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MDS Alert

Person-Centered Care: Use These Words, Avoid Certain Tones

Brush up on how your language affects every aspect of the care you provide.

Your facility can adjust its policies and procedures to prioritize residents and put them at the center of their own care, but real culture change will come when even language is truly resident-centered.

Pioneer Network, based in Rochester, New York, has led the way in the movement to change the culture of care in skilled nursing facilities. **Judah Ronch, PhD, and Galina Madjaroff, MA,** faculty at University of Maryland, Baltimore County, offer tips for small but mighty language adjustments for skilled nursing facility employees and other workers in long-term care in a paper: The Power of Language to Create Culture.

Here are some explanations of phrases and concepts to use and keep in mind, especially during care planning meetings, but also in your daily interactions with residents and colleagues.

Prioritize the use of some words or phrases over others, Ronch and Madjaroff say.

- Use the word "home" instead of "facility" in conversations with residents and their representatives.
- Try to think about (and call) those in your care "people" instead of "residents." This is a subtle but meaningful adjustment that can help you and your colleagues more fully realize and remember that the people who need your help now are interesting, accomplished people whose lives exist beyond the walls of your facility.
- Although the logistics involved in providing high-quality care to multiple people requires some organization, you can substitute the word "choice" for "schedule" to provide those in your care with more say in their health and choices.

These simple changes can be the foundation for a shift in the understanding and delivery of care for both the care providers and the recipients. "These are changes not only in language but more importantly in practice - welcome, refreshing changes with profound impact on the lives of people living and working in what is commonly referred to as long-term care," Ronch and Madjaroff say.

Recognize people, not their illnesses

When you're responsible for so many people, especially when they have medical issues that you must remember, it may seem easiest to remember individuals by thinking about their diagnoses. For example, you may think of Mr. Johnson, whose blood sugar you or a colleague measures every day, as "the diabetic," instead of Mr. Johnson, who lives with diabetes. This kind of categorizing can reduce people to their diagnoses or diseases, which can have subtle but outsize effects on how you perceive or treat them. The disability community developed the framework for person-first language, and is encouraging awareness in everyone's usage of language.

The tone you use when speaking to people in your care is also crucial. Avoid any temptation to talk to those in your care with different words, pitch, or speed of speech, Ronch and Madjaroff say. Here are some pitfalls to avoid:

- Baby talk
- Accommodative speech: Don't fall into the habit of making the pitch of your voice higher, exaggerating the pronunciation of words, or slowing your speech when talking to people in your care. It's definitely OK (and often necessary) to speak more loudly, especially if those in your care experience hearing loss.
- Institution-speak, such as employing "we" instead of "you" when speaking to those in your care or employing terms of endearment that aren't organically felt

- "Elderspeak," which is a variation on baby talk, and can involve lots of "cutesy" words that end in "y," as well as "words or phrases that reinforce ageist stereotypes that suggest that aging is the same thing as deterioration or failed adulthood such as 'we let our residents,' 'that resident is so cute' and 'my uncle still ....'" say Ronch and **William thomas, MD.**

Though acknowledging and documenting the minutiae of care is crucial for the logistical aspect of providing such important care to so many people (as well as for business), measuring the quantity of care you provide is different from evaluating the quality of care. You can seeand hear the difference in the language, say Ronch and Madjaroff.

"This tradition of documenting using measureable, precise quantified methods for readily measured biological areas of life (i.e. bowel and bladder output, pain intensity, medication records, treatment records, meal intake records) has made the language of work in the nursing home emphasize the information communicated through the vocabulary of science and technology, and confers its high status on those who master the scientific language, such as the doctors and nurses," Ronch and Madjaroff say.

Top Tip: Consider the difference in language during your next assessments and interviews. Remember, you're not asking the people in your care to talk about any discomfort for the sole purpose of adding problems to the clinical record, but because you want to help them become as comfortable as possible.

For example: Think about Section J's Pain Assessment Interview and consider how you and team members can make sure the person feels listened to, and the full scope of his or her pain (not just that it occurs, but that it affects other aspects of life).

Traditionally, you or a team member may ask about and record the presence of frequency of pain, and then work with the rest of the care planning team to figure out how to reduce the pain. "So while the degree of pain a person reports is documented on a pain scale and made part of the 'official record,' how the person feels about what the pain is doing to his/her quality of life is not," Ronch and Madjaroff say. If staff can more fully realize how to acknowledge and mitigate the further-reaching ripples - like quality of life - then staff can truly provide person-centered care.

Read more about how language is the key to unlocking better care provision here: https://www.pioneernetwork.net/wp-content/uploads/2016/10/The-Power-of-Language-to-Create-Culture.pdf.