



**Residential aged care nurses caring for dementia residents from
culturally and linguistically diverse backgrounds**



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Executive summary

This research project investigated residential aged care nursing of people with dementia from culturally and linguistically diverse (CALD) backgrounds. The research used qualitative methods to collect and analyse data from nine registered and enrolled nurses working in two ethnically specific residential aged care facilities in metropolitan Adelaide. It identified both general and culturally specific strategies which nurses use when caring for dementia residents. A number of problems encountered in caring for CALD residents emerged from the nurses' accounts of their work. The project also looked at the issue of resources and identified resources currently in place that were helpful for CALD aged care nursing and some that were lacking. This report concludes with recommendations for further research.

1. Introduction

This project investigated the role of nurses caring for people with dementia who are from culturally and linguistically diverse backgrounds and resident in an aged care facility offering ethnically specific aged care services. The literature on caring for people with dementia from ethnic backgrounds was found to be sparse, and most of it was centred on community care rather than residential aged care. Also, most of the research has been conducted overseas. The next section of this report briefly discusses this literature.

The third section on research methods describes the recruitment of participants, the research method used to collect and analyse the data, and the research questions that this project investigated. The fourth section presents the findings in relation to the research questions and the final section outlines recommendations for further research.

2. Literature review

The term ‘culturally and linguistically diverse background’ (CALD) was developed as a response to the limitations of the term ‘non-English-speaking background’ (NESB) which has been widely used but does not take into account the fact that there are many migrants in Australia who may speak English well, yet have cultural backgrounds that are very different from those of Anglo-Celtic Australians, for example Malaysians, Indians, and Singaporeans. It is used to include differences that result from a person’s country of birth, culture, language, race and religion, but is not restricted to these factors (Australian Institute of Health and Welfare 2001: xvii). The term ‘non-English-speaking background’ (NESB) is still in use in the academic literature, but it has been noted that it is ‘a crude categorisation which does not take account of the significant heterogeneity between and within ethnic communities’ (Hassett & George 2002: 626).

It is well known that Australia has both a multicultural society and an ageing population. However, the proportion of the aged population that was born overseas, particularly those from non-English backgrounds, is increasing. The growth rate of this group of elderly people is at least four times that of Australian-born elderly (Hassett & George 2002: 623). It is estimated that by 2011, one in every five people aged 80 years and over will be from culturally and linguistically diverse backgrounds (Australian Institute of Health and Welfare 2001: xviii). This indicates a need for culturally appropriate aged care services.

Australian aged care services need to manage the complexities of caring for a significant number of elderly people who do not speak English. These people are often marginalised from mainstream society and may feel rejected by their own cultural group because of their illness (Hassett & George 2002: 624). There is some evidence that people from culturally and linguistically diverse backgrounds that are suffering dementia may have less access to services, and that dementia may be viewed differently across cultural groups. A paucity of cross-cultural studies of behavioural and psychological symptoms of dementia has been noted (Haider & Shah 2004). However, studies that examine access to psychiatric clinics have found that elderly migrants from culturally and linguistically diverse backgrounds often have a low level of education, and a poor proficiency in English (LoGiudice et al. 2001: 328; Hassett & George 2002: 626), with women being less proficient in English than men of the same ethnic group (Hassett, George & Harrigan 1999: 577). In some ethnic groups, a decline in mental health is associated with stigma and shame (Hassett, George & Harrigan 1999: 576; Milne & Chryssanthopoulou 2005: 322). In some cases people's experience of dementia may be limited by the low life expectancy in their homeland reducing the number of people attaining a sufficient age for the onset of dementia, and because they may have migrated before their parents became elderly (Rait & Burns 1997: 976).

The most common primary diagnosis made by Aged Care Assessment Teams (ACATs) in Australia is dementia. It is associated with a high rate of admission to permanent residential care (Australian Institute of Health and Welfare 2007: 179). In 2003, there were 67,650 people in permanent residential aged care who had dementia and Alzheimer's disease; or 48 percent of the permanent resident population. Of this group, 83 percent were in high care settings and over half (56%) were aged over 85 (Australian Institute of Health and Welfare 2007: 180).

In 2006–07, about 27 percent of residents in residential aged care facilities was born overseas, and 14,722 permanent residents preferred to speak another language other than English (Australian Institute of Health and Welfare 2008: 44). Birthplaces of permanent residents not born in Australia have been categorised into other, Oceania/New Zealand/Antarctica, UK and Ireland, North/West and South/East Europe, North Africa/Middle East, Sub-Saharan Africa/South Africa, Southeast and Northeast Asia, Southern Asia/Central Asia, North America and Other America/Caribbean (Australian

Institute of Health and Welfare 2008: 66). This means that Australia's multiculturalism is of a global dimension and to provide ethnically specific aged care services is a complex challenge.

When people in residential aged care facilities who are suffering dementia and have CALD backgrounds come from such a diverse range of cultures, knowledge of the different cultural beliefs and behaviours of the various CALD communities related to health care is important for the provision of appropriate health care services (Hayward-Wright & McKenzie 2005: 15). The challenge in caring for clients from CALD backgrounds is to explore how they are supported by the current system and how this system can be improved to better support their cultural needs (Wall, Santalucia & Kyriazopoulos 2005: 135).

All of these factors are likely to affect the ability of nurses to care for elders from culturally and linguistically diverse backgrounds with dementia. There is a need for empirical studies to explore the complexities inherent in caring for this growing group of elders.

3. Research design and method

This research project investigated the complexity of providing nursing care to high care residents with dementia by investigating the following:

1. How do nurses understand their role in caring for residents with dementia?
2. Do nurses use different strategies when caring for dementia residents from culturally and linguistically diverse backgrounds?
3. Do nurses have enough resources to provide good quality holistic care to elders with dementia who are from culturally and linguistically diverse backgrounds?

Following approval from the university ethics committee, nurses were recruited by contacting directors of care at residential aged care facilities listed in the multicultural aged care resources guide at:

[www.culturaldiversity.com.au/Portals/0/MAC_Resource_Directory -A Guide to services for older people from CALDB Text 06.pdf](http://www.culturaldiversity.com.au/Portals/0/MAC_Resource_Directory_-_A_Guide_to_services_for_older_people_from_CALDB_Text_06.pdf)

This proved to be problematic. Directors of care were initially contacted by phone and then sent an email letter asking if they could accept recruitment materials to give to their nursing staff. This resulted in one acceptance via email. Follow-up phone calls and emails resulted in another two

acceptances. Residential aged care facilities were then contacted by phone and a time arranged to deliver the recruitment materials together with a consent form to be signed by the site manager when they accepted the flyers and information sheets. A total of 90 flyers and information sheets were distributed to six residential aged care facilities that offered ethnically specific services in the Adelaide metropolitan area. Nine nurses from two facilities were interviewed. In both these facilities, the site managers who consented to receiving recruitment materials promoted the project to their staff. This is relevant for future research in residential aged care facilities. It appears that the success of the recruitment process, and hence the research, can rely on the enthusiasm and cooperation of the site manager.

One site was a purpose built multicultural aged care facility that offered ethnically specific services to Indigenous Australians, people from the Philippines, Malta, Vietnam, Cambodia, China and people with Spanish speaking backgrounds. This was a large facility operated by a non-profit organisation that offered both high and low levels of care and had ageing in place. The other was a smaller high care facility operated by the Greek community. Therefore the research covered eight cultural groups. However, both facilities also had residents with cultural and linguistic backgrounds other than those that they specifically catered for. Between the two facilities, there were also residents who were German, Russian, Polish, Hungarian, French and Australian. This meant that the range of ethnic groups covered was substantial for a small project.

Participants signed a consent form, filled out a short database questionnaire, and semi-structured, digitally recorded interviews were conducted. The sample of nurses consisted of one director of care, one clinical nurse consultant, one clinical nurse, four registered nurses, and two enrolled nurses. The interviewees were all female, with the exception of one male registered nurse. These nurses ranged in age: two were 30–39, three were 40–49, and four were 50–59. Their experience in aged care varied: three registered nurses had worked in aged care less than five years, both enrolled nurses and one registered nurse had worked in aged care 5–10 years, the clinical nurse consultant had worked in aged care 11–15 years, the clinical nurse had worked in aged care 16–20 years, and the director of care had been working in aged care for over 20 years. Only the director of care was employed full-time, the clinical nurse consultant and the clinical nurse were employed part-time, one enrolled nurse worked full-time across two jobs (a part-time position and agency shifts), the other enrolled nurse worked part-time in one facility, two registered nurses were part-time and one of these also did agency shifts, and two registered nurses had casual shifts in one facility and one of them did agency shifts as well.

As most aged care facilities have some residents from culturally and linguistically diverse backgrounds, the nurses who did agency shifts were able to compare and comment on caring for people with dementia from CALD backgrounds when the facility they are resident in is not ethnically specific. This added an extra dimension to the data. As well as working in a facility that offered ethnically specific services, several of the nurses interviewed had ethnic backgrounds but, most often,

their cultural and linguistic backgrounds were different from the cultures being catered for in the facilities where they worked. The nurses interviewed were Croatian, Dutch, Polish, Greek, Romanian, Japanese and Australian. In several instances, they were able to comment on both the similarities and differences between the cultures of the residents and their own. This added to the richness of the cultures covered and the data collected.

Interviews were transcribed verbatim and, in line with research ethics, all identifiers were removed from the data. The interview transcripts were analysed using NVivo7 software for qualitative research.

4. Findings

The findings of this study are presented in accordance with the three research questions. The first section summarises how the nurses interviewed described their role of caring for residents with dementia. The second section describes the strategies these nurses used when caring for people with dementia and some problems they encountered. The third section covers the resources that these nurses found useful and a few areas where resources could be improved.

The nurse's role

The participants described a multi-faceted nursing role in caring for residents with dementia. Nurses working in residential aged care are responsible for administering the medication prescribed by the resident's doctor, initiating some medication, for example Panadol for mild pain, providing specialised nursing care such as wound management, and accompanying doctors when they visit. They are responsible for making sure that any changes in medication are implemented and that pharmacy supplies are ordered. Nurses are also responsible for observing and monitoring residents and arranging for a doctor to visit when required. They make appointments for residents when necessary, organise transport if required, and liaise with other health professionals. They also spend time with the residents and their family, addressing any concerns they may have and providing information and emotional support.

Oh yes, definitely, all the care we provide, clinical, emotional, you have to give emotional support, sometimes, some of the people with dementia are crying and haven't seen family for so long time, they're saying not for a long time, and you say, 'But your daughter was here yesterday' 'Oh, I don't know' but some is emotional care, the other is physical care, like helping them with dressing, some of them, providing assistance with feeding, providing other care like going to breakfast, taking them there. (Registered nurse)

No—emotional too, and we deal with the family, because most of the families, they can't cope with their relatives to be here, and they ask for advice, they share their thoughts, they look for support ... (Registered nurse)

Although these nurses saw supporting family members as part of their role, sometimes communication with family members was difficult due to a language barrier:

... as a family, they've often got sort of fairly limited English too, they've got that, you know, you have to sort of work out which family member you can talk to, because they understand, and which one you can't because they don't understand, and you know, because you usually ring the next of kin, but if the next of kin doesn't speak English, you've got to ring their daughter or whoever and so, you know, quite tricky. (Clinical nurse consultant)

The nurses' role also involves supervising the carers who help the residents with activities of daily living, such as showering, dressing and eating meals. The nurses are responsible for behaviour management where appropriate and for assisting the carers when necessary. They are responsible for reviewing care plans and making sure that residents receive the appropriate level of care for their needs.

An unexpected finding of this study is that the carers employed in residential aged care are becoming more multicultural. Although both the facilities in this study sought to employ people that spoke the languages required by their ethnically specific facilities, they also employed people from other CALD backgrounds. The reason for this is that the shortage in care staff is being met by international students who work as carers while studying:

It is challenging, but also, I appreciate it too, because these people from different cultures have got a lot to give as well ... The quality of the carer is better, because they're much more educated, these people that come here as students and they're only allowed to work as carers for twenty hours a week, or whatever, because they can't—you know, immigration laws and so forth. So, aged care is one of the few things where they're allowed to work because there's a need here. So, I find that the people that come are often doing law degrees or IT degrees, or registered nursing. So, your carers are intelligent people. (Director of care)

Many of these carers have had no experience in care work before coming to Australia and have English as their second language:

A: Yes it does, because a lot of them don't understand basic English.

Q: So even though they've managed to get into study, their English isn't that good?

A: No. And it's that part as well, communicating, and they've got a nice nature and everything but if they can't interact properly in English, it makes it a bit more difficult.

(Clinical nurse)

The increasingly multicultural care staff makes the nurses' role in supervising and directing the care staff more challenging:

And what I'm trying to sort of develop some ideas on now, on how to improve that sort of basic care of hygiene, for example, looking nice and treating gently, and doing occupational health and safety correctly, and from people that are from different cultures, training them. It's no good giving them a piece of paper with things on it. It's no good showing them a care plan, because they don't look at it, they don't understand it. So, I've noticed that they learn better from seeing. And so, that's not all of them, but I think that is the best way to sort of make sure that people that have dementia are looked after properly, is by teaching them through a visual sort of means, rather than through paper and books, and telling – talking – because of the language thing. (Director of care)

The usual practice in training new staff in both facilities was to pair the new carer with an experienced carer so the new recruit could see how the experienced person provided the care while the experienced carer supervised, instructed and offered support.

In addition, after hours, when the director of care is not on site, the registered nurses are responsible for the whole facility and all the support services, which include the cleaning, cooking and laundry as well as the care staff. They are also responsible for coping with any emergencies, including fire evacuations, and for ensuring the safety of both residents and staff at all times.

Strategies

Nurses described numerous strategies, only some of which were related to the resident having an ethnic background. Those that refer to caring for people with dementia in general are discussed first, then those that are specific to caring for people from a CALD background. Some problems that can arise in CALD dementia care have also been identified.

General strategies

The most common strategy in general was to use the 'right approach' with residents who had dementia:

Well my strategies—a lot of its non verbal anyway, isn't it, a lot of your approach to someone with dementia is non verbal anyway, you know, you're always calm, you know ... (director of care)

And

I think some people don't understand that people with dementia, they respond to the emotions rather than the actual words that's said, and um, yeah, I mean, I find that, the people, it really doesn't matter what language they speak, you can still communicate with people with dementia, you know, if you treat them respectfully and you know um, give them the right emotional care, they can respond back and it tends to work. (Clinical nurse consultant)

Another was to get to know what the resident liked and did not like:

But it depends on whether, as well you get to know what someone likes, you know, for example, well I've got my dad here for example, he's got dementia and I know that he doesn't like to get up in the morning and things like that, he becomes aggressive, so we let him sleep in and get up in his own time and have his meals when he feels like it. (Clinical nurse)

It was also seen as important to spend time talking to the residents:

Well, I feel like I've got a pretty good rapport with most of the residents here and it's just things like you know, just having a chat when I give them their medications for example, I'll sit down and have a chat with them. It might be the same thing day in and day out. There's one lady, this lady here she always says hello, and says my name and I'll say you remember me, and she goes are you married? And it's the same conversation every day, but she loves to, and has a bit of a giggle and things like that. And you can see it, she's really happy to see you and just have that little time with you, even though you're just giving her her medication, do you know what I mean? (Clinical nurse)

And

I think, all the residents it's the way you approach them. If you are kind and talk nicely to them, they trust you more. Some of them, they know my name. Are you [First name]—yes I'm [First name]. It's just the way you approach the residents. Of course, you are wanting to give them the medication, or do this – of course, they become scared then, they do—who is this—yeah, so approach, how you approach them and how you're close to them is very important. (Registered nurse)

When residents with dementia were uncooperative, a common strategy was to put that aspect of their care on hold and come back later:

But you go back, like I say, five minutes later and you'll get a different response. I've had that a lot, even when I go with the agency. (Enrolled nurse)

And

Here, we have a difficult Greek resident, he really doesn't want to take tablets. But I go once and he says, no I'm not getting out from the bed to take tablets, so I say ok, I come later.

(Registered nurse)

Another strategy was to try a different approach:

Well the kind of voice. I'm always loud anyway, but I might go up to them, and instead of going front on, I might go side on—hello—grab their hand—oh I like what you've got there. You know, because some of them might have ... an activity thing, or a book ... and—oh that's really nice—mm, did you have a good day today—and not that they probably understand, but for them it's just enough to get them through. (Enrolled nurse)

Nurses also read body language and used non-verbal cues:

Well say the resident is in pain, they might be able to tell you they're in pain, but they may not be able to tell you where the pain is, like describe it, so you might get them to show you where it is, or, so you say you put your hand where it's sore, or where you're hurting, also, language, because they forget certain words, words, they don't remember what words mean, so sometimes grimacing and expressions, they're frowning, colour, temperature can also mean, if they've got a high temperature, it can also mean they're in pain. (Registered nurse)

These strategies were used whether the resident had a CALD background or not and were seen as usual in nursing people with dementia.

Strategies specific to caring for residents from CALD backgrounds

Both the ethnically specific facilities where the nurses interviewed for this project worked had an interior décor appropriate to the residents' culture. For example, in the multicultural facility, the area designated as the Asian house had Asian décor and the Greek nursing home featured Greek religious icons and had a Greek television channel. Both facilities had community cultural groups that came in and offered culturally specific entertainment. For example, the multicultural facility had Indigenous days when Indigenous community members came in and did Aboriginal art, played the didgeridoo, cooked damper and had a barbeque lunch for all the residents. Because sharing food is central to Greek culture, the Greek nursing home supplied Greek dips, olives and bread at meal times for relatives and residents to share. The Greek Orthodox priest regularly conducted church services in the

nursing home and all the Greek religious and festive days were celebrated. The most common strategy used by nurses caring for residents with dementia whose first language is not English was to learn to say some words in the residents' language:

But a lot of the carers here, and we've had education learning basic Greek, we've got little booklets and pamphlets with basic words. A lot of the carers pick up words, like sit down, eat, what's the matter, have you got pain, how are you, you know.

Q: So, you do teach the staff to say those Greek words?

A: Yes and the staff are very pro-active in that way, anyway. (Director of care)

And

Yeah, and it's not just Greek, it's like you know, my Dad's Polish and then there's another lady who's Polish so they learn a few words in Polish from me, and it just helps, you know, in the day to day, even French, we've got one lady who's French and just to learn a few French words, just to say *bonjour* lights up her face, you know, that you're trying to be able to communicate with them. (Clinical nurse)

It was helpful if a staff member spoke the resident's language:

Different strategies, um there's one lady here, she's Polish as well, because I'm Polish speaking. So obviously if you speak their language, it's a big bonus. They immediately feel more relaxed that they can talk to you in their language. And I just, I know that she, in her life, she's been a bit of a loner and she's a bit eccentric and whatever, and I just try and bring out things from her past and you know, I've got some music for her in Polish and things that I know that she likes. But you know that you can bring it together and it seems to help her, you know, to calm her down and when she gets agitated or whatever, it really helps her. (Clinical nurse)

Both facilities had training sessions in the cultures and languages specific to that facility and paid staff to attend. They also had cue cards with commonly used words on them and signage in the relevant language. Staff that did not speak a particular language learnt from other staff that did, and there was a cross-fertilisation of cultural information as well. Because English was the residents' second language and, due to dementia, they often forgot how to speak in English, sensitivity resulting from English being the carer's second language was found to be helpful:

A: Yes that's carers. Yeah not so much nurses, but carers are your eyes and ears, they're the ones that give—deliver—the hands on care ... So, as far as emotional care goes, I think (pause) they have an affiliation, especially say, the Indian people with the Greek, because of the demonstrativeness of them. You know how the Greek culture is quite demonstrative?

Q: Yes.

A: Very much touch and hug, and talk and eat, you know, all of that. So, I think it's easy for people to relate, especially if English is their second language or something, because a lot of these people stop knowing how to speak English now. And people from other cultures, English is their second language too, so they rely and they pick up more on the non-verbal stuff that is consistent with a person with dementia, you know? (Director of care)

It was also helpful to know cultural practices:

Indigenous and Asians, they don't tend to look people in the eye, and if you look them in the eye it can be considered an insult, so you've got to be careful ... (registered nurse)

And

... oh it might be the way you present the food to a Chinese lady with dementia and you know, if it's in a nice little Chinese bowl, well then she'll eat it, if it's not, she won't. (Clinical nurse consultant)

This resident was no longer able to manage to eat with chopsticks, but would eat independently with a spoon, though not if the food was served on a plate. Asian residents tended to be unassertive and polite:

You have to ask them if this is alright, before they will actually say, you know, give them the opportunity to speak before they'll actually say, well you know 'I really wanted this' and sometimes then they won't say what they really, really want, they say what they think you want to hear. (Clinical nurse consultant)

Some staff had also noticed gender differences in and between cultures that needed to be taken into account when providing care:

I would say, the men tend to be more aggressive, and the women tend to be very emotional and anxious—it doesn't happen with everyone but as a generalised thread of how I'd see the difference between the manifestations of dementia of the men and the women in the Greek culture. Yeah the women would be anxious and, a lot of sadness there, or—but happiness ... emotion. (Director of care)

It was also found that when residents had a strong religious background, even though they had a serious short-term memory deficit, religious observances were an activity in which they could still participate:

And as I said too, about the spiritual part of it, the priest comes on any important days and he does the blessing, and so forth, and so on. And I've noticed that people with dementia that are Greek, their religion is very strong to them, even though they've got dementia at an advanced stage it's like something they've obviously been brought up with, because straight away the priest is the person that, and they respond really well straight away, and they remember all the spiritual sort of rituals and stuff that they have to do. And they remember the hymns and the singing, and things like that. (Director of care)

Although these strategies were useful when caring for people with dementia who came from CALD backgrounds, there were also problematic situations that arose from ethnicity.

Problems with CALD dementia care

Although the two facilities where the participants in this research worked were organised to provide ethnically specific residential aged care, one of the problems encountered with CALD dementia care was due to class tensions between two residents of the same culture:

I can recount one incident early on where we had, you know, technically the Chinese focus house, and there were two ladies of Chinese origin, of different um levels, one was the high standing that had no money, another one was of a low standing but had lots of money, and there was a really big disagreement between them, such that, they were drawing knives and all sorts of things. So it was really very difficult, so we had to separate them and you know.
(Clinical nurse consultant)

This facility had Chinese speaking staff who could identify the source of the tension, which was resolved when one resident, in consultation with the family, was moved to another location in the same facility. However, that serious difficulties can arise between people from the same ethnic background due to class distinctions or other issues that do not appear to have been covered in the literature on CALD aged care.

Another difficulty is that, even when a facility has staff members that speak a particular language, it may be a different dialect. This was the case in one of the facilities with a Chinese male resident:

I guess, you know, and because communication is so difficult, I mean, I've only probably got, one or two members of staff that do speak Mandarin, the rest speak Cantonese, so, it's, yeah, it's really difficult to communicate with him. (Clinical nurse consultant)

In this case there was also an issue of age and status:

He was very high up in university administration I think. And it was interesting, I had a, I'll tell you this little story, a student doing placement here, and he could speak Mandarin, but he looked very young, and in order to communicate with this man, he had to do a lot of bowing and scraping because the man was so high up in administration and he was only a young teenager, and he said 'Oh it took me a long time to get through to him, because, he just considered me a child' sort of thing. (Clinical nurse consultant)

Although the Mandarin speaking student was able to eventually get this resident to cooperate, the cause of the difficulty in this case was age and status, not language. Again, this sort of difficulty between people of the same culture has not been covered in the literature on CALD aged care.

Another difficulty encountered was a situation where the facility had staff that spoke the same language as the residents, but the cultural background was different and not accepted well by the residents:

Yes, yes, we've had a bit of a problem lately too where, there's the Spanish speaking from Spain, and there's the Spanish speaking from South America, there's a little bit of an antagonism there. We've got a couple of Spanish speaking people from Spain, particularly men, and they have particular objection to the Spanish speaking staff who are from Argentina and Chile and, it's, you know, um quite difficult, because we have the Spanish speaking to them, Spanish speaking, you think they'll be right, they'll be able to converse with them in their native language, well they can, they can speak the same basic language, but, they're so culturally, there's a big cultural divide because the two different communities. (Clinical nurse consultant)

This was a difficult problem to deal with as the only job applications from Spanish speaking people that this facility received were from young South Americans. There were also racial difficulties due to the care staff in residential aged care facilities becoming more multicultural:

A: Well like the one resident that we've got here, he's actually Australian, and he goes, can you get that Aboriginal boy away from me. Now, this boy wasn't Aboriginal, he's African.

Q: Right, but because he had dark skin he's an Aboriginal?

A: Yes. Yeah, you know, and I said, no he's not Aboriginal, you know, he's African. And he goes, no he's Aboriginal. We didn't—like he didn't attend to him. I got someone else straight away. (Enrolled nurse)

We had an indigenous lady who was verbally aggressive to anybody of an Asian origin.

Q: Really, only Asian people.

A: Or African. (Clinical nurse consultant)

Or perhaps whatever's happened they just are quite, can be quite racial. And that can be quite hurtful on both sides. You know, the carer, we had one African girl who used to go home and cry because this lady just would not warm to her, did not like her, even though she'd done nothing to her. (Clinical nurse)

Because the care staff in residential aged care facilities is becoming more multicultural and provides most of the assistance with activities of daily living, situations of residents rejecting particular carers on the basis of their ethnic origin are likely to become more common. The current strategy for dealing with this situation is to change the allocation of residents to carers, so that the resident is not being cared for by someone they object to. However, if the care staff in residential aged care becomes more multicultural, there may be times when implementing this strategy will be difficult.

There was also some difficulty with palliative care for people of European origins with dementia. Their families tended to want active treatment even though their relative could be cared for best by staff that knew them and it was inappropriate to transfer them to an acute care hospital:

Yeah. Oh yeah. Even when I get letters from the hospital saying, this person is palliative, don't send them to hospital, comfort care only. And then, we sort of try and say to the family, listen this is what the hospital has said, we need to stop doing active treatment here. Oh no. (Director of care)

And

Just that in most of the European cultures, death and dying is a very taboo subject. And like in most European homes, you like to get the funeral director or if there's any you know, funeral arrangements or what, do you want them sent off for acute care if the time comes, and people just don't want to talk about it, at all, until it sort of happens, you know? And they find it very, very hard to accept when their relative is dying. (Clinical nurse)

This situation makes it very difficult for nurses to implement best practice in palliative care and there appears to be no literature on cultural beliefs and traditions being at odds with the use of advance directives and advance care planning for people with dementia.

Resources

Although the nurses interviewed had all found some resources useful, they also mentioned resources that were lacking. The most useful resource for nurses caring for people with dementia from CALD backgrounds was knowledge of the culture and some commonly used words in the language of the residents they cared for:

We have run sessions on cultural awareness, um what else do we do, well we've got a little communication sheet, you know, a sheet on tips of communicating with people from different cultures that we hand out in orientation and um, give to agency staff and things like that, just, sort of a brief awareness. What else do we do, you sort of rely on the staff to talk about the different cultures too, as to what's normal for that culture and to share that with the other staff members.
(Clinical nurse consultant)

Well look, as far as being culturally specific, we belong to the multicultural group, and get their newsletters and stuff. All our pamphlets and that, I try to get in Greek as well. Palliative care stuff, complaints department stuff, aged care stuff, we've always got a little stash of Greek stuff.

Q: So, that's not hard to get hold of?

A: No not really. We also use the interpreter thing on the net. If you want to say something in Greek, translate—so, it translates it for you in Greek. (Director of care)

And

Yes, we have basic Greek and we have Greek words on sheets and things like that. And of course there's usually a Greek-speaking person on staff that you can always ask, whether it's someone in the kitchen or a cleaner or whatever, if you get into trouble, you can. A lot of the staff are pretty good here, they learn, they staff, are from various different cultures, there's a lot of Indian, Chinese and whatever. And they all learn. (Director of care)

As well as some formal training sessions, having people on staff from the same culture as the residents was highly regarded. Not only could they speak the residents' language, they could teach useful words to use and explain different aspects of the culture to other staff.

However, although some facilities offer ethnically specific services, there is no funding specifically allocated to CALD residential aged care. One purpose built facility had received funding to build a multicultural facility, but funding for ongoing operation of the facility was through the same funding formula as all other aged care facilities:

Yeah, the old RCS [Resident Classification Scale] funding, we used to be able to claim a lot for communication and behaviour and things like that, and yeah, but there's not so much allowance for it in the new ACFI [Aged Care Funding Instrument] funding. (Clinical nurse consultant)

As our aged ethnic population is growing faster than the non-ethnic aged population and the number of elderly people from CALD backgrounds requiring residential care is bound to increase, some funding for the ongoing operation of ethnically specific services would assist these services to offer more frequent training sessions to their staff. Communicating with residents with dementia who no longer speak English takes more time, but there is no provision in the funding for a higher staff ratio for ethnically specific facilities.

One nurse also spoke of the need for a more positive image of aged care and more support for staff:

I think people in aged care need a lot more support. I think it's a really hard job and it's quite demanding, it's very draining, and I think if people, especially with all the negativity that goes on in the media and things like that, negative reports and things like that, I think we need a bit more positive towards the aged care. You know, the staff and to let them know that they're worthwhile people in the workforce and they really deserve a lot of credit for what they do. Because not everyone can do this job. (Clinical nurse)

Although some aged care providers have organised a counselling service which staff can access, this is not an industry standard.

In conclusion, nurses who care for people with dementia who come from a CALD background have no more resources available to them than other aged care nurses, with the exception of some training sessions provided by ethnically specific facilities, and cultural awareness and language skills learnt on the job. In some instances, staff from different cultural backgrounds appear to be a resource for each other.

5. Recommendations

As this was only one small project, it does not provide enough data to be prescriptive of nursing practice for people with dementia from CALD backgrounds. However, it has identified strategies that support nurses to provide care, some problems that can arise, and several areas that require more research:

1. This research identified several practices which were helpful:
 - a. training sessions on cultural awareness and language which involved teaching nurses useful words and phrases
 - b. having a staff member on each shift, not necessarily a nurse, who spoke the residents' language
 - c. having the opportunity to learn on the job from these staff members.

2. The following problems which can arise when caring for dementia residents from CALD backgrounds:
 - a. tension or aggressive behaviour between residents of the same cultural background due to class hierarchy or other differences
 - b. care staff having difficulty caring for residents with the same cultural and language background as themselves due to issues of age and status
 - c. difficulty in having someone on staff who speaks the residents' language due to the multitude of different dialects in some cultures
 - d. difficulty with residents accepting staff who spoke the same language but had a different cultural background
 - e. difficulty with residents not wanting to be attended by a particular carer due to the carer's ethnic background.

3. Most of the literature identified was from overseas research and most was based on community care. Overall, more Australian research is needed on the ethnic groups in Australia, and more research that focuses on residential aged care is required. The following areas have been found by this project to require more research:
 - a. the issue of best practice in palliative care and cultural beliefs in which death is a taboo subject requires research to see if a culturally appropriate way to put advanced directives for palliative care in place can be identified

- b. because there are people with dementia from CALD backgrounds who are not resident in an aged care facility specific to their culture, a research project which identifies cultural beliefs and commonly used words relevant to providing care for each of the many ethnic groups in Australia would be useful. Publishing the information on a website would make it easily accessible to care staff and regular updating would be possible without being expensive
- c. research which sought to identify difference between different ethnic groups would also be useful, as people from CALD backgrounds are extremely heterogeneous. Even within a region such as South East Asia, it should not be assumed that all people share a similar 'Asian' culture. When caring for people with cognitive impairment who do not always have family members who visit, it would be useful for residential aged care staff to have easy access to information on differences between cultures.

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