LONG-TERM CARE AND RESPECTING OF THE SOCIO-CULTURAL AND PHISICAL DIVERSITIES AMONG NURSING STAFF AND RESIDENTS WITHIN THE ELDERLY HOMES

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Abstract: According to a 2019 report from the Agency for Healthcare Research and Quality, racial and ethnic minorities face more barriers to care and receive poorer quality of care when they can get it. Findings from the report included: Blacks received worse care than whites, and Hispanics received worse care than non-Hispanic whites for about 40% of quality measures. American Indians and Alaska Natives received worse care than whites for one-third of quality measures.
It is especially important to notice that the diversity will improve patient-nurse communication, collaboration and clinical practice for patients of all backgrounds. Experts believes the preparation to attain a formal education begins with good prenatal care, proper nutrition and support for parents. Also, there is a difference between caregivers who tend to look more toward the physical aspects of illness, and the ones who are accustomed to a holistic way of viewing a person. This paper presents the dimension of significance of socio-cultural and physical differences, both between medical staff and patients. On the basis of the stated, it is pointed out that it is necessary to respect the diversity and to emphasize mutual cooperation and positive communication in order to maximize the retention of professionalism, both between the medical staff and the sister-patient relationship. Increasing the numbers of minority and disadvantaged persons in the health and allied health professions to care for the underserved, such as the elderly, is an important component of health care reform. Shortages of minority providers may adversely affect access, cost, and quality of care. At the same time, the background and characteristics of many elderly nursing home staff may adversely affect their job performance. The lives of many nursing assistants, in particular, are beset with personal problems and tragedies that leave them with too few personal resources to respond effectively to residents and that interfere with their ability to provide quality care to the frail, dependent elderly. In their ethnographic study on quality of care, nursing homes, and nurse aides' cultures, Tellis-Nayak and Tellis-Nayak (2015, 307) concluded that the "institutional culture of the average nursing home not only ignores the affective needs of the nurse's aides, but it even assaults their self-esteem." This paper presents the dimension of significance of socio-cultural and physical differences, both between medical staff and patients. On the basis of the stated, it is pointed out that it is necessary to respect the diversity and to emphasize mutual cooperation and positive communication in order to maximize the retention of professionalism, both between the medical staff and the sister-patient relationship. Regarding the methodological framework, the paper uses the method of content analysis, method of comparison, method of synthesis and generalization, in order to draw relevant recommendation. In conclusion, increasing diversity in the workforce, will take individual and group efforts. In addition, some organizations have very active programs to promote diversity in leadership, but the diversity gap in leadership continues. Following, it is important for the minorities to be able to
participate in making changes to improve the practice environment and outcomes, which is very important.
Keywords: nursing staff, minority, elderly persons, elderly home, care

1. INTRODUCTION

Increasing the numbers of minority and disadvantaged persons in the health and allied health professions to care for the underserved, such as the elderly, is an important component of health care reform. Shortages of minority providers may adversely affect access, cost, and quality of care. At the same time, the background and characteristics of many elderly nursing home staff may adversely affect their job performance (Burgio, Scilley, 2017). The lives of many nursing assistants, in particular, are beset with personal problems and tragedies that leave them with too few personal resources to respond effectively to residents and that interfere with their ability to provide quality care to the frail, dependent elderly. In their ethnographic study on quality of care, nursing homes, and nurse aides' cultures, Tellis-Nayak and Tellis-Nayak (2015: 307) concluded that the "institutional culture of the average nursing home not only ignores the affective needs of the nurse's aides, but it even assaults their self-esteem." They also assert that out of a concern for quality, advocates and policymakers have inappropriately reduced a complex problem to one of staffing and training issues alone, failing to appreciate the important role social history can play in staff apathy and lack of concern for residents.
Every individual carries a cultural heritage, and older people generally have more ties to their heritage than do many in the younger generations. Elders of particular ethnic or racial minority groups may have customs and beliefs that

are important to them, but are no longer remembered or respected by the young. Although it is important for staff to respect and attend to the cultures of Black, Hispanic, Asian minorities, African minorities etc it also should be remembered that many Caucasian persons are also members of ethnic groups that have distinct cultures, such as Jews, Poles, or Irish persons (Snyder, 2017). While it is neither practical nor necessary for staff to share the same ethnicity or cultural heritage as the residents, staff do need to learn about the usual lifestyles and backgrounds of the elders for whom they are caring. Even staff who share a common culture with residents may find that differences between generations present obstacles to understanding and respect. The main goal of the paper is to point out that a clash of beliefs about health and illness and about appropriate remedies and treatments may be disconcerting to both staff and residents. When staff have some knowledge about the usual practices and beliefs of residents, there is a basis for communication that can optimize care and the residents' compliance with recommended treatment. The main recommendation of the paper is that in order to promote adjustment in the elderly nursing home, staff need to know at least some of the basic vocabulary of the residents, and it is important that someone, either volunteer or staff, be available for translation when elders speak limited English (Snyder, 2017). Furthermore, Problems related to cultural and racial diversity are particularly acute in urban elderly nursing homes, where a majority of staff may belong to minority groups, whereas the residents are predominantly white (Teresi et al., 2016).

2. MATERIALS AND METHODS

Within this paper, a wide range of information is presented, classified on the basis of a set of methodological framework, in the domain of qualitative research. Namely, in relation to the applied methods, the paper is dominated by the method of content analysis, method of comparison, method of synthesis and generalization. Additionally, the main goal is through the analysis of existing data, obtained from various reports, existing literature, print media and research centers, to draw relevant conclusions that will have a special contribution in setting future recommendations, realistically applicable and relevant for a certain period of time. and spatial framework. The scientific data sources used in the research are of theoretical and practical nature. In addition to secondary data sources, the author creates a realistic interpretation of the data, by entering his position and interpretation, without violating the concept of objectivity and transparency, while respecting the ethical dimension and moral aspects in the domain of the issue.

3. RESULTS

There is a lack of research and thus an inadequate knowledge base about the long-term health care needs of minority elders and other age groups. The research that does exist strongly suggests some disparity of service use and inequity of access for ethnic and minority populations, despite increased need (Barresi, Stull, 2010). While the general growth of the elderly population in the United States is well known, the increase in racial and ethnic elderly populations is less well recognized. Yet the elderly population is increasing faster among ethnic and racial minorities populations than among whites, and the total population of ethnic and minority elderly has doubled with each national census since 1960. In some parts of the world, these ethnic and minority elderly will soon be the majority among the population aged 65 years and older. A significant increase in the population 85 years of age and older and in the number of females is also occurring, and a substantial proportion of these elderly are of racial and ethnic minorities.

Despite having poorer health and less help from relatives than comparison groups of white elders, black elders are less likely to be institutionalized. At comparable rates of frailty, the likelihood of elderly nursing home admission for blacks is less than half that of whites (Belgrave, Bradsher, 2015). Poverty, geographical isolation, and discrimination are now given more weight in this pattern than the previous characterization of personal preference.

Although the Indian Health Service (IHS) has a statutory responsibility to meet the health needs of American Indians, it tends to define its mission in terms of acute care. As a result, the rapidly increasing long-term-care needs of the growing numbers of aging tribal members are largely ignored. Moreover, an additional problem confronting tribal elders is a policy of age discrimination in resource allocation. Specifically, he notes that some institutions concentrates its resources on the health problems of younger tribal members through the Resource Allocation Method, which is based on a calculation of potential years of productive life lost. This strategy virtually ignores health issues for elders over age 65. For example, there are only ten reservation-based elderly nursing homes in the United States, and they currently house 435 residents (Manson, 2009). A National Indian Council on Aging report indicated that 46 percent of older tribal members are assisted by extended family members to accomplish one or more activities of daily living.

Data regarding long-term care of the minority population are particularly lacking in respect to Hispanic elderly people, especially given the fact that Hispanics make up about 4 percent of the elderly population in the United States and are the fastest growing subgroup of the elderly (Lopez-Aqueres et al., 2014). More than 600,000

Hispanics are over the age of 65. What data do exist show that Hispanic populations report greater utilization of informal support systems than of professional health care providers. As with Asians and Pacific Islanders in the United States, elder Hispanics face hypertension, tuberculosis, and cancers as their major health concerns. These elderly are less likely to use formal health care services, including nursing homes, due to lack of knowledge of available services, cultural and language differences, and reliance on traditional medicine.

In a study of nine elderly nursing homes in San Antonio, Texas, Chiodo and colleagues found strong evidence that Mexican American nursing home residents are more cognitively and functionally impaired, after controlling for age and education, than non-Hispanic white residents. They also were significantly more likely to be funded by Medicaid, and they were more likely to have lived with relatives prior to institutionalization.

Major differences between Puerto Rican Hispanics and non-Hispanics admitted to nursing homes were identified in a study by Espino and coworkers. The Puerto Rican Hispanics were significantly younger and functionally more impaired, both physically and mentally, than their non-Hispanic counterparts and more similar to chronologically older non-Hispanic nursing home residents.

Some research documents the need for nurses to be aware of the implications of ethnicity in caring for the elderly. In a study of immigrant, Canadian-born, and Anglo-born elderly in long-term-care facilities, Jones and Van Amelsvoort Jones found significant differences in the observed interactions among the groups. Although the elderly as a whole had minimal verbal interaction directed to them during morning and evening care, overall, male residents were spoken to less than female residents, and ethnic females had the least number of commands, the fewest statements, and the least number of questions spoken to them by staff.

4. DISCUSSIONS

By 2030, the elderly will comprise 20 percent of the population and use 30 percent of health care resources (Select Committee on Aging, 2018). The majority of residents in elderly nursing homes will be 80 years and older, have multiple chronic illnesses, and be cognitively impaired. Because of continued short hospital stays for acute illnesses and increased use of home care services where possible, residents in nursing homes will tend to be sicker and more acute illnesses will be treated in the nursing home. At the same time, alternative settings, such as assisted living and group home facilities, will be more available and will house more of the younger elderly with fewer or less severe impairments (O'Connor, 2015). More emphasis in these facilities will be placed on rehabilitation to maintain and improve function. Convalescent nursing homes are also expected to be more prevalent, with many elderly discharged to their own home after a short stay for recovery and rehabilitation.

Elderly nursing homes will also include greater numbers of residents with AIDS, more residents with infections like methacycline-resistant *Staphylococcus aureus* and tuberculosis, elderly who are developmentally disabled, residents requiring rehabilitation, and hospice residents. Special units devoted to the care of residents with these conditions, as well as residents on ventilators and with pressure sores, are expected to increase.

Although it is positive that more alternatives to nursing homes will be available for the elderly, the downside is that the majority, if not all, of the residents of nursing homes will require more complex and intensive nursing care, and most will be highly functionally debilitated both cognitively and physically. Logically, this changing case-mix has clear implications for the types and numbers of staff that will be required to deliver quality care. More professional nursing staff (registered nurses) with gerontological training and greater use of gerontological nurse practitioners will be needed, both to plan and provide care and to direct and supervise the care provided by assisting staff. The nature of the work with mostly "old old," highly debilitated residents will provide quality-of-care challenges for assisting staff that they will not be able to meet without professional leadership and direction, and it will exacerbate stress, burnout, and turnover problems that are already of great concern.

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Discrimination against nurses in the elderly homes of different racial identity can happen in many ways. Patients are one of the primary offenders and can often refuse treatment from nurses who are not of their *preferred racial type*. This can cause hurt and confusion for the nurse who just wants to help and do their job.That is not where racial discrimination stops, however. An American study by Bessent discovered that 60% of African-American nurses,

53% of Asian / Pacific Islander nurses and 46% of Hispanic nurses felt they were overlooked for promotion due to their race (2012). Sometimes co-workers and doctors can use racially-motivated put-downs to silence a nurse they do not agree with in an attempt to bully them. Comments like '*go back to where you came from*' are rare but generally lead to feelings of hostility between co-workers (De Parle, Nancy-Ann, 2013).

One of the biggest causes of discrimination in nursing comes from accepting men as nurses. The Australian Human Rights Commission received 93 complaints from men under the *Sex Discrimination Act* in 2014 and 2015 (2015), but these numbers cannot fully encompass how much male nurses struggle for acceptance in this profession.

A study conducted on 498 male nurses concluded that the reason/s so few men are in nursing is due to the negative stereotypes, the domination of women in the fieldand the lack of male role models. Other reports have pointed to textbooks that always refer to nurses as '*she*' and nursing school faculty that are outwardly hostile to men who pursue a nursing degree.

Men are also not welcomed in the fields of obstetrics and gynecology, and men are often uncomfortable when examining the genitalia of female patients. This is because they are not taught proper techniques and approaches for men due to a gender bias in nursing schools.

If nursing could learn to embrace the idea of men as nurses, then male nurses could give better care to their patients.

Nurses with disabilities are often discriminated against because of the fear that they will harm the patient. Yet with reasonable accommodation, nurses who have a range of disabilities can be contributing members of the team. Nurses who have hearing loss can get amplified stethoscopes and use pagers that vibrate to answer calls from patients.

If a nurse has attention deficit disorder, he or she can learn methods to focus his or her attention or take medications to control the condition. Even physical disabilities, such as paraplegia, are not a barrier to becoming a successful nurse. A nurse with this disability could work in nursing informatics, telephone triage or work for an insurance company.

Many avenues exist for a differently-abled person to use the knowledge that nursing would give them, and they have the right to learn it, regardless of their disability.

5. CONCLUSIONS

Although Walton said the healthcare community is far from reflecting the demographics of the American population, she has hope as she looks into the future because diversity in the nursing workforce is being highlighted as a critical priority by more than minority nursing organizations.

Increasing diversity in the workforce, will take individual and group efforts. According to the 2019 National Sample Survey of Registered Nurses in USA, the largest sample to date, minority nurses were more likely to hold staff nurse positions than white, non-Hispanic nurses. Black nurses comprise 5.4% of the RN workforce, and 13.8% are in management positions, which is higher than any other ethnic group. Walton, however, said far more black nurses still are needed in leadership positions because this 13.8% is taken from a small pool of nurses.

Some organizations have very active programs to promote diversity in leadership, but the diversity gap in leadership continues. Still, there is a gap between how many minorities are recruited and how many are actually hired. These minorities in leadership roles are able to participate in making changes to improve the practice environment and outcomes, and this is very important.

This paper presents the dimension of significance of socio-cultural and physical differences, both between medical staff and patients. On the basis of the stated, it is pointed out that it is necessary to respect the diversity and to emphasize mutual cooperation and positive communication in order to maximize the retention of professionalism, both between the medical staff and the sister-patient relationship.

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