**Reviewer's report**

**Title:** Giving permission to care for people with dementia in residential homes: learning from a realistic synthesis of hearing-related communication'

**Version:** 0  **Date:** 01 Dec 2018

**Reviewer:** Kathleen Pichora Fuller

**Reviewer's report:**

Overall Comments: The paper is well-written and thought-provoking. It develops a theory using a seldom used 'realistic synthesis' approach to review literature and consider expert opinion concerning the complex situation of the management of hearing-related communication for people living in care facilities who have hearing loss and/or dementia. I enjoyed reading the paper. I have worked on this issue for over three decades and this paper prompted me to think about it in a new way. In particular, I found the CMOC and Figure 2 to be helpful. Nevertheless, the more I thought about these interesting ideas, the more I became convinced that the work as reported in the present paper is not as complete as it could/should be. It has not positioned the work in the most appropriate broader scholarly and health care system context. By starting with a focus on hearing, the literature search and the following realistic synthesis does not seem to connect well to the more mature broader literature on communication in this population and setting.

References: Clearly the authors have covered a wide inter-professional and inter-disciplinary literature, but it still seems to me that the paper overlooks some relevant works (examples listed below). These works may have been missed because some are very recent and some very old. The older ones may have been missed because the term 'home for the aged' was used to refer to residential care (these terms vary with jurisdiction and have changed over time). More importantly, I suspect that the focus on 'hearing' may have resulted in the broader and highly relevant literature on 'communication' being overlooked. Some authors who have carved out concepts, theories and empirical research regarding communication, health and aging in fields such as speech-language pathology, nursing, socio-linguistics etc. are suggested below.

Work of Marie Savundranayagam (including the Gerontological Society of America documents that provide guidance for communicating with people who have dementia):
https://scholar.google.ca/citations?user=OoVWV5IAAAAJ&hl=en

https://www.geron.org/publications/communicating-with-older-adults

Work of JB Orange on communication with people who have dementia:
https://scholar.google.ca/citations?user=w5fGMIQAAAJ&hl=en
Work of Jeff Small on communication training for communication partners of people who have dementia: http://audiospeech.ubc.ca/faculty-staff/academic-faculty/jeff-small/

Work of Katherine McGilton on communication between nurses and residents in long-term care: http://katherinemcgilton.com/index.html

Work on audiologic rehabilitation in nursing homes by Ronald L. Schow (see also multiple editions of the text on AR edited by Schow & Nerbonne: https://www.semanticscholar.org/author/Ronald-L-Schow/4724275


Specific Comments:

Abstract: "hearing communication" seems odd. It is common to talk about "speech communication". Probably the most appropriate term would be 'hearing-related communication' (which the authors do use later in the abstract but not throughout the paper). Using 'hearing communication' fits if the focus is on problems arising from hearing loss in a unimodal world. However, for this population in this setting, it seems to be problematic not to accept upfront that communication is multi-modal (hearing, vision, tactile, smell) and that all modalities need to be optimized to enable the person with dementia to connect to their social and physical environment in the most meaningful way. See GSA documents on communication with older adults which
foster this more comprehensive approach to communication that would apply to those who have dementia and/or hearing loss.

P 3, line 53: "more" compared to what? There are a number of places in the paper where comparative language is used without stating the comparator.

Pg 4, line 55: I think the authors need to question the place of hearing aids in care, especially for this population within this setting. Many authors have argued for an ecological approach (consistent with the WHO ICF) within which the use of hearing aids plays a relatively minor role, with more emphasis put on modifying the communication environment (e.g., see work of Mary Beth Jennings: https://www.cjslpa.ca/detail.php?lang=en&ID=137).

P 5, line 25: reference 20 is to palliative care but this important detail is glossed over in the use of the reference in the text. Following the authors own emphasis on the importance of context, they need to be more careful to distinguish between types and degrees of dementia and the presence of comorbidities rather than making potentially misleading over-generalized claims. A principle of aging research is to acknowledge heterogeneity and it would be incorrect to assume that there was a single account for all people who have dementia and/or hearing loss or even that an individual would have the same needs over time.

P 5, line 36: It seems that it would be useful to frame the important interactions of person and environment in terms of well-known gerontology theories (e.g., competence-environmental press) or even the WHO ICF. (for a review and general theory see Wahl, H.-W., Iwarsson, S., & Oswald, F (2012). Aging well and the environment: Toward an integrative model and research agenda for the future, The Gerontologist, 52 (3), 306-316.)

P 5, line 58: The authors state that they used the RAMESES quality and publication standards. However, most readers would not be familiar with RAMESES so it is not very helpful to claim to have complied with an unfamiliar standard, especially since there is no accounting of how exactly the present work was evaluated with respect to the standard. Does the present work meet all the criteria of RAMESES and if so how was this determined? I'm not sure what is actually unique about RAMESES since the elements of literature review and team discussion to develop theory do not seem to be new?

P 12. Line 2: See also work of McGilton

P 14, line 5: typo "fee" instead of "feel"

P 16 - it seems to be highly important to also appreciate the complementary use of vision by the high number of residents who will have dual sensory loss.
P 17 - If the authors want to focus on the concept of "permission" then it seems that this concept warrants its own literature review and a scholarly discussion comparing it to other prevailing concepts in the literature, including pertaining to communication with people who have dementia and/or hearing loss. There is some discussion in the paper about how 'permission' is compatible and likely necessary with the concept of 'patient-centered care'. There is mention of the staff needing to have 'authority'. I suspect that 'responsibility', the converse of 'authority', is also key yet the scope of professional responsibilities (duties) are not examined as carefully as might be useful. I appreciate the proposal of 'permission' as a factor in how health professionals fulfill their roles, but I don't think it is unique to communication with residents who have dementia and/or hearing loss. I wonder if the experience in the local settings where the experts worked may have been overly influenced by somewhat localized organizational challenges in the design of facilities and the delivery of care. Over the last decade, there have been many advances in the design of care facilities around the world and I'm not sure that the local experts were working in settings that are representative of the most modern practices. Perhaps the authors should present their study as a case study of the particular facilities they based their research on and also position the notion of 'permission' in a wider scholarly context including how it maps to the scopes of authority-responsibility for the various professionals? There is an enormous literature about the evolution of the notion of authoritarian vs. equalitarian approaches to clinician-patient communication in the literature on communication, health and aging (see classic works by authors such as Jon Nussbaum, Ellen Ryan, Howard Giles, MaryLee Hummert, Jo Ann Perry).

P 18 - "causal connections, beyond our analytical claims that certain contexts are related to one or more mechanisms and caused certain outcomes." On the one hand, I find the "CMOC" approach to be attractive insofar as it seems to offer a logical way to guide care planning and evaluation. On the other hand, I have serious doubts that this cause-effect view could actually work, especially for the population and setting in question. It seems that it may be more appropriate to adopt a systems model that acknowledges that there are interactions that may differ dynamically depending on the, possibly moment-to-moment, fluctuations in the person-environment fit. Processes may be more important than mechanisms. Dynamic adjustment of the system may be more important than somewhat static mechanisms. The over-arching goal of care may be to stabilize the person-environment balance for the person with hearing loss and/or dementia as demands fluctuate due to person and environment issues. How do the CMOCs drive goal-setting or vice versa? How would outcomes be evaluated to determine the success of care?

Pg 19, line 52 "This notion of permissive leadership chimes with McCormack et al (75), looking at person-centred care in general." See comment above about page 17.

Pg 20, line 2 "In addition, we believe this concept is potentially transferable, beyond hearing communication, to other complex care activities within the care home setting." I think the authors have the direction wrong - rather than it being the case that findings about hearing communication may generalize, it seems to me to be more the case that the broader culture of caring over-arches the shaping of the delivery of many forms of care, including hearing care. Indeed, this seems to be consistent with the authors comments about the importance of buy-in by
organizational leaders and managers. It may be that communication is integral to multiple relationships in the circle of care. I think the authors could frame their work at a more optimal altitude.

Figure 2 is key and needs to be explained in a caption.

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