meanings the participants ascribe. Qualitative descriptive research has been found suitable for amplifying the voice of those experiencing the phenomena (Bradshaw et al., 2017).

*Clinical setting.* Data were collected from an acute stroke unit and two-stroke rehabilitation units at a university hospital in the capital region of Denmark. The acute unit had 19 beds, and the rehabilitation units each had 14 rehabilitation beds. The nursing staff consisted of registered nurses and nursing assistants. Patients were admitted to the acute unit for a mean period of 4 days. If the patients needed in-hospital rehabilitation, they were transferred to one of the stroke rehabilitation units within the hospital. The patients admitted for rehabilitation differed in the complexity and severity of their conditions and stayed for a minimum of 2 weeks.

*Data collection and participants.* Multiple data collection methods were used (Morse, 2010), including field observations and interviews. First, observations of stroke care situations were carried out by the two last authors (an SLT and a researcher), both of whom were trained in the SCA<sup>TM</sup> method. The first author, a registered nurse and researcher, conducted interviews with the nurses and nurse assistants. None of the researchers were part of the daily care or directly involved in the SCA<sup>TM</sup> course. However, the first author is employed as a research manager in the department, hence to some degree (well-)known to the participating nursing staff.

The observations took place over 3 weeks. Different situations involving the care of PWA were selected for observation. The observers aimed to include situations with PWA who had had strokes with varying severity, involving various cognitive and/or physical impairments, and different ages and genders. The observations were centered around the nursing staff; hence the observer mainly followed the nurse or nurse assistant. The observations aimed at both planned situations in which the nursing staff interacted with PWA in

structured activities in the daily care, for example, when nurses and nurse assistants helped PWA with personal hygiene, eating situations or determined early warning scores (vital signs: respiratory rate, oxygen saturation, temperature, blood pressure, pulse/heart rate), but also more spontaneous situations, for example, when the patient needed to talk, had questions and so forth. The duration of each observation was 0.5 to 2 hours (mean 1.20 hour). Twelve patients were included (six women), together with 10 nurses (nine women), and three nurse assistants (three women). The proportion of females and males among patients and staff reflected the real-life composition.

The observations were based on a focused observation guide developed from earlier observations in the field, hence were focused on situations in which the communicative practice unfolded. The guide was structured in accordance with the two-fold aim of the study and maintained both grand tour observations (Spradley, 1979) focusing on the broad lines of the communicative practice; the context, the sounds, the artifacts and so forth and mini-tour observations (Spradley, 1979) which were more focused on the detail; the interactions, what was said, what was done and how was it done. Field notes were taken on the spot, and we aimed at writing down the fieldnotes as rich as possible, hence also supplementing the fieldnotes with clarifying notes immediately after the observation was done.

Semi-structured interviews were conducted using an interview guide with open-ended questions (see Supplemental file), followed by an invitation to elaborate. This heightened the level of detail in respondents' answers and helped to verify understanding (Kvale & Brinkmann, 2015). The guide was constructed by drawing on findings in the available literature and experiences from previously conducted field observations (Spradley, 1979). All interviews were audio-recorded and transcribed verbatim. Eight nurses (eight women) and two nurse assistants (two women) participated in the interviews. Two of the included participant nurses were nurse managers. We invited the nurse managers to participate as we appreciate the nurse managers' influence on the daily nursing practice. Hence, we wanted to include this angle in describing the barriers and facilitators affecting the nursing staff's communicative interactions and the use of the SCA™ method. We aimed to include participants who could contribute with rich descriptions, but we also aimed for variation; hence, nurses and nurse assistants with different degrees of seniority and experience were invited to participate. Ages ranged from 29 to 58 years, with an experience of 1 to 19 years. The interviews lasted for 24 to 48 minutes each. All invited participants for both the field observations and the interviews agreed to be included.

**Analysis.** We used qualitative content analysis (Elo & Kyngäs, 2008; Graneheim & Lundman, 2004; Kyngäs et al., 2020) to analyze the data. Content analysis is suitable for finding patterns and themes based on coding and is often used to answer questions about what, why and how (Graneheim & Lundman, 2004). We applied an inductive and deductive approach

to fulfill our research objective, thereby working with an unconstrained matrix (Elo & Kyngäs, 2008; Kyngäs et al., 2020; Loft et al., 2017). The approaches were employed because we first strived to get a broader perspective of the influences on nursing staff's communicative practices with PWA in the context of usual stroke care interactions guided by the empirical data, and secondly, to explore the use or non-use of supportive techniques, including the SCA™ method; hence, we applied a theoretical structure for the analysis based on the SCA™ method.

The analysis was a collaborative effort that involved all authors. First, the authors repeatedly read the transcripts and field notes to familiarize themselves with the data. For the first part of our research aim, the manifest content in the interviews and field observations was extracted and divided into meaningful units. These meaningful units were condensed, abstracted and coded inductively. The codes were compared to identify their differences and similarities and sorted into main categories, each including subcategories. The underlying meaning—the latent content—was finally formulated into two categories. For the second part of the analysis, we coded the data through the lens and theoretical underpinning of the SCA™ method to explore whether the interviews reflected the latent core principles of the SCA™ method (see Figure 1: Acknowledging and Revealing Competence), as well as to try and identify these principles in the field observations. To support the analysis, we used the NVivo® software (QSR International Pty Ltd., Victoria, Australia).

**Ethical considerations.** The Danish Data Protection Agency approved the study (J.No. VD-2019-02), and we followed the ethical principles of the Declaration of Helsinki. Both staff members and PWA were informed that their participation in the study was entirely voluntary and that all data would be handled confidentially. The first author contacted participants, and written consent was obtained before each observation/interview. If a patient was not capable of giving consent, relatives were involved.

## Results

Based on the content analysis, two major categories—*Organizational and environmental influences on nurses' communication with PWA* and *Nurses' roles and functions* adequately encompassed descriptions related to the first research aim, while one major category—*Supporting PWA in communication*—encompassed descriptions related to the second. Additionally, several subcategories were identified (see Figure 2).

### *Organizational and Environmental Influences on Nurses' Communication With PWA*

Some of the observed characteristics of nurses' communication with PWA arose from how stroke care was organized. The nursing staff's *lack of time or perceived time pressure*

Supported Conversation for Adults with Aphasia (SCA™)

Supported Conversation for Adults with Aphasia (SCA™) (Aura Kagan, 1998) is a method taught to communication partners of people with aphasia. It is based on the understanding, that people with aphasia are competent adults, who have the right to express their thoughts and feelings. Communication partners learn to assist people with aphasia in a respectful manner to participate in conversation.

The method is based on two general principles:

**1) Acknowledging competence**  
The communication partner acknowledges and shows the person with aphasia, that he or she is perceived as an intelligent adult person, for example by saying at appropriate times “I know that you know”. The communication partner should try to communicate as naturally as possible, show a willingness to have conversations about complex topics, and take on the responsibility for communicative breakdowns.

**2) Revealing competence**  
The communication partner may use specific strategies and tools to make conversation accessible to the person with aphasia, thus enabling the person to show his or her competence. The communication partner’s use of techniques can be compared to a ramp making stairs accessible for wheelchair users:

- a. Use strategies to help a message get IN: For example, use short sentences, write down key words, use gestures, pictures, or illustrations to help the person with aphasia understand the message.
- b. Use strategies to help the message OUT: For example, give the person with aphasia sufficient time to respond, ask yes/no questions and one question at a time, or suggest the person with aphasia use gesture or point to objects, key words etc.
- c. VERIFY that both parties have understood each other correctly, for example repeating a message, or summarizing the conversation while adding keywords or gestures to the summarization.

For more information, see the extensive resources relating to the SCA™ method provided by the Aphasia Institute in Toronto: <https://www.aphasia.ca>

**Figure 1.** Fact box describing the elements of the SCA™ method.

was a pervasive theme. Other influences relating to the organization of nurses’ daily work included *frequent interruptions and noise* and *lack of continuity in nurse-patient assignments* during daily care and communication.

**Lack of time or perceived time pressure.** All informants described time as having a significant influence on providing nursing care and rehabilitation to patients. Essentially, nurses felt that communication and forming relationships with stroke patients—especially PWA—needed time, quietness, and structure. A few nurses and nurse assistants explained that they consciously took the time because this was necessary for providing good nursing:

That’s why I take the necessary time—because it is time-consuming [caring for] patients with aphasia . . . You can’t leave them on the toilet and then come back later; it would be like leaving them at the main central station because they sit there feeling abandoned. (Interview with nurse assistant).

However, for most interviewees, time pressure was a daily concern, which they had to juggle, sometimes compromising on what they knew would be best for the patient.

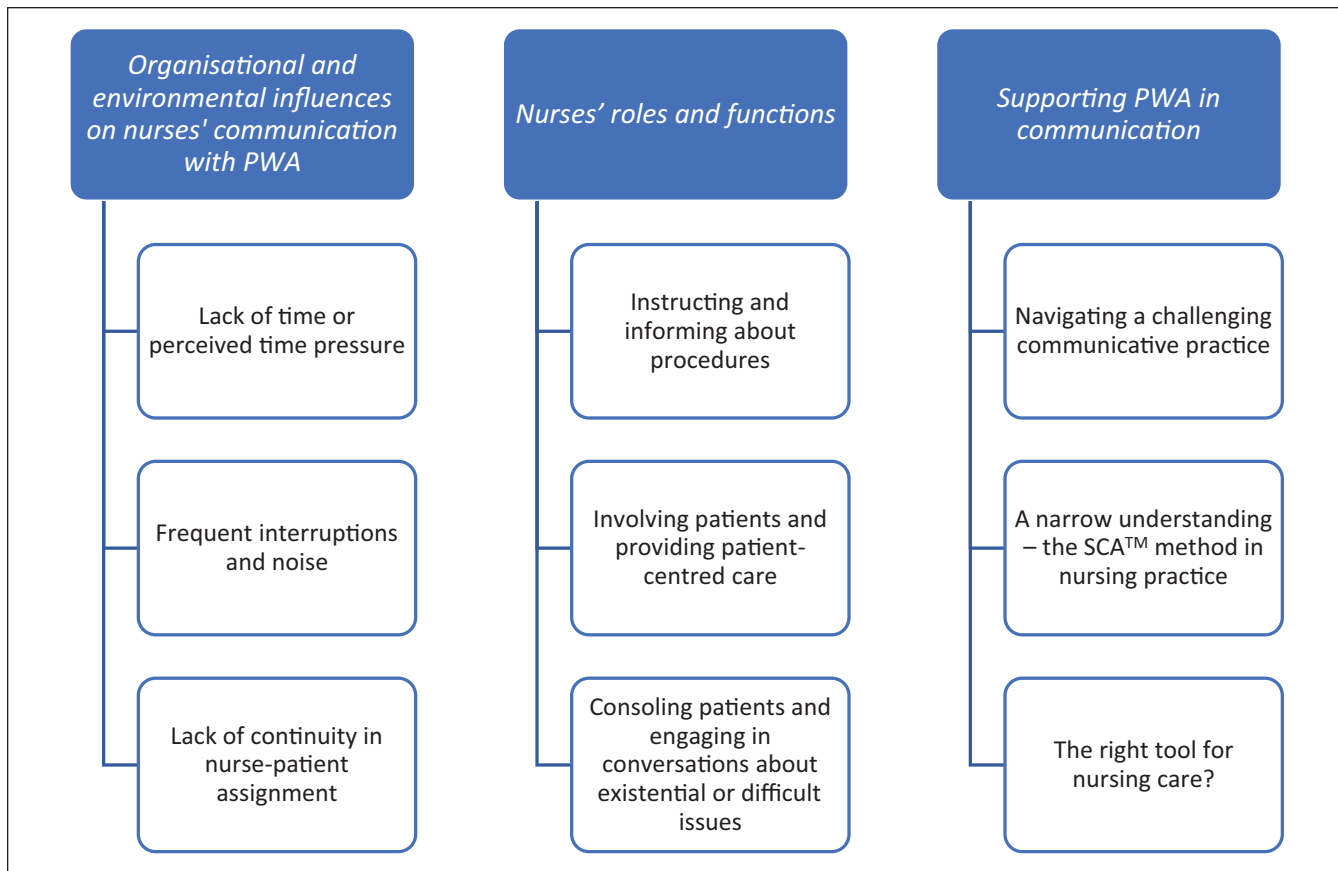
**Frequent interruptions and noise.** Nursing staff also stated that their general working conditions involved many

interruptions due to competing tasks and simultaneously attending to many patients’ needs. The general perception was that time pressure and interruptions prevented them from sitting down with patients for in-depth conversations:

We have so many other tasks that we cannot say, “I’ll take [care of] him, he really needs to talk with someone,” and then sit down for 45 minutes because . . . we would be bombarded with phone calls and there is bound to be a disturbance so you just can’t sit down. (Interview with Nurse).

During the field observations, interruptions were also frequently noted, mainly regarding colleagues asking for help or other staff groups entering the room to carry out a task or procedure with a patient. Self-interruptions also occurred frequently, for example, when nursing staff interrupted a procedure or left the room to pick up things they had forgotten to bring.

How tasks were structured seemed to be a source of noise, which could interfere with communication; for example, observations in the dining room during breakfast showed that several nurses might be dispensing medicine, measuring early warning scores, or carrying out other tasks for different patients while the patients were having their breakfast. At the same time, the television was on, creating further noise despite no one watching it.



**Figure 2.** Based on the content analysis, two major categories adequately encompassed descriptions of the first part of our research aim, while one major encompassed descriptions of the second. Additionally, several subcategories appeared.

*Lack of continuity in nurse-patient assignments.* The nursing staff perceived a lack of continuity in nurse-patient assignments as causing problems in building relationships. Knowing patients and their habits and ways of communicating was considered especially important for PWA since this might be a necessary precondition for successful communication:

If you have a patient with aphasia, it must be the same person you are caring for because then you do not have to spend as much time getting acquainted as when you just went in for the first time. (Interview with Nurse).

However, when organizing daily care, the charge nurse on each ward typically assigned patients to nurses during a shift based on multiple decision criteria, including available staff and their experience, general patient load, and specific tasks requirements. Continuity in nurse-patient assignments did not rank highly among this set of criteria. Furthermore, field observations indicated that patients did not always know the name of their assigned nurses because staff rarely introduced themselves. Also, an incorrect name (e.g., the nurse assigned the previous day) might still be listed on the whiteboard in a patient's room.

### *Nurses' roles and functions*

The complexity and diversity of the nurses' roles and functions were apparent during the field observations, which showed that several tasks and perspectives were at play simultaneously when the nursing staff interacted with PWA. Many tasks involved practical care activities and *instructing and informing about procedures*. Both observational and interview data provided insight into the nurses' role in *involving patients and providing person-centered care* and their awareness of their role in *consoling patients and engaging in conversations about existential or difficult issues*.

*Instructing and informing about procedures.* The nursing staff provided both explanations and orientation, using a range of different approaches to keep patients informed. This included individually adapted communication considering the patient's needs. In the following observation, a nurse explained everything she was doing to a PWA in a manner that seemed considerate of the patient's need for reassurance and comfort:

The nurse uses the patient's name often. She continues to talk about everything she is doing while she attaches the colostomy bag to the patient's leg. She speaks in a calm, comforting, and

clear voice at a steady pace. The patient seems to understand what the nurse is saying. (Observation).

In other cases, nurses' communication appeared to be habitual or not explicitly directed toward the patients whom it concerned, as illustrated in this observation:

The patient sits by the window eating breakfast. The nurse enters the room with a student carrying a blood pressure monitor. The nurse walks to the patient, places the cuff on the patient's arm and says into the air, "you are wearing the shirt on the inside out." The monitor starts measuring; the nurse and the student look at the monitor. The patient chews his food meanwhile. The nurse says the blood pressure value out loud. She then starts to explain something to the student about the blood pressure monitor. Addressed to the patient, she says, "Now you can eat again." The nurse and student then leave the room (Observation).

Furthermore, some regular tasks in the nursing staff's daily interactions with patients appeared to be highly complex, requiring focused attention and concentration on the part of the nurses; for example, moving a patient with severe hemiplegia safely from a bed to a wheelchair required help from another staff member and careful coordination between two nurses. In these situations, the complexity of the tasks appeared to leave little room for the communicative involvement of the patient.

*Involving patients and providing person-centered care.* Attention to patients' preferences and involvement in their care emerged as another recurrent aspect of nurses' roles and functions. Promoting patient participation and autonomy was observed when nurses yielded to patients' preferences in everyday routines or followed their lead; for example, by allowing patients to decide whether to take a bath or by verbally providing options for patients to choose between:

Nurse 1 says that the patient may now wheel himself into the bathroom to wash. The plan is for him to wash himself in the adjoining bathroom, but the patient wheels his wheelchair to the sink placed in the room by the door . . . "Would you rather do it over there?" Nurse 1 asks, accepting it and preparing to help with it. "Then you start by taking off your T-shirt." Nurse 1 waits while the patient tries to remove the shirt himself. It takes time, but he succeeds when Nurse 1 helps him a little with the sleeve. Nurse 1 hands the patient the washcloth, and the patient starts to wash his face, ears, and neck with the cloth himself. (Observation).

Participants explained that it was difficult to include PWA in their care and treatment, especially if the aphasia was severe or if the patients' overall conditions were significantly affected by the stroke. Nursing staff reported using various strategies to facilitate the involvement of PWA, such as sitting down at eye level signaling that they had time to talk.

*Consoling patients and engaging in conversations about existential or difficult issues.* The nursing staff were several times observed taking a consolatory role in their communication, for instance, by saying, "It's not going to be this difficult

forever." (Observation). Consoling remarks seemed intended to give patients hope and motivation:

Nurse 2 is helping the patient wash the upper body while Nurse 1 tidies up the room a little. The patient has trouble getting his shirt off. Nurse 1 helps him and says, "It will get better when it's summer, huh? Then sleeves will be shorter." It seemed like it was the right thing to say at the time, and the patient smiled. (Observation).

Sometimes, the nurse might try to make something that was difficult or potentially embarrassing more bearable: "'Never mind . . . I think the towel took most of it [the spilled water],' the nurse says, and she removes the wet towel from the patient's lap." (Observation).

Part of the nursing staff's role is to talk with patients about the future, including their thoughts on existential and difficult topics that often arise after a stroke. During the field observations, no such in-depth conversations between nursing staff and patients were observed, but this aspect of the nurses' role was brought up in the interviews. The staff, who claimed that they engaged in consolation and deep conversations with PWA, said that it was important to openly address the limitations imposed by the communication problems: "My experience with patients with aphasia is that the more open you are [about the communication problems] and the more you adjust your expectations, the easier it is." (Interview with Nurse).

Some participants suggested that the courage to engage in such conversations came with experience. A few participants admitted to consciously avoiding conversation with PWA, even when they were aware that the patient needed to talk, giving the reason as lack of time. The nurses in question felt they should not open a conversation that they were unlikely to be able to continue for as long as necessary:

I haven't seen anyone [enter conversations about complex topics], and I don't do it either. Sometimes in the evening, there may be time for other things, and maybe you can sit down with a patient and have a chat, for example, about football. Still, the thing is . . . you should not undertake a conversation with a patient with aphasia unless you can complete it properly. (Interview with Nurse).

Lack of time and its influence on communication was especially emphasized by nursing staff working in the acute ward. They explained that, during busy dayshifts, communication with PWA was often minimal and primarily took the form of brief information-giving.

### *Supporting PWA in Communication*

Exploring how nursing staff used supporting techniques, including the SCA<sup>TM</sup> method, gave an insight into the how the nursing staff supported or omitted to support PWA in communication. It became clear that it was about *Navigating a challenging communicative practice*. Providing care for PWA was described as challenging and sometimes complex. Not everyone from the nursing care group felt comfortable communicating with PWA. For some, it was described as

embarrassing and awkward when there was silence or when the nurse or nurse assistants were unable to understand what the patient said or wanted. Despite the nursing staff's descriptions of professional challenges and an experience of a complex practice demanding supportive techniques, the analysis revealed *A narrow understanding of the SCA™ method in nursing practice* which might lead the nursing staff to question if it was *the right tool for nursing care*.

*Navigating a challenging communicative practice.* Common to the participants' descriptions was that caring for PWA required structure and taking time to do things slower; for example, when providing care for patients' personal hygiene. It was necessary to allow extra time for eye contact and for showing utensils prior to carrying out a caring procedure, to avoid scaring the patient:

I probably spend more time with a patient who is linguistically or cognitively disturbed . . . so that they do not get frightened when I'm doing a lower-body wash . . . So, I spend more time with a patient with aphasia to make sure there is eye contact at least, and I show the washcloth just to make sure that something is recognisable to them. (Interview with Nurse).

Nursing staff, who reported that they approached PWA differently from other patients, also described observing patients' responses and modifying their interactions to suit the patients' needs:

I start by going in the morning and just taking their hand and making eye contact, and when the contact is there, I say, "Good morning." There may not be an answer, but they look at me, and then I ask, "Should we get started?" Occasionally there is a YES, and at other times the eyes flicker. And I use a lot of body gesture. (Interview with nurse assistant).

Some observations showed nurses and nurse assistants interacting with patients in ways that did not seem to acknowledge the needs and feelings of the PWA. Examples included attempts to elicit specific words from patients rather than focusing on what the patients were trying to communicate: Nurse: "Are you feeling h. . ." (trying to prompt the patient). Patient: "Hungry." (Observation).

Although the nurse or nurse assistants may have intended to help the patient practice their language, such interactions could seem to turn communication into a test or teaching session, emphasizing the inequality of the relationship. Talking about the patient using third-person pronouns or conversing with a colleague without including the patient also seemed to negatively influence patients. Additionally, interactions were occasionally observed in which the nurse showed impatience; "What are you trying to say?" (observation) or communicated in a corrective manner, which could appear devaluing to the patient:

When the other nurse comes to the dining table, she says in an unacknowledging tone, "You have started before time. You haven't even moved up to the table," after which, in collaboration

with the patient, she moves the chair nearer to the table. The patient looks unhappy with the situation. (Observation).

However, some of the interviewees said that they made sure they were respectful to patients by, for example, always saying "Good morning" and introducing themselves. They also asserted that it was important to communicate with patients in a positive, acknowledging tone, even if the patient was not responding in the desired way:

In a situation where there is apraxia . . . you may want to go, "NO, NO, NO—you should not take that comb!" Instead, you should say, "May I help you with the comb? It's terrific that you're trying [to do it], but [let me] just help you a little." (Interview with nurse assistant).

Several interviewees described making small talk during caring procedures. In contrast, others deliberately avoided small talk with PWA: "*You* mainly engage in small talk with patients who can talk, so it also depends on how accommodating the patients are". (Interview with Nurse).

One nurse felt that she needed to know the patient a little before she ventured into jokes and small talk, which was more difficult with PWA. Other nurses stated that they refrained from small talk because they were concerned that they would make the patient feel frustrated or awkward if they were unable to respond:

It is so frustrating because they cannot respond, especially if they have expressive aphasia. If I just sit and chat about the weather, they feel they must answer—this politeness we all feel—and they can't respond as they want to. (Interview with Nurse).

However, other nurses and nurse assistants used small talk to render potentially embarrassing situations more tolerable for patients. In conjunction with this, small talk also appeared to be an important way for nurses and nurse assistants to acknowledge the patient as a person and show that they remembered things about them: "*The nurse asks if the patient has slept well, and if the night was better than the night before because she remembered he didn't sleep well then.*" (Observation).

Humor and small talk could lighten the atmosphere and place focus on the patient as an individual:

The female patient, who is about to have breakfast, sits on the table's far side and has been given a cheese sandwich. The first nurse comes to her with medicine and says, "Now that's just a lovely sweater you are wearing! Where are you going looking so good?" The patient laughs, says, "To a party," and laughs again. The nurse then asks if she can scan her patient's ID and give the medicine to her. (Observation).

*A narrow understanding—the SCA™ method in nursing practice.* Describing the SCA™ method, most interviewees mentioned the two strategies of writing down keywords in the patients' conversation books and using the pictorial materials available in the nursing station. Overall, the staff perceived the SCA™



method as more or less identical to its physical materials. While they knew it was intended for use with PWA, they also associated the method with other patient groups who might benefit from the techniques. The nurses did not perceive the use of gestures and body language as directly related to the SCA™ method. These strategies were described as ways of communicating they had always used in their nursing care of PWA. However, one nurse did describe gesturing as a SCA™ relevant strategy, which she had come to use more systematically and deliberately along with other supportive strategies after the SCA™ method had been implemented in the stroke unit:

I generally use a lot of body language, but I think I probably use it more consciously now [after the implementation]. Maybe I'm not that conscious, but I believe I think more about where I position myself in relation to the patient or if I need to close the door to . . . get some quietness. I gesture with arms and legs, show things visually, and write and speak simultaneously, but now I pay a little more attention to what I am doing, and I'm more aware not to do it all at the same time. (Interview with Nurse).

Based on the field observations, it seemed that not all members of the nursing staff were familiar with the SCA™ principles and the associated tools; for example, a nurse was observed asking a patient about the purpose of the conversation book:

After finishing the measurements, the nurse looks at the table with flowers standing next to the bed. She picks up the conversation book and asks the patient, "What's this one for?" The patient explains to the nurse that everyone writes in that book, and she also writes in it because if you do not remember things well . . . you can look in the book. "Fine," says the nurse as she replaces the book. (Observation).

Furthermore, when the nursing staff were in situations requiring communicative support and actively seeking solutions to a communication problem, they appeared to be unfamiliar with the tools:

While the patient is trying to articulate why he has slept poorly, a nurse comes into the room to care for another patient behind the screen and starts a rather loud conversation. The patient seems disturbed by this, looking over at the screen, his eyes flickering. The nurse and nurse assistant have been waiting while the patient tries to say something. They now make a few guesses: "Were you uncomfortable in bed? Was there a lot of noise?" The patient does not seem to think these are suitable suggestions and again tries to say something: "It is . . . it is . . ." The nurse assistant asks, "Is it something I can help you with?" The patient still cannot answer. The nurse assistant says, "Can't you remember?" The nurse asks: "Doesn't he have a conversation book?" The nurse assistants look under the tabletop, find the book, and hand it to the nurse. The nurse takes the conversation book but places it on the windowsill next to her and tries some new guesses while the nurse assistants leave to pick up something for the patient's morning wash. (Observation).

Observations included patients with moderate aphasia, who were able to express themselves verbally but not successfully enough to make themselves understood. In such instances, when communication broke down, nursing staff were also observed making repeated guesses or collaborating to help solve the difficulties:

The patient points to the board and then points to the palm of his hand. The nurse repeatedly guesses what he is trying to say and then leaves to get help from another nurse. "She may understand what you are saying," she says as she leaves the patient. The other nurse comes up to the board and explains the plan for today to the patient. He points to his palm and draws something, and she asks if it's a clock he's drawing. "Yes," the patient answers. "Is the clock broken?" the nurse asks. "Yes," the patient answers. (Observation).

Using their imagination and trying to guess what the patient wanted to say seemed to be the most frequent way the nursing staff attempted to support patients in communication. Although supportive tools were available in the room, such as the patients' conversation books, nursing staff were not seen to use these to help solve communication breakdowns.

Most nursing staff members perceived the SCA™ method as a tool intended to assist them in their work with PWA. Still, it was rarely explicitly used as a tool for the benefit of patients, enabling them to be included, acknowledged, and given an opportunity to express themselves. However, one nurse explained that the SCA™ method ensured that patients felt safe in conversation with staff and suggested that it was necessary to obtain information about a patient's life to make use of this method in supporting conversation actively.

*The right tool for nursing care?* In general, nurses and nurse assistants expressed more critical than positive views of the relevance and usefulness of the SCA™ method for their profession. Because of the challenges imposed by aphasia, they acknowledged their need for useful communication strategies and methods. In the interviews, nursing staff said they knew about the materials and where to find them but rarely used them, ranging from "not at all" to "we could do more." None of these materials was used during any of the field observations. This was also corroborated and appeared to be accepted by the participating nursing managers. The nursing staff stated that their interdisciplinary colleagues (e.g., occupational therapists and physical therapists) used the method more frequently and systematically.

The reasons given for this were that they considered the materials unsuitable and impractical for application to daily nursing care tasks: "I honestly do not think it is the right tool for nursing care." (Interview with Nurse). Accordingly, when it came to deciding priorities on a busy day, using SCA™ techniques was one of the first things to be left out because it was perceived as requiring extra time:

It is a good method, but it is also very, very time-consuming, and this is inevitable because it requires time and knowledge of the tool to work properly. It is probably also a tool I use less often than I would like to. (Interview with Nurse).

The general attitude was that the SCA™ method was time-consuming and not tailored to the daily situations in which the nursing staff found themselves, such as serving food to patients, carrying out medical procedures, assisting with personal hygiene, or accompanying patients to the toilet:

I cannot stand with my gloves on while I am washing someone and write down yes/no/what do you think . . . This is probably why you do not see us using the box [of supportive materials] in the care process. (Interview with Nurse).

Besides the impracticality of using supporting materials, nursing staff also thought it was difficult to select suitable pictures for their interactions with certain patients. Some reported giving up because there were too many materials to choose from. The nursing staff felt it required experience and knowledge of the materials to use them properly. They knew they could turn to an SLT for help, but this was rarely done in practice. The most frequently used tools were the conversation book, yes/no cards, and smiley cards.

A few members of the nursing staff even felt that using supporting materials such as yes/no cards might disturb the natural interaction in a way that was negative for the patient or made the nurse feel like a schoolteacher. The hygienic issue of bringing physical materials into the patient's room and putting them back in the toolbox in the nursing station was also pointed out as a problem.

Some nurses and nurse assistants said that it seemed so easy when the SLT used the techniques, but when they had to use it themselves, they were uncertain about how to do it. Some also felt they needed support from an SLT to find useful solutions and strategies for individual patients, especially if communication was severely affected:

Sometimes I can be in doubt. Of course, I can read the medical journal, but I am not sure exactly what the challenge is for this patient or how much I can expect to use the method. Here, I feel I need the SLT to say that it might be good to use this strategy or this or that picture in this situation. (Interview with Nurse).

However, other staff members claimed that the SCA™ method was easy and similar to what they were used to doing anyway.

## Discussion

This study aimed to understand in greater depth the influences on the nursing staff's communicative practices with PWA in the context of usual stroke care interactions, and secondly, to explore the nursing staff's use or non-use of supportive techniques, including the SCA™ method.

When investigating the influences on nursing staff's communicative practices with PWA in the context of usual stroke care interactions, the results showed that nursing staff's interactions with PWA were influenced by organizational factors, especially the lack of time or perceived time pressure, frequent interruptions of care and communication and lack of continuity in nurse-patient assignments. Hence, in most cases, the organizational and environmental context appeared as a barrier to the communicative interactions between nursing staff and PWA. Several studies have highlighted the barriers to nursing staff's communication with PWA, especially a rapid working pace and time pressure, as well as frequent interruptions and short lengths of stay for patients (Barnard et al., 2021; Carragher et al., 2021; Heard et al., 2022; Hemsley et al., 2012; Loft et al., 2017; van Rijssen et al., 2021). The time constraints on nursing staff's opportunities to attend to patients' psychosocial well-being is a cause for serious concern, especially for PWA. They are likely to be more vulnerable than other patients in terms of understanding the nature of stroke and aphasia and their consequences. The nursing staff in our study explained that time pressure prevented them from engaging in conversations with patients even when they were aware that a particular patient might need to talk. Studies from a patient perspective have documented likewise—conversations with nurses about difficult topics, including existential issues, are often missed but needed for stroke patients, especially PWA (Balandin et al., 2001; Bright & Reeves, 2020; Clancy et al., 2020; Johansson et al., 2012; Loft et al., 2019; Manning et al., 2020; Nyström, 2009).

Contextual factors are known to influence how nursing care can be carried out (Kitson et al., 2013, 2014), which compromises both patient safety and affects the possibilities of a therapeutic relationship (Bright & Reeves, 2020; Kitson et al., 2013, 2014). Nursing care is performed in complex healthcare services and is ascribed to political and organizational factors (Kitson et al., 2013, 2014). Looking into the organizational level, the Fundamentals of Care framework describes how four central factors—resources, culture, leadership, evaluation, and feedback—play significant roles in the execution of nursing care (Mudd et al., 2020). The findings in our study indicated that culture and leadership do not always constitute an optimal frame for a communicative practice; hence, in the pressurized environment of stroke care, nursing leaders neither prioritized nursing staff's use of SCA™ techniques in their daily practice nor organized nurse-patient assignments to ensure continuity in the nursing care of patients with severe or moderate aphasia.

There is strong evidence that changing practice and ensuring that patients' fundamental care needs are requested; and that leadership play significant roles (Aarons et al., 2016; Bianchi et al., 2018; Kitson et al., 2013; Mudd et al., 2020). This is a fine chance for strong leaders to present their arguments for the significance of communicative interaction and practice in stroke care. This will provide more

time and space as well as competence development, thus ensuring that nursing staff with knowledge and resources will provide evidence-based communicative care.

The results further showed a facilitating culture for person-centered care; nurses and nurse assistants informed and instructed patients about procedures and attempted to involve PWA in their care, despite the difficulties. We observed examples of informational or instructional communication that appeared to give patients reassurance and comfort during procedures. Still, there were also examples of nurses speaking and providing information about, for example, temperature or blood pressure in a habitual, impersonal manner, which did not appear to address the concerned patient directly. As suggested by Pound and Jensen (2018), this type of impersonal interaction runs the risk of dehumanizing a patient by expressing a reductionist view, thereby reducing the person to a body rather than a person entitled to know about their bodily functions and conditions. Other studies have also found that many interactions between nurses and PWA are nurse-led, with limited opportunities for PWA to initiate conversations (Gordon et al., 2009; Hersh et al., 2016).

In its existing form, the organizational context for nursing care on micro- and meso-level barriers is most conspicuous for nursing staff's communicative interaction (Harvey & Kitson, 2015). On a microlevel, we found facilitators in individual nursing staff engagement and professionalism when they deliberately chose to overcome or overrule organizational barriers. However, in the interviews as well as the observations, substantial differences were found between individual staff members' approaches to caring for PWA. Some indicated that they approached PWA in much the same way as other stroke patients; others displayed a heightened sensitivity to patients' abilities to respond, which suggested a readiness to support patients in participating. In addition, some nursing staff members explicitly stated that it was important to communicate with patients in a positive, acknowledging tone. Thus, it depended on the individual nursing staff whether the PWA was met in a supportive, interactive environment.

With respect to our aim, in which we explored the nursing staff's use or non-use of supportive techniques, including the SCA<sup>TM</sup> method, we noted the use of consolatory communication and humorous small talk. However, some staff members tended to engage in small talk less often with PWA. Carragher et al. (2021) recently drew attention to this limitation of interactions with PWA; however, if used appropriately, humor and small talk may level the playing field between participants and signal to PWA that the nurses relate to them as competent adult social beings (Simmons-Mackie & Schultz, 2003). The use of humor and small talk has also been highlighted by Kagan (1995) as an implicit way of acknowledging the competence of PWA.

The strategies that some staff members described and were observed using aligned well with the principles of the SCA<sup>TM</sup> method. It was also observed that the uptake of

the SCA<sup>TM</sup> method and sensitivity to special needs nursing care for PWA varied considerably among nursing staff members. As suggested in a recent study by van Rijssen et al. (2021), nursing staff members who are uncertain about integrating and using SCA<sup>TM</sup> techniques in their practice, SCA<sup>TM</sup> courses may need to be followed by hands-on experience with PWA to ensure successful implementation.

Although the nursing staff had attended the same SCA<sup>TM</sup> courses, they differed substantially in their knowledge of and use of the method. For most staff members, the method was rather narrowly identified with picture tools and writing keywords in the patients' conversation books. While the staff acknowledged that these strategies might be relevant, they felt the techniques were time-consuming and unsuitable for interactions with patients while providing typical nursing care. Furthermore, they found the techniques difficult to adapt and apply to individual patients with varying forms and degrees of aphasia. Using gestures and body language, allowing time for the patient to respond and providing "yes/no" choices verbally were a few strategies that were used sometimes; however, most did not perceive these techniques to be directly associated with the SCA<sup>TM</sup> method; rather, they were considered strategies that formed part of their usual nursing care approach to PWA.

In this study, the critical attitudes of nursing staff toward the SCA<sup>TM</sup> method were contrasted with other studies that researched its successful implementation in-hospital stroke units, targeting mixed rehabilitation staff, including nurses and nurse assistants (Cameron et al., 2017; Chu et al., 2018; Hansen et al., 2020; Heard et al., 2017; Horton et al., 2016; Jensen et al., 2015; McGilton et al., 2018). In our study (Jensen et al., 2015), the implementation of the SCA<sup>TM</sup> method was deemed successful based on questionnaires and interview data from nursing staff in the initial phase after implementation. The findings from the present study revealed a less favorable outcome. One possible explanation is that the results in (Jensen et al., 2015) were colored by the staff's enthusiasm for learning new techniques and principles that had not yet been tried and tested over time in daily practice.

Mixed results regarding implementation may be ascribed to various factors. One review found that at least 23 contextual factors influenced new implementation strategies (Durlak & DuPre, 2008); thus, if a new method is flexible and modified in practice, there is a higher probability that the implementation will be successful (Durlak & DuPre, 2008; Dusenbury et al., 2003). According to Beinecke (2004), overloaded healthcare professionals cannot be expected to have the energy to implement new strategies. It is also essential to consider whether interdisciplinary courses on the SCA<sup>TM</sup> method, delivered as part of its implementation in hospitals, should be adapted to target nursing staff directly (van Rijssen et al., 2021). Keeping in mind that the SCA<sup>TM</sup> method was developed by SLTs and initially applied in a slightly different setting and with different experiences and knowledge our

study underscores the importance of collaboration between SLTs and nurses to guide future implementation. Hence, for more successful implementation the clinical practice and communicative interactions of nursing staff must be considered, and the method modified accordingly.

### Strengths, Limitations, and Future Directions

The main limitation of this study was that it did not include patients' perspectives on communication with the nursing staff. Another limitation is that the study was carried out as a single-center stroke department in one region of Denmark. The results related to a specific implementation of the SCA<sup>TM</sup> method, which took place 5 years before the study. Also, observations were made only during day shifts and focused on the types of nurse-patient encounters that were common during the mornings and early afternoons. These restrictions may have affected the relevance and generalizability of the results to other contexts for nursing care of PWA. Despite these limitations, the study has broader implications beyond the regional setting where it was conducted. The findings align well with other research regarding nursing staff's communication with PWA and were strengthened by the collaboration between a nurse and two SLTs and the stroke unit containing both acute and rehabilitation wards.

Credibility was increased by rich and detailed descriptions and triangulation in our data collection strategy, based on field observations and semi-structured interviews conducted in one acute care setting and two rehabilitation units (Shenton, 2004). Our adherence to COREQ guidelines also increased the trustworthiness of the study (Tong et al., 2007).

To our knowledge, this is the first study to examine the long-term effects of implementing the SCA<sup>TM</sup> method in a hospital stroke-care setting. The results suggest that the previous SCA<sup>TM</sup> implementation and training program studied by Jensen et al. (2015) should be revised and adapted more carefully to nursing staff and the specific nature of their encounters with patients during stroke care. These implications will be explored in a future study aiming to develop a systematic strategy for reimplementing the SCA<sup>TM</sup> method for nursing staff.

### Conclusion

The results showed that the nursing staff's interactions with PWA were influenced by organizational factors, their roles and functions, and general caring practices for PWA and how the SCA<sup>TM</sup> method in nursing practice was integrated to support the communicative practice. The findings highlighted that the role of nursing staff in caring for the psychosocial well-being of patients is deprioritized in favor of other tasks. If there is no time or culture for prioritizing time in a stroke unit for conversing with patients and supporting their psychosocial well-being, the SCA<sup>TM</sup> method or any similar approach to communication-partner training is likely to be

hindered. However, the results also highlighted that professionalism and engagement in the individual nursing staff were a facilitator for communicative interactions.

Knowledge and use of the SCA<sup>TM</sup> method varied among staff members, and the method tended to be rather narrowly identified with the use of associated picture tools and writing keywords in patients' conversation books. The method should be supplemented by organizational changes or changes in the work culture to enable nursing staff to provide more holistic care. For nursing staff, successful long-term implementation of the SCA<sup>TM</sup> method may require adaptation of its principles and techniques to the nature of stroke care, together with organizational changes that prioritize communication with patients as an essential part of nursing care.

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### Supplemental Material

Supplemental material for this article is available online.

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