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Nurses' Communication Barriers when Providing Nursing Care to the Elderly — the Pilot Study

Bariery komunikacyjne pielęgniarek podczas sprawowania opieki pielęgniarskiej nad osobami starszymi — badanie pilotażowe

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Abstract

Introduction. When providing highquality nursing care to seniors, communication barriers often arise during interactions with healthcare personnel. It is unquestionable that the use of "appropriate language" by nurses is of primary importance so that the patient can understand complex professional terms. Effective communication positively influences the improvement of seniors' health status and the course of therapy. The professionalism of healthcare personnel in conversations with seniors is a priority for all healthcare institutions.
Aim. The aim of our exploratory analysis was to map nurses' use of the elements of inappropriate communication — elderspeak — in their communication with seniors.
Material and Methods. The survey was conducted through internet. The sample consisted of 75 respondents. The health care workers were from different health care institutions of the Slovak Republic. An unstructured questionnaire was used for data collection. The scale of the investigated variables used in survey was 5-level Likert scale (Strongly agree, Agree, Neither agree nor disagree, Disagree, Strongly disagree). Stepwise ordinal regression method was used for data analysis, all computations were done in IBM SPSS Statistics v. 28.
Results. Of the 75 (100%) respondents, 44% reported using diminutives in their communication with seniors. The use of technical terms was reported by 25.3% of the respondents. Up to 80% of the respondents used an elevated tone of voice when communicating with seniors and 73.3% of the respondents used a slower speech rate. The use of excessive mimicry was reported by 38.6% of respondents, and the use of excessive gesticulation was reported by 42.7% of respondents. Eye contact was maintained by up to 88% of respondents when communicating with seniors. The most significant factors which were influencing way of communication with seniors were level of education and length of professional experience. After processing the results, we found a statistically significant relationship in the following areas, among others: use of plural p=0.015, keeping eye contact p=0.013, use of familiar addressing p=0.001 (dependent on length of experience), use of technical terms p=0.006, use of raised tone p=0.005, use of excessive mimics p=0.005, use of excessive gesturing p=0.005, limited communication p=0.006.
Conclusions. Only effective communication without elements of inappropriate communication positively helps in establishing mutual trust between nurse and patient. The elderly are a vulnerable population in relation to changing health status and the aging process. They may experience feelings of helplessness and unappreciation through inadequate communication. There is a need to train healthcare professionals in the development of specifics of communication with seniors and to apply them in nursing practice. We need to be aware of how we approach the elderly and avoid negative stereotypes. **(JNNN 0000;0(0):0–0)**
Key Words: barriers in the communication process, communication, nursing, seniors

Streszczenie

Wstęp. Podczas zapewniania wysokiej jakości opieki pielęgniarskiej seniorom często pojawiają się bariery komunikacyjne w kontaktach z personelem medycznym. Niewątpliwie używanie przez pielęgniarki „odpowiedniego języka" ma kluczowe znaczenie, aby pacjent mógł zrozumieć złożone, specjalistyczne terminy. Skuteczna komunikacja pozytywnie wpływa na poprawę stanu zdrowia seniorów oraz przebieg terapii. Profesjonalizm personelu medycznego w rozmowach z seniorami jest priorytetem wszystkich placówek opieki zdrowotnej.

Cel. Celem naszej analizy eksploracyjnej było zmapowanie wykorzystywania przez pielęgniarki elementów nieodpowiedniej komunikacji — elderspeak — w ich komunikacji z seniorami.

Materiał i metody. Badanie zostało przeprowadzone za pośrednictwem internetu. Próba składała się z 75 respondentów. Pracownicy ochrony zdrowia pochodzili z różnych placówek medycznych Republiki Słowackiej. Do zbierania danych wykorzystano nieustrukturyzowany kwestionariusz. W badaniu zastosowano 5-stopniową skalę Likerta (zdecydowanie się zgadzam, zgadzam się, ani się nie zgadzam, ani nie zgadzam, nie zgadzam się, zdecydowanie się nie zgadzam). Do analizy danych użyto krokowej metody regresji porządkowej; wszystkie obliczenia wykonano w programie IBM SPSS Statistics v. 28.

Wyniki. Spośród 75 respondentów (100%), 44% zgłosiło używanie zdrobnień w komunikacji z seniorami. Stosowanie terminologii specjalistycznej zgłosiło 25,3% respondentów. Aż 80% używało podniesionego tonu głosu podczas komunikacji z seniorami, natomiast 73,3% stosowało wolniejsze tempo mówienia. Nadmierną mimikę stosowało 38,6% ankietowanych, a nadmierną gestykulację — 42,7%. Kontakt wzrokowy podczas rozmowy z seniorami utrzymywało do 88% respondentów. Najważniejszymi czynnikami wpływającymi na sposób komunikacji z seniorami były poziom wykształcenia i długość doświadczenia zawodowego. Po analizie wyników stwierdzono istotny statystycznie związek m.in. w następujących obszarach: używanie liczby mnogiej (p=0,015), utrzymywanie kontaktu wzrokowego (p=0,013), stosowanie poufałego zwrotu (p=0,001 — zależne od długości stażu), używanie terminów specjalistycznych (p=0,006), używanie podniesionego tonu (p=0,005), używanie nadmiernej mimiki (p=0,005), stosowanie nadmiernej gestykulacji (p=0,005), komunikacja ograniczona (p=0,006).

Wnioski. Tylko skuteczna komunikacja, pozbawiona elementów nieodpowiedniej komunikacji, pozytywnie wpływa na budowanie wzajemnego zaufania między pielęgniarką a pacjentem. Osoby starsze stanowią populację szczególnie wrażliwą w związku ze zmianami stanu zdrowia i procesem starzenia. Niewłaściwa komunikacja może wywoływać u nich poczucie bezradności i niedocenienia. Istnieje potrzeba szkolenia pracowników ochrony zdrowia w zakresie specyfiki komunikacji z seniorami oraz wdrażania tej wiedzy w praktyce pielęgniarskiej. Musimy być świadomi, w jaki sposób zwracamy się do osób starszych, i unikać negatywnych stereotypów. **(PNN 0000;0(0):0–0)**

Słowa kluczowe: bariery w procesie komunikacji, komunikacja, pielęgniarstwo, seniorzy

Introduction

The current times are characterized by the workload of health care professionals and it often happens that they cannot find enough time to talk to seniors. Despite of the fact that communication is one of the most important links in the delivery of nursing care, most health care workers are not willing to communicate with them beyond the scope of their duties. They only come to patients during nursing interventions and discuss only the essentials with them. They do not attempt to remove this barrier and often conduct communication in an unprofessional manner [1,2]. Population ageing is being addressed by an increasing number of authors, including the most recent ones Bloom and Luca and other authors [3–5]. This phenomenon is also associated with a greater demand for comprehensive nursing care for the elderly, including communication. When communicating with the elderly, nurses use inappropriate elements such as diminutives, excessive facial expressions and gesticulations, professional terminology, and incorrect patient address. Communication with seniors resembles the level and conduct of communication with children, which is referred to in the literature as 'baby talk'. Elderspeak is also characterised by a slower speech rate, an increase in the tone of voice, even if we do not know whether the senior has a hearing problem. Communication positively influences the building of relationships between healthcare professionals and patients, which can initiate the patient to care and ensure the delivery of quality and personalized healthcare [6]. A differentiated approach is very important when working with seniors [7]. When conducting communication with seniors, it is essential to recognize their specific emotional reactions. Many times they feel alienated by society, they are afraid of the future, of death, and they have a hard time experiencing life's losses [8]. Nurses perceive the patient only with biological needs and forget that the person has interests, needs, hobbies and problems [9]. Therefore, the nurse must have good communication skills. Every nurse should show the patient that we are interested and interested in listening to what he/she is saying. Non-verbal communication in the performance of gestures and body language is also important [5,10]. The authora describes the signals of active listening, which include nodding the head, leaning towards the communicator, repeating what the communicator has just said, further questions about the topic, eye contact. The communicator

should be patient and should be able to create the right atmosphere, especially in tense communication. To express oneself clearly and precisely, not to deviate from the topic [10,11]. It is important to adapt the communication style to the individual needs of the patient [9,12]. Just as it is necessary to learn how to treat a patient, it is important to learn how to communicate with a patient [13,14]. To improve communication, it would be advisable to spend enough time with each patient to make sure they understand everything [15].

Help should be provided in an atmosphere of trust and human understanding. Problem situations cause uncertainty, worries and fear. Therefore, helping professionals should arouse trust, safety and peace. This naturally, demands time for listening and talking [16]. Communication is useless or even harmful if the target does not understand or grasp the essence of the message. An important factor in communication is comprehensibility [17]. Miscommunication between healthcare providers is one factor that contributes to error rates. Effective communication requires an engaged receiver and sender [18]. Can also improve hospital service quality, reduce errors and increase patient safety and satisfaction [19]. Man has been a member of human society for millennia and an important part of his life is the exchange of information. The quality of his life depends not only on the economic development of the country, the social policy of the state in which he lives, but also on the creation of positive interpersonal relationships, the basis of which is the acquisition and provision of information, or effective communication, which can result in various forms of behavior [14]. Ageing and the associated old age is a life cycle in which we all participate. Each of us would surely like to live our lives in the best possible way, with quality and meaning. However, these priorities are not only relevant for the younger generation, but also appear in the much older generation, where they are mainly represented by self-sufficiency, the possibility of participating in social life, being an asset to society and being perceived as a rightful member of society with respect for dignity [20,21]. It is the duty of health professionals to learn how to communicate eruditely with the patient and to use balanced and objective information in their reasoning. Even though communicating with seniors is sometimes extremely difficult, it is always important to remember that we are there for them and to remember to control our behaviour in front of them.

The purpose of our exploratory analysis was to examine how nurses use elements of inappropriate communication, known as elderspeak, when interacting with older adults.

Material and Methods

The survey was conducted by a questionnaire sent via internet to health care professionals working in different randomly chosen health care institutions in Slovakia between 1 December 2022 and 28 February 2023. The number of returned questionnaires was 75 out of 100. Thus, the sample consisted of 75 respondents. The investigated communication characteristics were the following ones: use of diminutives, use of familiar addressing, use of inadequate addressing, use of plural, use of technical terms, use of slow speech tempo, use of raised tone, use of suggestive questions, use of excessive mimics, use of excessive gesturing, keeping eye contact, willingness to communicate at any time, communication limited to nursing interventions, equal communication regardless of ethnic origin.

The scale of the investigated variables used in survey was 5-level Likert scale (Strongly agree, Agree, Neither agree nor disagree, Disagree, Strongly disagree). The survey also contained check-in question, whether respondents know the term "elderspeak", with just yes/no answer. The investigated communication characteristics (dependent variables) were tried to be explained by the following set of potential factors (explanatory variables): sex, age, level of education, length of professional experience, and ward/clinic. All predictors were categorized as indicated in Table 1. It is worth noting that classical contingency tables methods of analysis could not be applied due to zero or low number of observations in many cells. Since the data (communication characteristics) collected were on ordinal scale, ordinal logistic regression was used to form their statistical model. Also the predictors, with the exception of sex and ward, were ordinal. Basic method of estimation was chosen to be profile likelihood. In each case, a series of nested models was formed, leaving out sequentially non-significant predictors. Due to relatively small sample size (N=75), bootstrap confidence interval with 10 000 repetitions were used to assess the reliability of statistical significance of the model parameters. In general, these intervals were substantially wider than those formed from a single (original) sample. This suggests that results from original sample should be interpreted with caution, and we decided to consider as significant predictors at level 5% ($p<\alpha=0.05$) or less. Due to small sample size, we have considered only main effects of the predictors and no interactions. All computations were done in IBM SPSS Statistics v. 28.

The study included 75 participants. The majority were women (N=66; 88.0%), while men constituted 12.0% (N=9) of the sample. With regard to age, the largest proportion of respondents were younger adults: 21–30 years (N=30; 40.0%), followed by those aged 31–40 years (N=19; 25.3%) and 41–50 years (N=19; 25.3%). A smaller number of respondents were between

51–60 years (N=6; 8.0%), and only one respondent (1.3%) was older than 60 years.

In terms of educational attainment, nearly half of the respondents held a university bachelor's degree (N=36; 48.0%), while 18 (24.0%) had a university master's degree. Additionally, 9 respondents (12.0%) had secondary education, 7 (9.3%) had higher professional training, and 5 (6.7%) reported other types of education.

Participants represented a wide range of clinical settings, ensuring diversity of professional experience. Respondents worked in surgical wards (N=16; 21.3%), homes of social services (N=14; 18.7%), internal medicine units (N=10; 13.3%), long-term care wards (N=9; 12.0%), and neurology departments (N=8; 10.7%), while 18 participants (24.0%) reported employment in other clinical environments.

Regarding professional experience, the largest subgroup consisted of nurses with 1–5 years of experience (N=30; 40.0%). Respondents with 6–10 years of experience represented 14.7% (N=11), followed by those with 11–15 years (N=9; 12.0%), 16–20 years (N=8; 10.7%), and 21–25 years (N=10; 13.3%). A small proportion of participants reported 26–30 years (N=3; 4.0%) or more than 30 years (N=4; 5.3%) of professional practice.

In summary, the study sample was predominantly composed of young female nurses with higher nursing education, most of whom had less than 10 years of professional experience. Respondents worked across various types of healthcare institutions, providing a broad representation of clinical environments relevant to nursing practice (Table 1).

Table 1. Characteristics of the study group (N=75)

Variable	N	%
Gender		
Men	9	12.0
Women	66	88.0
Age		
21–30 years	30	40.0
31–40 years	19	25.3
41–50 years	19	25.3
51–60 years	6	8.0
Over 60 years	1	1.3
Education		
Secondary	9	12.0
Higher professional	7	9.3
University bachelor's degree	36	48.0
University master's degree	18	24.0
Other	5	6.7
Ward (clinic)		
Internal medicine	10	13.3
Surgical	16	21.3
Neurological	8	10.7
Long-term patients	9	12.0
Home of social services	14	18.7
Other	18	24.0
Work experience		
1–5 years	30	40.0
6–10 years	11	14.7
11–15 years	9	12.0
16–20 years	8	10.7
21–25 years	10	13.3
26–30 years	3	4.0
Over 30 years	4	5.3

N — number of observations; % — percent

Results

Table 2 presents the frequencies and proportions of selected communication behaviors used by nurses when interacting with seniors. The results show considerable variability in the occurrence of specific communication strategies, including both desirable and potentially inappropriate elements.

Table 2. List of communication characteristics

Variable	N	%
Use of diminutives	33	44
Use of technical terms	19	25.3
Use of elevated tone of voice	60	80
Use of slower speech rate	55	73.3
Use of excessive mimicry	29	38.6
Use of excessive gesticulation	32	42.7
Use of eye contact	66	88

N — number of observations; % — percent

The most commonly reported behavior was maintaining eye contact, declared by 66 respondents (88%), indicating that the majority of nurses recognize the importance of visual connection in communication with elderly patients. A similarly high proportion of participants reported using an elevated tone of voice — 60 respondents (80%) — which may reflect an attempt to ensure audibility, although it is also considered a feature of elderspeak.

A slower speech rate was used by 55 respondents (73.3%), suggesting that many nurses intentionally adjust their pace of speaking when interacting with older adults. In contrast, diminutives — a characteristic element of paternalistic communication — were used by 33 respondents (44%).

Regarding nonverbal communication, excessive gesticulation was reported by 32 respondents (42.7%), while excessive mimicry was noted by 29 respondents (38.6%). These behaviors, although sometimes meant to facilitate understanding, may also be perceived as infantilizing or inappropriate.

The least frequent behavior was the use of technical terms, reported by 19 respondents (25.3%), which suggests that most nurses avoid specialized terminology and attempt to adapt language to the comprehension level of elderly patients.

Overall, the data illustrate that while certain effective communication behaviors — such as eye contact — are widely practiced, elements associated with elderspeak (e.g., elevated tone, diminutives, exaggerated nonverbal behavior) remain present in a significant portion of nurse–patient interactions.

Table 3. List of characteristics with significant predictors found

Dependent variable	Remark
Knowledge of Elderspeak	Only 40% of respondents were familiar with the term
Use of plural	p=0.015
Keeping eye contact	p=0.013

Table 4. Level of statistical significance in final models with significant predictors

Dependent variable	Statistical significance of explanatory variables			
	age p	ward/ clinic p	length of experience p	level of education p
Use of familiar addressing			0.001	0.004
Use of technical terms	0.006			
		0.001		
			0.002	
Use of raised tone			0.005	
			0.002	
		0.002		
Use of excessive mimics			0.005	
Use of excessive gesturing			0.005	
Limited communication			0.006	

Table 3 presents an overview of the communication-related variables for which statistically significant predictors were identified in the ordinal regression analysis. These findings indicate that certain demographic or professional factors among nurses significantly influenced specific aspects of communication with older adults.

The first variable concerns the knowledge of the term "elderspeak", which was familiar to only 40% of respondents. This limited level of awareness suggests that many healthcare professionals may not fully recognize inappropriate communication patterns directed toward older adults, which could affect the quality of nurse–patient interactions.

Statistically significant associations were also found for two additional communication behaviors:

• Use of plural forms — p=0.015.

This indicates that selected predictors (such as education level or professional experience) significantly influenced the likelihood of nurses using plural forms when addressing older adults — an element often associated with infantilizing communication.

• Maintaining eye contact — p=0.013.

This result suggests that certain factors, such as clinical experience or workplace environment, significantly affected the quality of nonverbal communication, particularly the ability to sustain eye contact, which is crucial when interacting with elderly patients.

Table 4 summarizes the dependent (communication) variables alongside the predictors that reached statistical significance ($p<0.05$) in the final ordinal logistic regression models. In the original table, the legend indicates single significant predictors in grey, pairs in light green, and triples in light red. In all models, category ordering was set so that a higher category of a predictor implies a more positive influence on the communication characteristic, i.e., a more favorable nurse attitude toward the patient.

• Use of familiar addressing.

Significant predictors: length of professional experience (p=0.001) and level of education (p=0.004).

• Use of technical terms.

Significance was observed for multiple configurations: age (p=0.006); the pair age + ward/ clinic (p=0.001); and a triple — predictor model (p=0.002), indicating multifactorial dependence.

• Use of raised tone.

Significant effects for length of professional experience (p=0.005); a two — predictor combination (p=0.002); and a three — predictor combination (p=0.002).

• Use of excessive mimics.

A pair of predictors — length of professional experience and level of education — was significant (p=0.005).

• Use of excessive gesturing.

A pair of predictors — length of professional experience and level of education — was significant (p=0.005).

• Limited communication (restricted to nursing interventions).

A pair of predictors — length of professional experience and level of education — was significant (p=0.006).

In all cases, the order of categories was chosen in such a way that statistical significance means positive influence of the factor on the characteristic under study, i.e. higher value of the factor leads to improved attitude towards the patient.

Discussion

Communication in nursing practice is universally recognized as a fundamental component of high-quality care for older adults. The results of our study confirm that nurses' communication with elderly patients includes both desirable behaviors and elements characteristic of elderspeak. On one hand, the vast majority of respondents reported maintaining eye contact (88%), which is widely considered supportive of therapeutic rapport. On the other hand, several communication patterns reflective of paternalistic or infantilizing interaction — such as raised tone of voice (80%), slower speech tempo (73.3%), use of diminutives (44%), excessive mimicry (38.6%), and excessive gesturing (42.7%) — were frequently present. Technical terminology was used by 25.3% of the respondents. Importantly, education level and length of professional experience were statistically significant predictors for a range of communication behaviors (e.g., familiar addressing, raised tone, excessive nonverbal cues, limiting communication to nursing tasks). This indicates that communication competence is strongly linked to professional preparation and clinical experience.

Published research consistently emphasizes that communication significantly affects patient satisfaction, trust, and perceived quality of care [1–3]. International literature on elderspeak highlights that features such as prosodic exaggeration, simplified vocabulary, and infantilizing expressions can reinforce age-related stereotypes and negatively influence patient well-being, particularly in the context of cognitive impairment [7,8]. The prevalence of slowed speech and elevated tone observed in our study is consistent with these global findings.

With regard to nonverbal communication, maintaining eye contact is recognized globally as a gesture of respect and attentiveness. Reviews of evidence point to its importance in interactions with older adults, particularly in emotionally sensitive contexts [5,10]. The high prevalence in our sample (88%) confirms that this nonverbal element is well established in the communication habits of the surveyed nurses.

The use of diminutives, which can be perceived as infantilizing, has been documented in Central European studies, often in settings characterized by high workload and time pressure [11,12,14,15]. The 44% prevalence in our study aligns closely with these regional data, suggesting that such linguistic habits remain deeply ingrained and may require targeted intervention through formal training.

Role of Education and Experience. The significant associations identified in the ordinal regression models indicate that higher education and longer professional experience are related to more favorable communication behaviors. This is aligned with the principles of person-centred practice, where communication competence is considered a core element of professionalism and typically improves with advanced training and accumulated clinical practice [9,10]. Our findings reinforce the need to strengthen communication — focused education both at the undergraduate level and within continuous professional development.

Broader Context. Demographic trends indicate continuous population ageing and growing demand for complex geriatric care. In this context, eliminating age-biased communication and protecting the dignity and autonomy of older adults should be viewed as a core quality standard across healthcare systems [4,20,21]. Our findings underscore the relevance of these priorities.

Taken together, our findings reveal a coexistence of effective and potentially inappropriate communication behaviors among nurses interacting with older patients. While eye contact and other elements of respectful communication are widely practiced, features of elderspeak remain prevalent. Education and clinical experience clearly differentiate communication quality, highlighting the importance of targeted curricular strategies and continuing professional training.

Conclusions

The findings of this study demonstrate that while nurses frequently apply positive communication strategies — such as maintaining eye contact — elements of inappropriate communication, including features characteristic of elderspeak, remain common in interactions with older adults. A substantial proportion of nurses reported using a raised tone of voice, slower speech tempo, diminutives, and exaggerated nonverbal expressions. These behaviors, although sometimes intended to support understanding, may be perceived as infantilizing and can negatively affect the dignity and comfort of elderly patients.

The analysis further revealed that education level and length of professional experience significantly influence several communication behaviors, indicating that professional training and accumulated clinical practice improve the quality of nurse–patient communication. However, the limited awareness of the term elderspeak among respondents suggests a gap in knowledge that should be addressed in both undergraduate and continuing education.

In summary, effective, respectful, and individualized communication remains essential in geriatric nursing care. Eliminating inappropriate communication patterns and reinforcing professional communication skills are key to improving patient trust, safety, and overall quality of care for older adults.

Limitations

Interpretation of results should take into account the small sample size (N=75) and the use of bootstrap confidence intervals, which suggest caution regarding generalizability. Additionally, the study employed a non-standardized, researcher-designed questionnaire, which may influence measurement accuracy of communication characteristics. These limitations are inherent to the study design and should be considered in planning further research.

Implications for Nursing Practice

Based on the results of this research, several practical recommendations emerge that may enhance communication quality and improve the overall care experience for elderly patients.

Strengthen education on communication with older adults. The low awareness of elderspeak and its consequences highlights the need to integrate more structured content on geriatric communication into undergraduate nursing curricula and postgraduate training. Courses should include practical examples, simulations, and case-based learning.

Promote awareness of inappropriate communication habits. Given the high prevalence of raised tone, slow speech, diminutives, and exaggerated nonverbal behaviors, targeted interventions should focus on helping nurses recognize and eliminate infantilizing language and gestures in routine practice. Educational materials, workshops, and reflective practice sessions can support this effort.

Encourage individualized, person-centred communication. Nurses should adapt their communication style to each patient's cognitive, sensory, and emotional needs rather than relying on stereotypical assumptions about older adults. Person-centred approaches enhance trust, improve patient participation in care, and support autonomy.

Allocate protected time for communication. The study supports previous findings indicating that time pressure reduces the quality of nurse–patient communication. Healthcare institutions should consider organizational changes that allow nurses sufficient time to interact meaningfully with elderly patients beyond procedural tasks.

Implement communication skills training in workplace settings. Regular in-service training — including communication models, feedback-based supervision, and standardized communication tools — may help improve clarity, reduce misunderstandings, and strengthen nurse–patient relationships.

Foster reflective practice and team dialogue. Encouraging nurses to discuss challenging communication situations and reflect on their own communication styles may support professional growth and reduce the unintentional use of elderspeak.

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A — Concept and design of research, B — Collection and/or compilation of data, C — Analysis and interpretation of data, D — Statistical analysis, E — Writing an article, F — Search of the literature, G — Critical article analysis, H — Approval of the final version of the article, I — Acquisition of assets [eg financial]

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