Factors That Influence the Care of Chinese Nursing Home Residents: The Person-Environment Interaction

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Factors That Influence the Care of Chinese Nursing Home Residents:

The Person-Environment Interaction

by

Joyce Chan

DISSERTATION

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ABSTRACT

Factors That Influence the Care of Chinese Nursing Home Residents:
The Person-Environment Interaction

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University of California, San Francisco, 2007

Elderly Chinese residents in nursing homes in the United States experience cultural and language barriers, encounter Western health care practices, and have difficulty adjusting to a new environment. The purpose of this ethnographic study is to identify, describe, and analyze the factors: clinical, environmental, social, and cultural, that influence the care of elderly Chinese residents in nursing homes. Data were collected through participant observation and interviews on Chinese residents, their families, and nursing home staff at a 100-bed nursing home facility. The mission of this facility is to provide compassionate and quality care that recognizes the ethnic diversity of its residents.

Kayser-Jones’ Conceptual Model of Person-Environment Interaction was used to illustrate the effects that the interactions of multiple factors in the physical, organizational, personal-suprapersonal, and cultural and psychosocial environment have on elderly Chinese nursing home residents. It was found that the teamwork between the nursing home operator, Asian community, and the nursing home leadership team was important in helping this facility reach its goals in providing quality care. They have implemented and maintained an
organizational structure with the goal of meeting the needs of the Chinese elders and the other residents in the facility (organizational environment). This affects the physical and cultural-psychosocial environment, as this team works together to provide a home-like environment sensitive to the needs of the Chinese residents (physical and cultural-psychosocial environment). Chinese elders seeking long-term care are thus drawn to this facility, one which supports an environment sensitive to the social, psychological, and cultural needs of this population (personal supra-personal environment). The outcome for the resident is that there is a good person-environment fit, resulting in high resident morale and self-esteem and thus, a high level of resident satisfaction. This research has shown that positive outcomes occur for Chinese elders in a nursing home providing culturally-specific care. These findings offer valuable information in helping to develop and implement interventions to improve the care of Chinese elders in nursing homes.
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Introduction

Mrs. Wong, a 69 year-old Chinese woman, was born and raised in Macao, China. She did not receive a formal education as a child. Thus, she is unable to read or write in Chinese or English, but she fluently speaks Toishanese Chinese. Mrs. Wong, a widow, has two sons and two daughters. All of her children and grandchildren live in California. When Mrs. Wong’s husband died in 1998, she moved from China to California to live with her eldest son and his family.

Six months ago, Mrs. Wong was diagnosed with lung cancer. By the time the cancer was discovered, it had metastasized to several areas in her body. Her physician told her children that she was terminally ill. Her children, all of whom had full-time jobs, found it difficult to care for her at home. As Mrs. Wong’s health continued to decline, her family decided to place her in a nursing home, where she has been a resident for the past three months.

Nursing homes in the United States are becoming more ethnically diverse, and it is expected that many Chinese elders, like Mrs. Wong, will enter and reside in nursing homes. Many factors affect how care is provided to ethnic elders. Yet, little research has been done on the elderly Chinese population in nursing homes in the United States. The purpose of this study is to identify, describe, and analyze the factors: clinical, environmental, social, and cultural, that influence the care of elderly Chinese residents in nursing homes.
Chapter One

Review of the Literature

The Chinese: Issues in Aging and Long-Term Care
Elderly Chinese residents in nursing homes in the United States, face unique problems and challenges. They experience cultural and language barriers, encounter Western health care practices, and have difficulty adjusting to a new environment. Understanding this experience from their perspective may help health care providers develop and implement strategies to provide culturally sensitive care for these residents.

Significance

Growth of the Elderly Population

The elderly population is defined as individuals over the age of 65. According to Census data, in 2000, there were 35 million people 65 years of age and over in the United States (2000e). The elderly population has increased 12% over the last 10 years and constitutes 12.4% of the population of the United States (U.S. Census, 2000e). It is expected that by the year 2050, the number of older people will more than double to 82 million individuals, making up over 20% of the population (U.S. Census, 2000b).

Over 1.5 million people, or 4.5% of our elders, live in nursing homes (U.S. Census, 2000e). Over 18% of the fastest growing segment of the elderly population, those over the age of 85, reside in nursing homes (U.S. Census, 2000e). If the number of older people increases to 82 million by the year 2050, and the percentage of elders who enter nursing homes remains at or above 4.5% of the population, it can be projected that by the year 2050, over 3.5 million people will reside in nursing homes.
Growth of the Minority Elderly Population

The elderly population in the United States is becoming more ethnically diverse. Between 2000 and 2030, the U.S. Department of Health and Human Services (2003) projects that the elderly white population will increase by 77%, African Americans by 164%, Hispanics by 342%, and Asian and Pacific Islanders by 302%. Members of minority groups, who currently represent 13.1% of the elderly population, are projected to represent 35.8% of the population by the year 2050 (U.S. Census, 2000b; U.S. Census, 2000c). Undoubtedly, there will be an increasing number of ethnically diverse individuals in nursing homes.

Growth of the Elderly Chinese Population. The term “Asian” refers to people with origins in the Far East, Southeast Asia, or the Indian subcontinent (e.g. China, Japan, Korea, Vietnam, and India) (U.S. Census, 2000d). The Chinese, the largest Asian group in the United States, make up 24.2% of the Asian population (U.S. Census, 2000d). The Asian population is estimated to grow from 10 million in 2000 to nearly 36 million by the year 2050 (U.S. Census, 2000b; U.S. Census, 2000c).

Individuals age 65 and older constitute 8% of the Chinese population in the United States (Chinese American Data Center, 1990); 83% of these individuals are immigrants from Mainland China, Hong Kong, Taiwan, and Southeast Asia. With the increasing number of elderly Chinese in the United States, we will be caring for a greater number of Chinese residents in nursing homes.
Aging in China

Chinese elders have beliefs and expectations about how they want to be cared for as they age. Given that the majority of Chinese elders in the United States are immigrants from China, I will examine the factors that influence how China cares for their elders. This will enable us to envision aging from a Chinese perspective and use this knowledge to improve care for Chinese residents in nursing homes in the United States.

Religious Beliefs

Chinese philosophies and religions strongly influence the Chinese way of life and perceptions about health and health care (Chen, 2001). The Chinese religious system is characterized as polytheistic; people pray to different gods for different purposes (Jung, 1998). Predominant religious beliefs include a combination of Buddhism, Taoism, and Confucianism, with a mixture of local folklore, superstition, and magical belief systems (Jung, 1998).

Buddhism. The basic doctrines of Buddhism are the Four Noble Truths: 1) life is painful, 2) pain originates from desire, 3) for pain to end, desire must end, and 4) the path to the end of pain is righteous living (Lee, P.C., 1995). One fundamental belief is in reincarnation. After many cycles of birth, life, and death, if one is able to release their desires, they will attain the ultimate, peaceful state, Nirvana (Jung, 1998). The accumulation of good deeds through compassion during one’s lifetime can lead to a better life, if not in this, then in the next life (Ching, 1993; Lee, S.M., 1995; Shih, 1996). The Buddhist outlook, moreover,
maintains that the life force is further strengthened by qualities such as hope, courage, and a strong sense of purpose in life (Soka Gakkai International, 2002).

The Buddhist understanding of good health emphasizes the balanced interaction between mind and body, as well as between life and its environment (Soka Gakkai International, 2002). Illness occurs when there is an imbalance of these elements, and the aim is to restore balance. Yet, the value of illness presents an opportunity for self-growth. The challenge of fighting and/or overcoming an illness is not only important because it strengthens oneself, it also encourages and inspires hope in others (Soka Gakkai International, 2002). This perspective has enabled many to endure suffering in their lives (Hwu, Coates, Boore, & Bunting, 2002).

Taoism. The central teaching of Taoism is to find ‘Tao’ or ‘The Way.’ This is achieved by following the ebb and flow of nature, because nature provides the elements necessary for one to live (Chen, 2001; Shih, 1996). To achieve and maintain health, one must modify him or herself to fit the natural rhythms of the universe (Chen, 2001).

Expanded by Taoism, the principles of yin and yang have long dominated health and illness in traditional Chinese thought (Chen, 2001). Yin and yang symbolize two independent, complimentary, and yet opposing principles, with yin representing that which is negative, cool, and dark, and yang representing that which is positive, warm, and light. Qi is the energy and source of life that circulates in the body (Hwu, Coates, & Boore, 2001). Health is achieved when qi flows freely in the body, and there is a balance of the forces of yin and yang
amongst the body and the environment. Illness results when there is a blockage in the circulation of qi and/or an imbalance of yin and yang. In Traditional Chinese medicine, analysis of qi and deficiencies and excesses of yin and yang form the basis for the diagnosis and treatment of illnesses (Chen, 2001).

Confucianism. The teachings of Confucius emphasize interpersonal relationships and social obligation (Shih, 1996). It has also been described as a philosophy to bring peace, hierarchy, and order to society (Yick & Gupta, 2002). Five important concepts in Confucianism are benevolence, righteousness, loyalty, filial piety, and virtue (Graham, 1990). Major teachings stress that individuals should maintain harmony with all others, exhibit a lack of self-centeredness, respect one’s parents, and be loyal to one’s family (Chen, 2001).

In China, it is considered a blessing to reach old age. Aging represents having enriched life experiences, wisdom, authority, and being able to enjoy both power and prestige, due to the frequently articulated Confucian virtue of filial piety (Silverman, Hecht, & McMillin, 2000; Tsai & Lopez, 1997). Filial piety is a system of obligations of a child to a parent, where the child provides aid, economic and emotional support, and glory or prestige to the parent (Lin & Liu, 1993). Through concept analysis, Yang, Yen, and Huang (1988) identified four attributes of traditional filial piety: 1) respect and care for parents, 2) obedience to parents, 3) protection and glorification of parents, and 4) worship of deceased parents and ancestors. Not only are individuals obligated to care for their parents, Confucian teachings state that their devotion to their family should never
be compromised by giving preference to individual needs and desires
(Silverman, Hecht, & McMillin, 2000).

Family Roles and Responsibilities

Chinese people are very devoted to the well-being of their families. They have been characterized as having family values that foster intense interdependent family ties, high filial expectations, and strong intergenerational cohesiveness (Bond, 1996; Chow, N., 1996). Filial children are expected to sacrifice their own interests in physical, financial, and social aspects for the well-being of their parents or family (Dai & Dimond, 1998). Providing care for ill or elderly family members is considered a primary duty, a life-long commitment, and a desired outcome (Chao & Roth 2000; Dai & Diamond, 1998; Holroyd, 2003). Children are also expected to take on a paternalistic role and make health care decisions on behalf of their elderly parents, including disclosure or non-disclosure of their diagnosis (Chan, Lam, Chun, Dai, & Leung, 1998). Chao & Roth (2000) found that striving to provide this care has resulted in differing caregiver perceptions, ranging from serenity to personal self-sacrifice.

Filial piety continues to be important to the Chinese people, but industrialization has changed society and affected familial relationships. Gradually, an increasing number of individuals of the younger generation are migrating from rural to urban areas, with many young families relying on dual incomes to meet their financial obligations. Philips (1988) finds that although family obligations remain strong, the demands and trends of a modern society and the need for high achievement present paradoxical and competing elements
within families who are caring for dependents. Because of this, difficulties arise for many elderly Chinese who have been left behind in rural villages. This transitional generation is caught between the social messages and experiences of two generations, finding themselves looking both backward and forward (Berkanovic, Lubben, Kitano, & Chi, 1994; Holroyd, 2002). Holroyd (2002) finds that the current generation of elderly individuals may have shifted their notion of entitlement to family support, to that of not wanting to be a burden to their family; and though some might not like being alone, they have accepted the reality of it and have prepared for it.

Health and Health Care

Health is identified by the Chinese as a holistic three dimensional construct: physical, psychosocial, and spiritual (Hwu et al., 2002). Good physical health behavior involves: using the health care system, following a proper diet, exercising, maintaining adequate sleep/rest/relaxation, and avoiding known health risks (Hwu et al., 2001). Having sound thoughts and attitudes and developing close interpersonal relationships with family and friends were found to be important for psychosocial health (Hwu et al., 2001). Spiritual health is achieved by engaging in religion and acting according to a higher order to achieve inner peace and strength (Hwu et al., 2001).

There are 88 million people over the age of 65 in China, constituting over 7% of the population (Lee, 2004). Many factors are associated with a positive aging experience in China. Chou & Chi (2002) found that age, gender, years of education, number of close relatives, frequency of contact with friends, financial
status, number of chronic illnesses, self-rated health, hearing impairment, and life satisfaction were associated with successful aging among the Chinese. Leading causes of death in China are: cancer, stroke, cardiovascular disease, and respiratory disease (Fitzner, Coughlin, Tomori, & Bennett, 2000).

*Western Medicine.* The ability of the Chinese to pay for Western medicine varies by location. It differs from urban China, to rural China, to Hong Kong, and to Taiwan. Elderly residents in mainland China receive financial support for their health from their families, public pension schemes, and the state income maintenance program (Pei & Pillai, 1999). The public pension schemes cover employees in the industrial sector, in state-sponsored institutions, and government agencies; and the state income maintenance programs are welfare programs that provide support to childless elders (Pei & Pillai, 1999). However, coverage in mainland China varies widely. Chappell (2003) found that in Shanghai, an urban city, only 68% received either a pension or social assistance. It has been estimated that 50 million or more rural residents aged 65 and over lack effective old age security provisions (Bartlett & Phillips, 1997). In Hong Kong, most people do not have health insurance. But Hong Kong’s health care system, which has relatively equitable health care services, is heavily subsidized by the government (Chou & Chi, 2002; The Harvard Team, 1999). The people of Taiwan have universal health insurance coverage through the National Health Insurance program.

As payment for health care services vary for the Chinese, the type and availability of health care services also vary by location. Those in rural China
receive their health care services at county hospitals and village clinics. Though individuals in rural China make up 70% of the total population of the country, it is served by only 37.5% of national technical health workers (Lee, 2004). Heath care in urban China is provided by hospitals and community clinics. The health service system in Hong Kong is made up of an extensive public and private sector (Chow & Chi, 1997; The Harvard Team, 1999). This system includes a network of hospitals, clinics, and community support services (Chou & Chi, 2002). Like Hong Kong, Taiwan has a very similar health service system.

*Traditional Chinese medicine.* Traditional Chinese medicine (TCM) is an ancient healing art. It is not simply pharmacologic in nature, but encompasses diet, herbal, and folk methods (O'Hara & Zhan, 1994). Specifically, common TCM therapies include: food and herbal remedies, acupuncture, acupressure, and massage (Hesketh & Zhu, 1997; Nestler, 2002). In addition to belief in the power of TCM, the Chinese have found that exercising, through such activities as qi gong and tai chi, is vital to a person’s overall health (Nestler, 2002).

The Chinese believe that TCM works slowly, is milder, and does not have strong side effects, like those found in Western medicine (Holroyd, 2002; Lam, 2001). It is believed that TCM is a better method for the prevention of illness and maintenance of health and for treating mild conditions and chronic illness (Holroyd, 2002; Ma, 2000; Ren & Chang, 1998). Western medicine is seen to be more technically advanced and therefore more efficient in curing acute diseases and serious conditions (Holroyd, 2002). Lam (2001) finds that TCM is often used in conjunction with or as a supplement to Western medicine.
In China, people utilize both TCM and Western medicine. In fact, it is the only country in the world where TCM and Western medicine are practiced alongside each other at every level of the healthcare system (Hesketh & Zhu, 1997). In 95% of the hospitals practicing Western medicine, there are departments of TCM; and when patients arrive, they can opt for Chinese or Western treatment (Hesketh & Zhu, 1997).

**Long-Term Care**

It is the responsibility of the family to provide long-term care for older people in China, and in 1979 it became a legal obligation (Ikels, 1997; Xia & Ma, 1995). Due to traditional family values, the majority of Chinese elders prefer to be cared for at home (Chao & Roth, 2000; Chappell, 2003; Gui, 2001; Lui, Lee, & Mackenzie, 2000). Chappell (2003) found that over 88% of Chinese elders in Shanghai expressed preference for spending the rest of their lives at home. With most of the elderly population preferring to live at home, efforts have been made to build more collaborative relationships between professional service providers and family caregivers to assist families in caring for elders in home settings (Chao & Roth, 2000). Many children, who are not able to provide care for their parents, are hiring caregivers (Chappell, 2003).

The one-child per couple policy in China was initiated in 1979 to control the staggering population growth (Population Control Programs, 2003). Though it has been effective in controlling the population growth, it has resulted in unforeseen problems. For example, one child may have difficulty caring for two ill parents, and a further dilemma occurs if that one child precedes his/her
parents in death. Because this policy was initiated just over 25 years ago, this problem will become even more significant as these children age and must care for their elderly parents. Thus, an impetus for implementing the Western concept of institutional care began in China about 25 years ago. Thorson (1984) documents this in a paper, “The People’s First Social Welfare Institution for the Aged: A Chinese Nursing Home.”

Though it has been over 25 years since the first facilities appeared, it has been found that many Chinese elders are not familiar with the meaning of long-term care or nursing homes (Lai, Wu, & Chiang, 1996; Lee, 1997). However, the spread of this concept is forging ahead slowly. The growing proportion of childless elderly and elderly people with families unable to provide care for them at home necessitates the need for nursing homes (Bartlett & Phillips, 1997). Studies have been conducted on estimating community needs (Chen, 2000) and long-term care needs (Woo, Ho, Yu, & Lau, 2000). Research scientists in China are trying to determine what future long-term care needs may be.

Beds are limited in China’s nursing homes, and admission is often restricted to those without the ability to work, a source of income, and family support (Leung, 1997). Those residing in a facility consider themselves very lucky to have been “given” a place in a nursing home (Lee, Woo, & Mackenzie, 2002). Facilities vary in size, averaging from 13 to 63 people (Bartlett & Phillips, 1997). The main reasons for admission are failing physical health and family members’ anticipated inability to provide care at home (Lee, 1999; Lee, Woo, & Mackenzie, 2002). Research has been conducted on residents of nursing homes
on a variety of topics such as exploring the age and marital status of residents (Woo, Ho, Lau, & Yuen, 1994), nutritional status (Woo, Ho, Mak & Swaminatnan, 1991), health and mortality (Leung, Tang, & Lue, 1997), bipsychosocial functioning (Yang & Yin, 1999), and morale (Lin & Ou, 1996). These studies have helped researchers in China gain a better understanding of the residents and their experience in nursing homes.

Immigration of the Chinese to the United States

As previously mentioned, the majority of Chinese elders in the United States are immigrants. Each immigrant’s experience in the United States is dependant on the reason for immigration, the number of years since immigration, and the level of acculturation achieved since arrival in the United States.

The earliest Chinese immigrants were men who worked as miners, railroad workers, farmers, and laborers between the 1850s and 1920s (Lee, 1998). At that time, the Chinese suffered tremendous prejudice and discrimination in the United States. Strong anti-Chinese sentiments culminated in the passage of the Chinese Exclusion Act in 1882, which prohibited the immigration of Chinese laborers (Lee, 1998; National Asian Pacific American Legal Consortium, 2003). In 1943, “China’s status as an ally during World War II made such discriminatory laws politically untenable” (Lee, 1998, p.6). The McCarran-Walter Act, also known as the Immigration and Nationality Act of 1952, established the basic laws of U.S. citizenship and immigration, and admitted a certain number of immigrants of each nationality (Braziel, 2000).
Immigration from Asia remained low until the passage of the landmark Immigration and Nationality Act Amendments in 1965 (Lee, 1998). This legislation reflected the attitudes of the civil rights era. The 1965 law limited the annual number of immigrants, but eliminated the place of nationality and ethnic considerations as a basis for admitting immigrants to the United States (FAIR U.S. Immigration History, 1996). Priority for immigration was based on family reunification and for people with occupational skills needed in the United States (Bureau of Citizenship and Immigration Services, 2003). The Immigration Act of 1990 maintained the preference system for individuals with close relatives of U.S. citizens and those with job skills needed in the United States, but increased the total number of immigrants admitted (FAIR U.S. Immigration History, 1996). As a result, the Chinese immigrant population in the United States increased dramatically.

The Elderly Chinese in the United States

The Chinese have been immigrating to the United States for over 150 years. The elderly Chinese in the United States today include individuals who have immigrated from China (Chinese immigrants) and individuals of Chinese descent born in the United States (Chinese Americans). Due to the tremendous diversity of Chinese immigrants and the Chinese American population, they have acculturated in varying degrees. Acculturation may be conceived as a continuum that describes the degree to which individuals adopt the values, attitudes, beliefs, practices, and behaviors of their new culture (Roysicar-Sodowsky & Maestas, 2000; Sue, Mak, & Sue, 1998). Diversification of the elderly Chinese population
can be understood largely through seniors’ immigration status (e.g. age at immigration, time in the U.S., and citizenship status), occupational status history (e.g. professional, non-professional), family characteristics (e.g. living arrangements, role in taking care of grandchildren), and language and driving ability (Liu, 2003). In addition, Yick & Gupta (2002) found that level of education, socioeconomic status, and religion also contributes to the heterogeneity of this population.

I.C. Lee (1992) suggests that specific immigrant waves from China netted three categories of sociocultural characteristics for this population. Prior to 1950, a majority of Chinese immigrants were uneducated laborers who arrived from largely Cantonese-speaking areas of Canton and Hong Kong; this group still practices strong retention of Chinese cultural traits and traditions (Lee, 1992). Many of these individuals reside in Chinese enclaves that resemble their former villages and towns in China, with other co-nationals with similar backgrounds, language, and culture, where they receive support from each other. Those living in these Chinese communities, which provides for the majority of their needs, tend to be less acculturated to the society-at-large.

A second wave of Chinese immigrants arriving from mainland China and Taiwan after 1950, included many highly educated professionals and politicians, escaping intellectual and political persecution; acculturation patterns for this group mirror those of European immigrants where acculturation and adoption of middle-class values has been the mode (Lee, 1992). Many of the more educated tend to be more geographically dispersed and less likely to choose to live in
areas based on the location of fellow ethnic s (Bartel, 1989). Over the years, these individuals continuously adapt to their environment, and as a result have become quite highly acculturated.

The third wave of Chinese immigrants, arriving after 1965, includes a variety of educated professionals, business persons, uneducated laborers, and refugees, as well as non-working members of families who immigrate under family reunification provisions of current immigration laws (Lee, 1992). Based on their own varying characteristics and qualities, these individuals have exhibited differing degrees of acculturation.

Diminished by a new and different cultural environment in the United States, the traditional Chinese values emphasizing strong family ties and filial piety may no longer present viable resources of support for the elderly Chinese (Cheung, 1989; Wong, Yoo, & Stewart, 2006). Family roles, responsibilities, and obligation towards care for the elderly varies from family to family. Much like the current trends in China, many Chinese families in the United States rely on dual incomes to meet their financial obligations. Frequently, it becomes a challenge for families to provide care for their elderly relative. This dilemma is further intensified by the fact that care for Chinese elders is provided by a health care system that is unfamiliar to many of these individuals.

Health and Health Care

Health outcomes reflect complex interactions between genetic background, socioeconomic status, and access to health care services (Reyes,
that are prominent among the Chinese in the United States, include hypertension, diabetes, renal disease, and chronic lung disease (Lin-Fu, 1993). A greater percentage of the Chinese are affected by hepatoma, esophageal and gastric carcinoma, and nasopharyngeal carcinoma (Chow, E., 1996). The Chinese also appear to suffer disproportionately from communicable diseases including tuberculosis and hepatitis B (Chen, 1995). Unhealthy acculturation patterns in food consumption have resulted in changing profiles of cardiovascular morbidity and mortality, as well as higher rates of dietary related cancers (Chen, 1995).

Western Medicine. Health insurance coverage and access is vitally important to maintaining good health and has been associated with differences in health outcomes (Kuo & Porter, 1998). Recent immigration to the United States, residency status, age, lower income, and low educational attainment are associated with a lack of health insurance coverage (Carrasquillo, Carrsquillo, & Shea, 2000). One study found that only 61% of the Chinese had health insurance coverage (Takeuchi, Chung, & Shen, 1998). Ma (2000) concurs and finds that 32.6% have employer purchased insurance, 13.5% have self-purchased insurance, 9.6% are covered by Medicare, 5.8% are covered by Medicaid, and 38.5% are uninsured.

A major issue for elderly Chinese, especially recent immigrants, is a lack of insurance coverage. Legislation, such as the 1996 Welfare Reform Bill, made
legal immigrants, who are not citizens, ineligible for many federal social support programs (Lee, 1998). Additionally, immigrants who are in the process of applying for permanent residency or citizenship, as well as those who are undocumented, may lack knowledge of publicly-funded health services such as Medicaid and fear that using such services will jeopardize their immigrant status (Flaskerud & Kim, 1999). The lack of health insurance coverage and fear of using publicly-funded health services contribute to poorer health outcomes for these immigrants.

Access to health care is a major barrier for many Chinese elders. They experience cultural barriers in seeking health care, including communication difficulties, beliefs about health, health care, and illness, and lack of familiarity and mistrust of the Western health care system (Ma, 2000). In addition, poverty and noncitizenship status serve as significant barriers to health care access and use (Jang, Lee, & Woo, 1998).

Tsai and Lopez (1997) found that social security, recreational activities, and housing were the top three services that Chinese elders actually utilized; in contrast, the top three problems for which elders needed help were identified as language-related problems, cultural adjustment, and transportation. Language and communication difficulties are major barriers to accessing health care services, with over 75% of elders needing help with English translation during visits with health care providers (Ma, 2000; Pang, Jordan-Marsh, Silverstein, & Cody, 2003). Over 70% of elders were found to have transportation difficulties (Ma, 2000; Pang et al., 2003).
Traditional Chinese Medicine. There is a preference for Western over traditional Chinese medicine (TCM). But, the Chinese continue to utilize TCM practices for health maintenance and in treating illness. This includes high rates of self-treatment and home remedies (balanced diets and other alternative medicines); moderate rates of utilization of integrated Western and traditional health services, including travel to country of origin for care; and low rates of exclusive utilization of Western or traditional Chinese treatments (Ma, 1999). Chinese elders continue to be skeptical about relying solely on the Western health care system for their care. This distrust often leaves the Chinese in doubt, and if there is not a quick improvement in their health condition after seeing a Western physician, they tend to visit a number of physicians, including physicians of TCM (Ma, 1999).

Long-Term Care

Filial piety is a life-long responsibility, and children of Chinese elders in the United States strive for this as a desired outcome. However, the demands of a modern society make it difficult for families to be primary caregivers. Many Chinese elders realize that the provision of long-term care in the United States may be quite different from care they were accustomed to in China.

When discussing long-term care, several options exist, including: care by the family at home, hiring a caregiver to care for the elder at home, or placement in a long-term care facility, such as an assisted living facility, skilled nursing facility, or a nursing home. According to Chinese family members, when possible, the first choice would be to hire someone to care for the family member
at home (Fitzgerald, Mullavey-O'Byrne, & Clemson, 2001). Though this scenario is ideal, it is expensive. Chow (2000) found that among Chinese seniors, many of whom had close relatives living nearby, 87.4% would choose a nursing home if they required long term health care. The focus of this study is on Chinese nursing home residents.

Literature on the Chinese in nursing homes in the United States is very limited. There are only three studies conducted on Chinese elders in nursing homes. The first study, published in 1987, explored the incidence of dementia among 61 Chinese nursing home residents of one nursing home in an urban community (Serby, Chou, & Franssen, 1987). The second study, investigated the sociodemographic characteristics and health status of older Chinese admitted to a nursing home (Huang et al., 2003). In analyzing the Minimum Data Set, Huang et al. found that compared with whites, the Chinese were: more likely to be married, less likely to have lived alone, more likely to be using Medicaid, less likely to make medical decisions alone, and more likely to depend on family members for decision-making. The seven most frequently diagnoses/conditions in this population were: bowel incontinence (70%), bladder incontinence (68%), chewing problems (47%), hypertension (44%), swallowing problems (39%), anemia (39%), and stroke (36%) (Huang et al., 2003). A third study, part of a larger study that investigated factors that influenced the quality of care of terminally-ill nursing home residents, explored the experience of dying for Chinese nursing home residents (Chan & Kayser-Jones, 2005). The investigators found that the most significant factors influencing the care Chinese
residents received were communication barriers, dislike of Western food, and differing cultural beliefs and customs (Chan & Kayser-Jones, 2005). Additional research is needed on Chinese elders to further explore their needs as nursing home residents.

Conclusion

Chinese elders have beliefs and expectations about how they would like to be cared for as they age. The majority of Chinese elders in the United States are immigrants from China. To provide culturally sensitive care to this population, an understanding of the influence of Chinese culture on issues in aging is important. Several factors that influence how China and its people care for the elderly were examined. Religious beliefs, family roles and responsibilities, health and health care, and long-term care were discussed. This information provides insight into aging from the Chinese perspective. Health care providers can use this knowledge to improve care for Chinese elders in nursing homes in the United States.

Chinese elders in the United States receive their health care from a system that is unfamiliar in many aspects to many of them. They often navigate this system with many language and cultural barriers. Chinese residents in nursing homes are challenged to adapt to and cope with communication barriers and cultural differences in a new environment. Literature on the Chinese in nursing homes in the United States is very limited. In fact, there are only three known studies conducted on Chinese elders in nursing homes. One study investigated the incidence of dementia in Chinese nursing home residents, one
investigated the sociodemographic characteristics and health status of Chinese individuals in a nursing home, and the last analyzed the factors that influenced the experience of dying for Chinese nursing home residents. Additional research needs to be conducted on Chinese elders in the nursing home setting. While we know that these residents encounter challenges and barriers as residents in nursing homes, which issues are most troubling for them? What do they believe can be done to improve care for themselves and others like them?

The American population is growing in size, living longer, and becoming more ethnically diverse. Nursing homes are challenged, often by financial and labor constraints, to provide quality care for a diverse group of individuals. An understanding of what Chinese elders, expect of their families and of the health care system, will help healthcare professionals provide culturally sensitive and appropriate care. In sum, “even as it may liberate, diversity also complicates. It calls upon society to exhibit a greater sensitivity and responsiveness to the needs of older individuals who vary widely in all dimensions…and flexibility on the part of our social institutions” (Bass, Kutza, & Torres-Gil, 1990, p. 183).
Chapter Two

Theoretical Framework

Kayser-Jones' Conceptual Model of Person-Environment Interaction
Understanding the effect of environmental settings on older people and searching for optimal environments have become major concerns within the field of social gerontology (Kahana, Liang, & Felton, 1980). The environment has been observed to have significant effects on the overall well being of the elderly (Kahana, 1974; Lawton, 1976; Moos, 1974). Nursing home environments that are able to meet the needs of its residents will have a positive impact on its residents.

Transition and Adaptation

The move to a nursing home introduces uncertainty into all aspects of people’s lives. The relocation of an elderly individual to a nursing home marks the transition to a new phase of the life cycle, requiring adaptation to a new environment, set of norms, diet, social milieu, and activity schedule (Sasson, 2001).

The transition and adaptation to life in a nursing home is a process that occurs over time. Wilson (1997) found that the transition to life in a nursing home occurs in three phases: the overwhelmed phase, the adjustment phase, and the initial acceptance phase. In the nursing home setting, adaptation was found to take place in four phases: 1) disorganization, in which residents feel displaced, abandoned and vulnerable; 2) reorganization, when residents are trying to find meaning and legitimize their life in their new home; 3) relationship building, as new residents begin to form emotional ties with other residents and staff; and 4) stabilization, the time during which a sense of belonging develops (Brooke,
1989). Every individual is unique and moves through these phases at different paces.

**Transitioning and Adapting to Nursing Homes in the United States**

While Americans value autonomy and independence, nursing homes have restrictions and regulations. When elders move into nursing homes, much of their independence and control over various aspects of their lives are limited. A central factor in residents’ psychological responses to placement continues to be their perception of how much control over their lives will be lost (Mikhail, 1992). Frequently identified are feelings of abandonment and loss of a home, lifestyle, autonomy, privacy, and the opportunities for contact with family and friends (Fiveash, 1998; Iwasiw, Goldenberg, MacMaster, McCutcheon, & Bol, 1996; Nay, 1995; Wilson, 1997). Residents also stated that good staff attitude, cleanliness, and prompt attention were important to them (Lindgren & Murphy, 2002).

Groger (2002) found that the process of coming to terms with life in a nursing home was mediated by two mechanisms: the function the institution fulfilled for different residents and their caregivers, and the coping strategies residents used to come to terms with institutional living. Residents used a variety of strategies in trying to “make the best of it”, to successfully adapt, defined as the ability to operate within the values of the institution without compromising their own core values (Groger, 2002; Kahn, 1999). In spite of the deficiencies they cited, many residents have come to consider the nursing home their home, a place that offers comfort, security, sociability, freedom from chores, and medical attention (Groger, 2002).
Transitioning and Adapting to Nursing Homes in China

How well do elderly Chinese residents transition and adapt to the nursing home environment? Due to the lack of research on Chinese elders in nursing homes in the United States, literature published in China will be examined to gain perspective on how the Chinese view the nursing home experience.

Admission to a nursing home signifies a defiance of moral standards, a break in the tradition of filial piety, resulting in a loss of face for the whole family (Lee, Woo, & Mackenzie, 2002). This is an issue Chinese elders and their families must resolve. It is not uncommon for elders and their families to tell white lies to others explaining their “absence from the family” (Lee et al., 2002). However, in recent years, as modern society has necessitated increased use of these facilities, admission to facilities is becoming more common and acceptable.

The literature suggests that living with rules and regulations are barriers to adjustment, but the communal nature of nursing home life was not regarded as important by Chinese elders (Lee et al., 2002). The Chinese are accustomed to living with large families and tight-knit communities. The Chinese values of balance, harmony, and collectivism have made it easier for them to remain open and accept the communal way of living (Lee, 1999). Contrary to their positive attitude toward communal living and the rules and regulations of the home, elders are cautious in dealing with other residents and staff. Elders claimed that it is important to be cooperative and not be seen as “troublesome”; therefore, they did not actively seek to establish relations with staff and reveal their difficulties in settling in (Lee et al., 2002). They tend to be more reserved and
keep to themselves. These values have restricted Chinese elders in developing new relationships with staff and other residents (Lee, 1999; Lee et al., 2002).

Accepting fate and taking root is the process used by frail elders to achieve or preserve wellness after relocating to a nursing home (Chen & Shyu, 2000). The process of accepting fate and taking root includes four components: recognizing the real conditions, weighing the differences, triggering emotional reactions, adopting accepting fate and taking root strategies (Chen & Shyu, 2000). The Chinese cultural values of tolerance, acceptance, and being thankful were seen as appropriate attitudes for them to continue their life inside the home (Lee et al., 2002). These coping strategies allow Chinese residents to come to terms with residing in facilities and have peace in their new surroundings.

Nursing Research on the Environment and Patient Care

Historically, there has been relatively little research conducted on the environment and patient care by nursing research scientists. The majority of nursing research in this arena has been conducted in labor and delivery and neonatal units and adult intensive care units (Williams, 1988). Patients in these units are vulnerable, and environmental influences can have a great impact on them.

In recent years, several studies have been conducted on various aspects of the nursing home environment. These studies have investigated the design and/or redesign of the nursing home environment (Fisher, 1995; Noell, 1995-1996), residents’ attitudes, beliefs, and wishes regarding room accommodations (Kayser-Jones, 1986), the person-environment fit and psychological adjustment
(O’Connor & Vallerand, 1994), the social environment in nursing homes (Cole, 1984; Herzberg, 1997), the influence of the environment on engagement in recreational activities (Voelkl, Winkelhake, Jeffries, & Yoshioka, 2003), how the environment affects quality of life and quality of care (Kayser-Jones 1989a, 1989b), and incontinence care and the nighttime environment (Cruise, Schnelle, Alessi, Simmons, & Ouslander, 1998). Sloane and his colleagues have developed an objective assessment of the physical nursing home environment, the Therapeutic Environment Screening Survey for Nursing Homes (TESS-NH) (Sloane et al., 2002). The majority of these studies have focused on specific aspects of the environment, such as the physical, social, and organizational factors. The total environment is a combination of all of these factors; understanding the complex interactions amongst and between these factors is important.

**Person-Environment Fit**

Residents of nursing homes in the United States and residents of nursing homes in China differ as to which environmental factors are most salient, when it comes to transitioning and adapting in this setting. Entering nursing homes in the United States is a major adjustment for any individual, but for Chinese elders it is an environment with a different health care system, and cultural and language barriers. Understanding which aspects of the environment are most important to Chinese residents will enable nursing homes to provide an environment that will lead to a positive experience for them.
Person-environment fit refers to the degree of congruence between an individual's needs, capacities, and aspirations, and his environment's resources, demands, and opportunities (Coulton, 1979). The target population for understanding person-environment fit is Chinese elders in nursing homes.

Theoretical Models of Person-Environment Interaction

The first psychologist to conceptualize person-environment relations was Kurt Lewin (1951), who formulated the ecological equation \( B = f(P,E) \); that is, behavior (B) is a function (f) of both the person (P) and the environment (E). More recently, researchers have adopted the formula: \( B = f(P,E,PxE) \), where behavior (B) is a function (f) of the person (P), the environment (E), and the interaction between the two (PxE) (Wister, 1989).

Several models provide a framework accounting for person-environment interactions. The most influential of these theories in social gerontology is Lawton’s Ecological Model of Aging (Lawton & Nahemow, 1973). Like Lawton’s model, Moos’ Conceptual Framework of Specialized Living Environments (1980) is a model that examines the components of an overall social-ecological system. Kayser-Jones’ Conceptual Model of Person-Environment Interaction (1998) is based on and builds on Moos’ model.

Kayser-Jones’ Conceptual Model of Person-Environment Interaction

Kayser-Jones (1998) developed a conceptual model illustrating the effects that the interaction of multiple factors in the physical, organizational, psychosocial, and personal-suprapersonal environment may have on elderly nursing home residents. This model builds on Moos’ (1980) conceptual
framework, which examines specialized living environments and their influence on older people.

Moos’ framework (see Figure 1) depicts the major elements of personal and environmental factors, and mediating mechanisms that are involved in the environments of group living settings (Moos, 1980). The environmental system consists of the physical and architectural features of the setting, policy and program factors, resident and staff characteristics (human aggregate), and the social climate. The personal system consists of an individual's characteristics including age, gender, ethnicity, general health, cognitive and functional ability, and self-esteem. Interaction of the environmental and personal systems results in cognitive appraisal and activation or arousal. Cognitive appraisal and activation or arousal are mediating variables that influence efforts to adapt (cope) and results in resident stability or change (e.g. morale, well being, health, or activity level) (Moos, 1980).

An individual’s efforts at adaption, determined in part by the personal and environmental system, will affect outcome variables such as the individual’s health, level of functioning, and well being. Outcomes of the interactions between personal and environmental systems results in either stability or change. Changes in either the personal and/or environmental systems will subsequently cause changes in coping and outcomes.

Most studies have focused on four major features of the environment: the physical characteristics, the organizational climate, the personal and supra-personal environment, and the social-psychological milieu (Kayser-Jones,
These components, although sometimes discussed separately, are in constant interaction with and influence one another (Kayser-Jones, 1991). Building on Moos’ (1980) conceptual framework, Kayser-Jones (1998) developed a conceptual model (see Figure 2) illustrating the effects that the interaction of multiple factors in the physical, organizational, cultural-psychosocial, and personal-suprapersonal environment may have on the institutionalized aged.

In the Kayser-Jones model, the physical environment includes such characteristics as building design, space, furnishings, color, and lighting. The organizational environment refers to the policies, staffing, financing, leadership, and philosophy of an institution. The presence or absence of mechanisms such as residents’ councils for the elderly to participate in planning their care and airing grievances are also included as part of the organizational environment (Kayser-Jones, 1989b). The cultural-psychosocial environment includes the norms, values, attitudes, beliefs, activities, and personal interactions of all who are part of the institution (e.g. residents, staff, and visitors) (Kayser-Jones, 1989b). The personal environment has been defined as the significant others who constitute the major one-to-one social relationships of an individual (e.g. family members and friends) and the supra-personal environment as the modal characteristics of all the people in physical proximity to an individual (e.g. the predominant race or the mean age of other residents in a person’s neighborhood) (Lawton, 1982). In the nursing home setting, a patient’s personal and supra-personal environment includes primarily the staff and other residents in the facility (Kayser-Jones, 1992a).
Each of the environmental aspects mentioned above, the physical, organizational, cultural-psychosocial, and personal and supra-personal, makes up one segment of the model, as seen in Figure 2. Although each domain is presented separately, it must be emphasized that variables from each area are in constant interaction with, and thus influence, one another (Kayser-Jones, 1992a). At the center of the model is the resident. Residents are characterized, for example, by their functional, cognitive, and physiological status, sensory-perceptual capacity, and gait and mobility. Dynamic interactions occur between the environment and the resident.

The two-way arrows between the environmental influences and the resident illustrate the complex interaction that occurs amongst and between these variables. This model also indicates, by the two-way arrows, that just as the environment influences its residents, the residents also have an influence on their environment. Surrounding the micro environment of the nursing home is the macro environment. The micro environment of the nursing home is influenced by the macro environment, that is, social and cultural factors such as ageism, health policy, cost of care, and the fact that we live in a litigious society (Kayser-Jones, 1998). Elderly people are placed in this complex environment, and how they appraise, respond to, and cope with the multiple environmental factors influences their outcome (Kayser-Jones, 1998).

A key element of this conceptual framework, is that it views nursing home residents as an integral part of a complex environmental system (Kayser-Jones, 1992b). This model illustrates how an individual resident influencing and being
influenced by their environment responds to and copes with their situation, which produces a particular outcome. This relationship between residents and their environment is not a simple one, but rather a unique and complex web of interactions. Kayser-Jones states that this conceptual model is not meant to be all-inclusive, but serves to illustrate the dynamic interaction of multiple environmental factors (1992b).

Application of Kayser-Jones' Conceptual Model

Application of Kayser-Jones' Conceptual Model to diverse populations, like Chinese elders in nursing homes, has important implications in evaluating the outcome of person-environment interaction and fit. It is not expected that Chinese residents will differ markedly from other residents in the facility in resident characteristics such as functional, cognitive, or physiological status. But elderly Chinese individuals may have different needs and preferences in what they expect of their environment. For instance, does the physical environment meet their needs and expectations? Do the policies and philosophies of the institution facilitate or create barriers in meeting their needs? How does the difference in language and cultural values and beliefs affect them? Are they able to interact with those in their personal and/or supra-personal environment? These complex interactions, occur simultaneously in both directions from person to environment and vice versa. Appraisal and coping then occurs. The outcome is whether Chinese residents have a positive or negative nursing home experience.
The nursing home experience for Chinese elders will undoubtedly be neither a completely positive or negative experience, but may fall somewhere along a positive to negative continuum. This model may help to identify those factors that influence the nursing home experience for Chinese elders. Understanding of the needs and preferences of Chinese elders in this setting will help nurses provide an environment that is more suited to their needs.

The nursing home environment has a significant effect on the well-being of its residents. An environment that is able to meet the needs of its residents will have a positive impact on its residents. Kayser-Jones’ Conceptual Model of Person-Environment Interaction provides a framework to evaluate the many dimensions of person-environment interaction and fit. This model allows researchers and clinicians to systematize their efforts to provide an optimal environment for individuals in a nursing home environment.

Conclusion

Individuals entering nursing homes face adjustment to an unfamiliar environment. The ability of an environment to meet individual needs will affect the well-being of each individual. A close fit between environmental characteristics and individual preferences and needs should contribute to a sense of well-being and adequate functioning of the elderly individual (Kahana, 1980).

Forced relocation, such as that experienced by most institutionalized older people is likely to lead to low levels of person-environment congruence and fit (Kahana & Kahana, 1983). For elderly Chinese individuals, entering nursing
homes often means entering an environment with different cultural beliefs, practices, and values. Utilization of Kayser-Jones’ Conceptual Model of Person-Environment Interaction will provide insight on salient dimensions that influence the experience of living in a nursing home for this population. Health care providers can focus their attention on these areas when providing services to Chinese elders. The goal is that the environment will increase the well being of Chinese elders in nursing homes.
Chapter Three

Methodology

Factors That Influence the Care of Chinese Nursing Home Residents:

An Ethnographic Study
Quantitative and Qualitative Methods

Scientific research methods fall into two broad categories: quantitative and qualitative methods. Quantitative studies emphasize the measurement and analysis of relationships between variables. Measurement, whether it be at the nominal, ordinal, interval, or ratio level, lies at center of these studies. Quantitative methods are, by nature, viewed as deductive, that is their primary purpose is to test theory. Utilizing experimental methods, a research hypothesis based in theory is proposed; data are collected and statistically analyzed, and based on these results the investigator rejects or accepts their hypothesis. Rejection entails deducing that either the theory was in error or that the experiment did not directly test the theory; while acceptance entails both deducing that the theory was correct and assuming that the experiment directly tested the theory (Brink & Wood, 1998). Quantitative methods are frequently used in scientific research, with its methods best suited for scientists utilizing the experimental model. Though quantitative studies are ideal for many research questions, they are limited in their ability to answer questions on processes and meanings that are not experimentally measured in terms of quantity, amount, intensity, or frequency (Denzin & Lincoln, 2000).

In 1967, social scientists like Barney Glaser and Anselm Strauss were challenging the dominant view that quantitative studies provided the only form of systematic social scientific inquiry. Qualitative research stresses the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry (Denzin &
Qualitative methodology can be used to obtain intricate details about phenomena such as feelings, thought processes, and emotions that are difficult to extract or learn about through more conventional research methods (Strauss & Corbin, 1998). These methods are frequently used to explore substantive areas about which little is known or to gain novel understandings on research problems (Stern, 1980). Qualitative methods are viewed as inductive; their primary purpose is to create or build theory. Through the richness and descriptiveness of words and other non-numerical data, data collected from a qualitative study aim to represent a phenomenon and all its complexities. These data helps to develop concepts that are subsequently used to develop theory. The choice between selecting a quantitative or qualitative methodology is generally dictated by the research question. For this study, where little is known about this topic, a qualitative approach is most suited towards understanding the factors that influence the care of Chinese elders in nursing homes.

Three major qualitative research traditions are: phenomenology, grounded theory, and ethnography. The phenomenon of interest can be approached from different perspectives by each of these methods. Ethnography, the qualitative method of choice, will be described in greater detail.

Ethnography

A Brief History. Ethnos, a Greek term, refers to a people, a race, or cultural group (Smith, 1989). When ethno as a prefix is combined with graphic to form the term ethnographic, the reference is to the subdiscipline known as descriptive anthropology, in its broadest sense, the science devoted to describing
ways of life of humankind (Vidich & Lyman, 2000). Ethnography has been described as a social scientific description of a people and the cultural basis of their peoplehood (Peacock, 1986).

Early ethnography grew within the field of cultural anthropology. Scholarly “fieldwork” was derived from the discourse of field naturalists, like Alfred Haddon, who in 1903, spoke of gaining deeper connections and meanings of data collected (Tedlock, 2000). By the end of the 19th century, due to the fieldwork carried out among Native Americans by investigators such as Alice Fletcher, Franz Boas, and Frank Hamilton Cushing, the model of experientially gained knowledge of other cultures had displaced armchair methods of study (Visweswaran, 1998). Though these early ethnographers realized that their direct participation in the lives of their subjects was the basis of their method, Bronislaw Malinowski has been credited with the enshrinement of fieldwork as a central element of ethnography as a new genre (Firth 1985; Rabinow, 1985). Malinowski suggested that an ethnographer’s goal should be to grasp the “native’s point of view” (1922, p. 25). Since then, there has been an expectation that “participant observation” would lead to human understanding through a field-worker’s learning to see, think, feel, and sometimes even behave as an insider or “native” (Tedlock, 2000). Today, the use of ethnographic methods has expanded from the field of cultural anthropology to a number of different disciplines including education, sociology, psychology, nursing, and law.

The aim in ethnography is to understand the culture of a phenomenon from various key informants’ point of view. Agar (1997) describes it as
“assembling a fragment of culture, for that’s what culture is, knowledge you construct to show how acts in the context of one world can be understood from the point of view of another world” (p. 1159). It is a combination of research design, fieldwork, and various methods of inquiry to produce historically, politically, and personally situated accounts, descriptions, interpretations, and representations of human lives (Tedlock, 2000). Ethnographers participate overtly or covertly in people’s daily lives for an extended period of time, watching what happens, listening to what is said, asking questions – in fact collecting any data that are available to throw light on the issues that are the focus of the research (Hammersley & Atkinson, 1995). Doing ethnography, is not simply a matter of “grasping what’s there through close participation,” but of actively interpreting ongoing social life and transforming those experiences and interpretations into texts that can be made available to others as versions or representations of “what’s there” (Emerson, 2001).

Ethnography does not aim to represent social processes or the social world in itself, but seeks understanding of it through the impression and meanings it generates for those experiencing these events. This mandate to “understand the way that group members interpret the flow of events in their lives” lies at the core of contemporary ethnography (Agar, 1980, p. 194). In addition, the ethnographer does not grasp members’ perspectives “in themselves, “ but also as mediated through his or her own theoretical, cultural, and personal constructs, which can potentially reconfigure and perhaps distort members’ meanings (Emerson, 2001).
Ethnography as the Methodology of Choice

Nursing homes provide care for many diverse older people. On any given day, interactions occur between facility staff, residents, family members, and other visitors. In this action-filled environment, one may expect to find nurse aides providing physical care for residents, physical therapists providing rehabilitative services, nurses conferring with facility administrators, or family members visiting their relatives. Interactions and experiences amongst this diverse group of individuals create a unique culture in this complex social world.

Residents entering nursing homes in the United States must learn to adapt to an unfamiliar environment. These residents face learning the everyday routines, adapting to living with others, and generally coping with settling into this environment. Though residing in a facility may be a new experience for residents, these facilities are rooted in a familiar Western health care environment and culture. Chinese elders, many of whom are unfamiliar with the practices of Western culture, thus face additional challenges in adapting to the nursing home environment.

This ethnographic study will examine the culture of the nursing home environment as experienced by Chinese elders. Ethnography provides an account of human social activity out of which cultural patterning can be discerned (Wolcott, 1999). Ethnography does not aim to represent social processes or the social world in itself, but seeks understanding of it through the impression and meanings it generates for those experiencing these events. This mandate to “understand the way that group members interpret the flow of events in their
lives” lies at the core of ethnography (Agar, 1980, p. 194). Ethnography is the method of choice for this study because it is most suited to unravel this complex social world by identifying, describing, and analyzing those factors Chinese elders deem to be most important for their care.

Purpose and Specific Aims

Many factors affect how care is allocated and delivered to Chinese elders. Yet, very little research has been done on the elderly Chinese population in nursing homes in the United States. The purpose of this study is to identify, describe, and analyze the factors: clinical, environmental, social, and cultural, that influence the care of elderly Chinese residents in nursing homes. The specific aims are to explore:

1. Does the physical environment (e.g. room accommodations) meet the residents needs and expectations?

2. Do the organizational factors (e.g. policies and philosophies of the facility) create barriers or facilitate residents in meeting their needs?

3. What cultural-psychosocial factors (e.g. cultural beliefs and values, presence or absence of family) influence the care of residents?

4. Are the residents able to interact with people (e.g. nursing staff) in their personal and/or supra-personal environment?

5. Are strategies being implemented to help bridge social-cultural barriers?

Study Sample

The goal in sampling is to select informants that are representative of the population at large including such variables as age, gender, and education, yet
representative of the many aspects of the phenomenon of interest. It is important to select key informants, members of the culture who have experience or will provide knowledge to the topic being studied. Underlying this objective is the assumption that human groups are infinitely variable and that the researcher's responsibility is to document the group's idiosyncratic, distinctive, and singular characteristics and processes (Goetz & LeCompte, 1984). Once the population to be studied is determined, it can be studied in its entirety or a representative sample chosen for analysis. Procedures for choosing participants and other units can vary from rigorous randomized or stratified strategies to the informal strategies of volunteer or convenience selection (Goetz & LeCompte, 1984).

Statistical sampling may be irrelevant where initial description of a hitherto little-known or singular phenomenon is desired, where social constructs to be tested later in more stringently controlled designs are to be generated, where the goal of the research is explication of meanings or microsocial processes, or where the subject of an investigation is an entire population (Goetz & LeCompte, 1984). The goal for studies under these circumstances is to generate data that can be compared and contrasted with other groups.

Sampling in this study will be purposive. Purpose sampling has been said to be the ideal in collecting data spanning the full spectrum of the phenomena (Robertson & Boyle, 1984). Purposive sampling is directed at producing rich and complete data. The aim is not to have a large sample in the study, but to select a sample of the population under study that represents the various aspects of the culture to be examined. Thus, the sample size tends to be small, as the focus is
not on quantity, but the content and quality of the data collected. Sampling will evolve over time as certain categories become saturated and other categories are not yet fully developed (Strauss & Corbin, 1998). Sampling may also change over time as data emerge.

The total sample included 44 people. In this sample, the following individuals, meeting inclusion/exclusion criteria, were interviewed:

- 10 Chinese nursing home residents.
- 10 family members of the relatives of residents interviewed.
- 5 nurses, including both registered nurses (RN) and licensed vocational nurses (LVN).
- 5 certified nursing assistants (CNA’s).
- 2 social workers.
- 12 nursing home staff, including: administrators, managers, therapists, activity coordinators, dieticians, and volunteers.

Data collected from these interviews will be presented in the next chapter.

Data Collection

In ethnographies, multiple methods are used to collect data including: participant observation, interviews, life histories, and surveys (Goetz & LeCompte, 1984). Much of the field work is composed of participant observation and key-informant interviewing. Therefore a large portion of methodological writing is devoted to these aspects of research procedures (Pelto & Pelto, 1978).
Participant Observation.

Participant observation is the primary technique used by ethnographers to gain access to data (Goetz & LeCompte, 1984). Participant observation involves establishing a place in a particular setting on a relatively long-term basis, in order to investigate, experience, and represent the social life and social processes that occur in that setting (Emerson, Fretz, & Shaw, 2001). Participant observation implies taking on the role of being a participant and an observer. As a participant, the researcher enters the worlds and activities of others, to experience their “matrix of meaning, to participate in their system of organized activities, and to feel subject to their code of moral regulation” (Wax, 1980, p. 272). As an observer, the researcher collects data while maintaining enough distance to provide for objective and analytical reflections. Data collected through participant observation indicate what is important and unimportant, how people view each other, and how they evaluate their participation in groups and programs, providing the basis for determining the extent to which formal and informal goals and objectives of a group are being met (Goetz & LeCompte, 1984).

Hammersley and Atkinson (1995) describe researcher styles as being located along a continuum from complete participant to complete observer. At times, a study may dictate that the researcher needs to be a total participant. At other times, a study may dictate that the researcher needs to be a total observer. Various scenarios arise during the study where one should vacillate somewhere along both ends of the continuum.
The participant observer begins by gaining access and creating trust among individuals in the environment. By carefully observing the interactions of others and interacting with others in the environment, observers can begin to learn the culture of the environment, or in this case the nursing home. Observers do not need to always necessarily do as others are doing, but they should be able to “feel” and “sense” the nature of the experiences that are occurring. These observations are not limited to what others are doing or how they are interacting, but should include the sights, sounds, and smells that contribute to the overall experience. In time, it is important for the observer to becoming thoroughly familiar with all aspects of the environment.

Initial field work through participant observation should include a general overview of the culture being studied. Details about every aspect of the environment should be given consideration. Upon analysis and reflection of these initial data, new questions may be generated. Then as the observer becomes increasingly “immersed” in the environment, observations may just focus on specific aspects of interest (Emerson, 2001, p.17). Further field work may then expand on these specific areas of interest. As important as it is to be immersed in the setting, Hammersley & Atkinson (1995) state that throughout participant observation, it is important to maintain a more or less marginal position, thereby providing access to participant perspectives but at the same time minimizing the dangers of over-rapport.
Interviewing informants is a very effective method to gather data. Interviews may help explain what the ethnographer sees and experiences (Fetterman, 1989). Directive questioning and non-directive questioning are likely to provide different kinds of data, and thus may be useful at different stages of inquiry (Hammersley & Atkinson, 1995). Focused questions will direct the informant to disclose information on a very specific topic. Open-ended questions will allow informants to express their own ideas or share experiences. Specific interview questions and/or topics to be discussed are often decided before the interview begins. But a more flexible approach to the interview process is important, allowing the discussion to flow in a way that seems natural (Hammersley & Atkinson, 1995).

Establishing good rapport with informants is important. In the long-term care setting, sensitive topics regarding health status, disability, and death and dying are frequently at the forefront of many people’s thoughts. Thus, interviews can be quite unsuccessful if informants do not feel safe and/or comfortable in sharing their thoughts, feelings, and ideas.

Interviewing Chinese elders about the factors they find most salient in influencing their care is essential in attempting to understand their experiences. To fully understand the world in which these Chinese elders see themselves in, it is important to interview other informants in their environment. Interviews with family members, non-Chinese residents, facility staff, and administrators will provide additional insight to resident experiences.
Field Notes.

Field notes are intended to provide descriptive accounts of people, scenes, and dialogue, as well as personal experiences and reactions (Emerson, Fretz, & Shaw, 2001). Field notes are the record of an ethnographer’s observations, conversations, interpretations, and suggestions for future information to be gathered (Agar, 1980). They are a representation, a way of recording details. These descriptions are not a simple matter of recording “facts”, of producing written accounts that “mirror” reality, but writing that embodies a particular purpose (Atkinson, 1990; Emerson, Fretz, & Shaw 1995). Whatever the level of concreteness of field notes, it is essential that direct quotations are clearly distinguished from summaries in the researcher’s words, and those gaps and uncertainties in the record are clearly indicated (Hammersley & Atkinson, 1995). Clarity in all notes taken during the course of the study will help the researcher avoid doubt and confusion during data analysis. Field notes will consist, according to this scheme, of two types of data: First, some ideas from observation to follow up with interviews, or some observations/questions to follow up that came from interviews; second, some things you’ve noticed that you want to be sure to get to eventually. Field notes, then, are working notes. They are a step on a ladder used for an ascent towards an understanding of some group (Agar, 1980).

Theoretical Memos.

Theoretical memos are important tools used to keep track of and refine ideas that develop, in contemplating concepts and comparing concepts with one
another. These memos will be a collection of concepts encountered during data collection and how these concepts relate to each other. They help the analyst move from working with the data to conceptualizing (Strauss & Corbin, 1998).

Data Collection Procedures

Data were collected at the nursing home for four months. Data collection procedures included:

- Participation observation. General observations were made on all aspects of day-to-day life, interactions, and experiences of Chinese residents, their families, and the facility residents and staff. Two weeks were spent collecting data specifically through participant observation. Observations were made on weekdays, weekends, mornings, afternoons, and evenings. Details about every aspect of the environment (e.g. mealtimes, bathing, activities, special events, interactions etc.) were given consideration (e.g. At mealtimes: Who feeds the residents? What is fed to the residents? When do they eat? Where do they eat?)

- Interviews were conducted with Chinese residents, their families, non-Chinese residents, and facility staff.

  Interviews were conducted at the nursing home. Each interview took approximately one hour.

- Extensive field notes were taken on observations.

  Gathering data through multiple techniques and from multiple people, including residents, families, facility staff, and administrators, allows the
researcher to focus not only the Chinese elder’s perspective of their experience, but to view the situation and all its complexities from the perspective of others.

Data Analysis

Qualitative analysis is the search for patterns in data and for ideas that help explain the existence of those patterns (Bernard, 1988). Several methods were used to analyze the data, including coding, content analysis, and thematic analysis (Bernard, 1988; Strauss & Corbin, 1998).

Ethnography has suffered in the past from a rigid and artificial separation of data collection and analysis (Charmaz & Mitchell, 2001). Data analysis begins shortly after data collection begins. Data analysis that occurs simultaneously with data collection allows the researcher to interpret data early in the research process, which in turn, allows future data collection efforts to be more focused to certain areas of interest (Charmaz, 2000).

Analysis begins with careful and systematic reading of the data. Data are coded and then categorized. Coding is the initial process of thinking, reflecting, and defining what the data are about (Charmaz, 2001). The codes should emerge from the data. Further analysis of the coded data may lead directly to the development of categories. Categories are generated through coding and comparisons made between and amongst the data (Charmaz, 2001). Questions about the data or gaps in the data can emerge during this process of analysis. At this point, further data collection in the field focuses on addressing and exploring these issues.
These categories are then analyzed for content and recurrent themes. One strategy used is Glaser and Strauss’s “constant comparative method” (1967). Using this method, the researcher examines items of data coded in terms of a particular category or theme, and notes its similarities with and differences to other data that have been similarly categorized (Glaser & Strauss, 1967). As this process develops, relationships and meanings amongst and between various categories and themes may begin to emerge. The goal is to examine how various factors influence and interact with others to influence the care of Chinese elders.

Reliability and Validity

In qualitative research, reliability refers to the extent on which studies can be replicated. Reliability in ethnographic research is dependent upon the resolution of both external and internal methodological issues (Hansen, 1979). External reliability is present when independent researchers discover the same phenomena or generate the same constructs in the same or similar settings (Goetz & LeCompte, 1984). To ensure replicability of findings by others, the researcher must be clear about the research objectives, how data were collected, give precise details on data analysis, and clearly explain the findings. Internal reliability refers to the degree that independent investigators discover the same phenomena or generate the same constructs from the same data.

Validity refers to the accuracy of findings, that is, how accurately the data and findings represent reality. Validity is also dependent of the resolution of both external and internal methodological issues (Hansen, 1979). External validity
refers to the generalizability of the findings. Under optimal circumstances, the results represent that which can be found in similar cultures. Internal validity is described as whether there is consensus between the quality of fit of observations and the basis on which it was made (Kirk & Miller, 1986).

There are no really good methods to truly validate qualitative findings. As Bloor remarks, “history, contrary to popular opinion, never repeats itself” (2001, pg. 384). There are just too many factors involved. But some validation of qualitative findings can be achieved through a variety of techniques. There are two main techniques of validation, triangulation and member validation (Bloor, 2001).

In triangulation, a combination of different research strategies is used to collect data from respondents and identical findings from the various strategies help to validate the data (Denzin, 1978). If different strategies of gathering data from the same respondents yield similar findings, then these findings must have some validity. This method brings validity to data when multiple strategies result in similar findings, but what happens when the findings are not similar, does that necessarily mean that data gathered from one strategy or another is not valid? Which data are more valid, the one gathered from the better strategy or method?

Member or respondent validation involves using various techniques to bring findings interpreted from the gathered data back to the respondents to judge the degree of accuracy of the researcher’s analysis. The value of respondent validation lies in the fact that the participants involved in the events documented in the data may have access to additional knowledge of the context
of other relevant events, of temporal framework, of others’ ulterior motives, for example, that is not available to the researcher (Hammersley & Atkinson, 1995). This seems to be the ideal way to validate findings. The researcher gathers data from a respondent, then the researcher goes back to the respondent to see if he/she accurately interpreted the data.

Validation using this technique is not quite that simple and/or appropriate for all qualitative research. The concern is for the well-being of the respondents. Will returning to the field to validate findings be harmful or cause stress to the respondents? Informants in this study may be living in very difficult circumstances; they may be unhappy and uncomfortable in their situation. Informants often find themselves sharing difficult and sometimes painful experiences, but how they would react upon hearing how these experiences were analyzed? Is this too confrontational? Would this be too painful? Rehashing topics, possibly painful topics that they may live through on a daily basis, may not in the best interest of these informants.

Time is also a factor. Things change as time passes, people change. Circumstances that might have been very relevant may no longer be quite the same. Respondents may no longer be the same (Bloor, 2001). Some of the elderly respondents may have passed on since being interviewed. Due to their age, there is a higher likelihood that this may have happened. In this population, memory may be a factor, especially short-term memory. Will respondents even remember being interviewed? Will they remember what was talked about and what was said? Use of member validation may not be ideal for this study.
Validation of findings with “experts” may be an approach more appropriate for use in this study. These “experts” could consist of people who are familiar with nursing homes and/or work with elderly Chinese people. They would include facility staff, including, but not limited to: administrators, managers, physicians, nurses, dietitians, and social workers. This could be done individually or as a group. Though this approach might not be as ideal as member validation, it may be more appropriate considering the population being studied. Facility staff, especially the Chinese-speaking staff, who work with the respondents on a daily basis will have some understanding of the Chinese elder experience in a nursing home. They will, to a degree, be able to comment whether analysis of the data represents what occurs in this environment.

Conclusion

Elderly Chinese residents residing in nursing homes in the United States face living in an environment where they may unable to communicate with others, where they are served food unfamiliar to them, and where they have to adjust to different cultural practices. A deeper understanding of this phenomenon will help healthcare professionals develop and implement strategies to provide culturally sensitive and appropriate care for Chinese elders. The purpose of this study is to identify, describe, and analyze the factors: clinical, environmental, social, and cultural, that influence the care of elderly Chinese residents in nursing homes. Ethnography was the method used to gather and analyze data to understand the meanings, relationships, and interactions of the Chinese elders in this study.
Chapter Four

Results
Data were collected through participant observation and interviews at a 100-bed nursing home facility. The mission of this facility is to provide compassionate and quality care that recognizes the ethnic diversity of its residents. Identifying variables and names have been altered to protect the anonymity of the facility and its residents and staff.

The Physical Environment

Description of the City.

This facility is located in a large growing city in California. The average per capita income in this county of 1,600,000 people is $22,607; 11.5% of the population is over the age of 65 (U.S. Census, 2000a). The Asian population, including the Chinese, makes up nearly 9% of the population (U.S. Census, 2000a).

The majority of the elderly Chinese residents in this city live in two neighborhoods, where there is a large Chinese population. These neighborhoods include access, many within walking distance, to amenities such as Chinese supermarkets and shopping centers, Traditional Chinese Medicine health care clinics, and Chinese schools and activity centers. Many of the monolingual Chinese elders who live in these neighborhoods are able to meet their needs of daily living with little difficulty. The facility is situated in one of the two aforementioned neighborhoods, with a large Chinese population.

Physical Description of the Facility.

The facility, built in the mid-1980’s, is a grey single level, five wing building. Double glass doors open into the lobby of the facility. Upon entering,
one is surrounded by the beauty and tranquility of the Asian style décor of the large lobby. The lobby, painted a dark magenta-purple color, is dimly lit with natural sunlight coming in from the windows. A tall waterfall feature, surrounded by a few green plants, is in the right corner of the room. The tranquil sounds of water can be heard as the water hits the base of the fountain. At the left corner of the room, is a seating area with a large sofa, a pair of matching sofa chairs, and a coffee table. This seating area is flanked by several potted plants. A beautiful large fish tank, with several black and orange goldfish, sits against the back right wall of the room. At the back left wall of the room, is a black cabinet housing a very large glass birdhouse. Five colorful, chirping finches, live in luxury amongst faux tree branches, tiny hanging wicker birdhouses, and an elaborate feeding structure. Residents often come to the lobby to sit and enjoy the fish and the birds. The lobby is also frequently used by residents to socialize with one another and with their visitors. It is a peaceful, comfortable place to sit, relax, and enjoy the features of the room.

At the back of the lobby are double wooden doors leading to the center of the facility, the nursing station. The other four wings of the facility protrude outwards from the nursing station. Three of these four wings contain resident rooms. The fourth wing contains various resident and staff areas.

One hundred residents live in this facility. In the resident wings, there are four private rooms, 26 semi-private rooms, four three-person rooms, and eight four-person rooms, for a total of 42 rooms. Each resident has a bed, bedside chair, tray table, nightstand, closet and bulletin board. With the exception of
those in private rooms, residents share a bathroom with two or three other residents. The semi-private rooms are small, with little space to move around. One resident, Mrs. Lin says, “My roommate and I both use wheelchairs. With the two of us in our wheelchairs, trying to get around in our room at the same time can be quite difficult.” The private rooms and three and four-person rooms, however, are quite spacious. All the rooms are painted white with no décor, a stark contrast from the other painted and decorated resident areas in the facility. Many residents choose to decorate their space with photos and art, like Mrs. Wang, who has decorated the walls surrounding her bed with over 50 photos of her family and friends. Several small banners with Chinese characters wishing her health, happiness, and good fortune also adorn her walls. Televisions and telephones are not provided in the rooms. Many residents bring their own televisions and VCR/DVD players from home. Residents may use a common cordless telephone at the nursing station, and several residents had their own personal cellular phones. Overall, the rooms are neat, clean, and tidy.

Unlike the other resident rooms, four-person rooms contained not only a sink and toilet, but a shower stall. Residents in this facility bathed in either the showers in these four-person rooms or in the tub room. The tub room is fairly large with a sink, toilet, one shower stall, and a large whirlpool tub. The room is clean, but looks dated. The tub room will soon be remodeled and will include a new state-of-the-art whirlpool tub.

The beauty salon in the facility is beautifully decorated and has the feel of a relaxing salon. It is painted a golden orange color, with several pieces of
coordinating artwork on the walls. Live potted plants sit in the corners of the room. A mirror hangs on the wall to the left, with a large counterspace and sink in front. Hair dryers line the right side of the room. At the far end of the room is a flat screen TV hanging on the wall and a small sitting area, with two chairs and a small table with a few magazines. Sandra, the hair stylist, provides services for a fee at the facility twice a week.

The meeting room and day room is actually one very large room separated by a room divider. The entire room is used during special events. On most days, the room divider is up; one room functions as a meeting room for the staff and the other as a day room for the residents. At the center of the meeting room is a large conference table and chairs. Two vending machines with snacks and drinks are available here for the staff and residents. Many of the residents like to spend time in the day room. A sofa and loveseat, and several wingback chairs provide seating in this cozy room. The focal point of this room is the large entertainment center. Here the residents can watch cable television. Books on various topics, in English, Chinese, and Japanese, fill the shelves of the entertainment center. The local daily newspaper and current popular magazines are also available for the residents to read. On cold days, the beautiful faux stone gas fireplace provides a wonderful feeling of warmth to this room. The attention given to the details in this room makes one feel like they are sitting in a family room of a home. One resident, Mr. Lee, an avid reader, has a favorite chair in the dayroom. He begins every morning sitting in his favorite chair reading the newspaper. He says, “There is not a lot of activities I like to do here,
but I love to sit here and read. It’s just quiet enough for me to read, but not too quiet so that I feel like I’m all alone here.”

The dining room, the largest room in the facility, is adjacent to the kitchen. Asian art pieces decorate the all-white walls of this brightly lit room. At the center of this room are eight large white dining tables. Rows of stacked chairs, for extra seating, line one side of the room. On another side of the room, there are also six u-shaped tables, for residents who need help with their meals. The dining room functions as a multi-purpose room. On any given day, this room is the center of activity, but during mealtimes, it is used as a dining room. Nearly all of the activities offered by the facility take place in this room, including arts and crafts hour, social hour, and game time. On Sundays, religious services are held here.

This facility is over 20 years old. It is nestled in a quiet middle-class residential community. The neatly manicured trees along the street and surrounding the building are mature and reflect the beautiful colors of the fall season. Behind the facility is a newly-remodeled garden area. At the right corner of the garden is a beautiful waterfall feature which empties into a small fish pond. Two small redwood patio structures provide shade to those wanting to sit and admire the waterfall. A low brick wall behind the patio structure provides additional seating. A large area of grass lies to the left of the waterfall feature. A concrete path across the grassy area leads to a large white gazebo. The gazebo houses a brand-new barbeque grill, a refrigerator, and six large table and chair sets. One of the residents, Mrs. Mak, remarked, “The staff had asked the
residents for input regarding the garden re-model project. They asked all the residents to offer suggestions on what they would like to be included in the new garden. I suggested a waterfall, or some sort of water feature, which is what was eventually installed. I think the new garden looks beautiful, but it’s too bad we can’t go out there by ourselves.” Family members and friends may take residents out to enjoy the garden, but due to safety issues residents are not allowed to go out to the garden alone.

A noticeably absent feature of this facility is the absence of unpleasant odors. Cleanliness is a top priority, particularly for the housekeeping staff. Mrs. Wong, a resident, says, “It is very clean here. It is not like other nursing homes that smell bad. You can smell the medicine or something. There is no smell here. I really love that there is not that “nursing home smell” if you know what I mean.” June is a CNA that has been with the facility for four months. While searching for a job, she was offered positions at several facilities. When asked why she had chosen to work at this facility, she replied, “One thing I noticed is that this place does not have a smell. It is so very clean here. I think it has something to do with the pride of the housekeeping staff. They take pride in their work. For instance, if someone accidently gets urine on the floor, at other places that I have worked, they will say, “I will get it later.” Here, they come right away to clean it right up. This attitude makes all the difference.” The resident and staff frequently commented on the cleanliness of this facility.
The Organizational Environment

Thirty years ago, Mr. Gee was looking for a facility for his ailing mother. There were many in the area, but he worried about how his mother, who did not speak English, would adjust to living in a nursing home. Many of Mr. Gee’s friends found themselves in a similar situation. The Asian community banded together to establish a non-profit corporation (Asian Community Group) dedicated to providing culturally sensitive health and social services for the older adults in the community. First on the agenda was the construction of a nursing home facility. The Asian Community Group spent 15 years planning and fundraising. The new facility opened its doors in the mid-1980s and has been in operation now for nearly 20 years.

The mission of this facility is to provide compassionate and quality care that recognizes the ethnic diversity of its residents. The facility is designed to meet the needs of the Asian population, but welcomes all residents. The facility provides culturally sensitive services to help meet the needs of their residents including: a bilingual staff, specialized dietary services (Asian and Western cuisine); rehabilitation services including physical therapy, occupational therapy, and speech pathology; family counseling; multi-cultural activities for groups and individuals; art and craft activities; religious services; special entertainment events; laundry services; and a beauty salon. Their vision is to be a premier facility in the community, providing a “home away from home,” for elders requiring nursing home care.
This non-profit facility is owned and operated by the Asian Community Group, and governed by the Board of Directors. Board members are active members of the Asian community. When a position opens, they collectively decide whom to invite to join their board; 14 of the 15 board members are Chinese or Japanese individuals. On a day to day basis, an executive director, Dr. Lee, runs the Asian Community Group. Dr. Lee has over 20 years of experience in long-term care. The Asian Community Group she runs includes the nursing home facility and the community center. The community center offers classes for older adults and family caregivers in the community. Respite day services and transportation services are also available through the community center.

Mr. Wong, a board member, serves as a liaison between the board and the facility. He explains, “As the liaison, I head the nursing home committee. This group of about seven people at the facility discuss, on a monthly basis, all things related to the nursing home, reviewing the policies, discussing new projects etc. When the board meets, I give a report to them about what is happening at the nursing home.”

The facility employs 110 staff members. The age range of the 24 staff members interviewed was 19 to 60, with a mean age of 37. These staff members have been employed by the facility from 6 months to 19 years. The average length of employment was 7.8 years. A profile of all of the staff in the facility is presented in Table 1.

Mr. Williams, the facility administrator, has been with the facility for over
six years. He is quite pleased with the organizational environment of this facility and during his interview said, “I think we are successful here because of the Asian Community Group, the wonderful staff we have here, and the fact that we are a non-profit facility. Unlike other nursing home chains I have worked for, who like things done a certain way and are looking to make a profit, this facility is different. The board members and executive director are flexible and open to new changes, and we work together and are constantly making changes to improve life for the residents at this facility. I enjoy working in a collaborative environment and have no desire to leave. The trouble with many other facilities is that administrators often feel like they are fighting to get what they need or to try to make changes, and often to no avail, and so eventually they get so frustrated they leave their positions after a year or two. New administrators are always coming in and starting from the beginning, so it’s hard to get much accomplished when they always seem to be starting from the beginning. Sometimes it takes time to institute changes and I believe that consistency in leadership is important.”

Leadership roles in the facility related to direct resident care, include the director of nursing, the director of staff development, the social worker, the activities coordinator, and the dietary manager. The director of nursing, assisted by the director of staff development, is responsible for nursing staff. The facility employs 5 registered nurses (RN), 16 licensed vocational nurses (LVN), and 49 certified nurses aides (CNA). The average nursing staffing hours at this facility was 3.3 hours per resident day.
Mrs. Lo is the Director of Nursing at the facility. She is well-liked by the staff and seems to have a good working relationship with them. Cathy, an LVN, who has been with the facility for over 17 years, says, “Mrs. Lo expects a lot out of us, but is very laid back and easy to work with. She is not one to just sit in her office and do paperwork or go to meetings, but she spends time getting to know the residents, the staff, and managing what goes on in the facility every day. We may not always agree on things, but she is always fair.”

When asked about staffing Mrs. Lo said, “The facility has a very good reputation, so finding staff is not too difficult. Pay rates here are on average (about $26 for LVN and $12 for CNA) and lower than what you would find at a hospital, but most who work here are Asian (over 80%) and enjoy working with Asian elders.” In being an Asian-oriented facility, we naturally attract Asian staff members. Mrs. Lo explains, however, that when considering potential staff members, she is more interested in individuals for their experience and skill competencies.

In the 20 years that this facility has been in operation, they have never used registry staff. Mr. Williams explains that using registry staff is costly and can drain the budget quickly. The facility pays twice as much money for a registry nurse as they would pay their own nurses. Even if they need to ask one of their nurses to work overtime, that nurse would receive 1 ½ times their pay rate, still less than what registries charge. The facility is able to manage to keep their facility staffed with their current staff of full and part-time nurses and aides. Mrs. Lo is proud of the fact that her staff, as a whole, is dedicated to their jobs
and has a good work ethic. They appreciate the opportunity to make extra money and will work extra if they are needed. Many of the staff have worked here for many years and the friendship and camaraderie are evident. Maria, an LVN who has been with the facility for 15 years, says, “It’s not just a job to us. We are like a family, and when your family needs you, you try to be there. That is not to say that on the mornings when we find ourselves suddenly short staffed, chaos doesn’t occur, but once things get ironed out, we are ok again.”

The nursing staff, LVN and CNAs, are given the same resident assignment for three months and then they rotate. Mrs. Lo explains that she would like the staff to eventually get to know all the residents in the facility. She says, “We could let the staff always have the same resident assignment and not rotate them, but I think it’s nice that, for example, if any particular resident was sitting here and needed help, any of our nurses would know the resident by name and how to help him/her.”

Nurses, primarily LVNs, typically have 33 residents to care for during the day and evening shifts, and 50 during the night shift. The workload is heavy. One LVN, Karen, who has been with the facility 17 years, says “I do not have enough time to provide the care I would like to for the residents. I mostly just pass out the medications. That is all I have time for. There is not enough time to do everything that I want. Sometimes I have to call the doctor, and that takes up a lot of time. I just barely get everything done on time these days.” Though the workloads are heavy, having the same residents to care for everyday makes it easier for both the nurse and resident. Nurses and residents really get to “know”
one another. Leslie, an LVN, remarks, “I've been working a long time here, 10 years. It’s a lot, but I manage to get things done because I pretty much know what each resident needs. Routine things are ok, but when problems come up, that’s what slows me down.”

CNAs typically have about 6 to 8 residents to care for during the day shift, 10 during the evening shift, and 20 during the night shift. In general, they are responsible for their assigned residents. However, during meal times, each CNA is assigned one of 15 stations. Since each CNA inevitably would have some residents eating in the dining room and others eating in their room, stations were created to divide up the work. For example, staff at station one, pass out meal trays to residents eating in their rooms, staff at station two, serve meals to residents in the dining room, staff at station three, answer call lights during meal time. This division of work during meal time allows some staff to care for those in the dining room and others to care for residents in their rooms. Shower schedules are also divided so that CNA’s give two showers each in the morning and afternoon.

Committees are set up so that there is a multidisciplinary approach to resident care. There is a committee devoted to monitoring each resident’s weight and diet. Every Friday, the dietary manager, dietitian, director of nursing, nursing supervisor, and charge nurse meet to review a few of the resident charts, as well as to get updates on particular residents they are closely monitoring. They keep track of how each resident is eating and note any significant weight loss or gain. Plans are made for those needing to gain or lose weight. Similar
committees exist for fall prevention, infection control (particularly urinary tract infection), and pressure ulcer detection and treatment. Generally, these committees are attended by the director of nursing, director of staff development, nursing supervisor, staff nurse and/or CNA.

All-staff meetings are held once a month by Mr. Williams. New staff members are introduced and welcomed to the facility. Staff members celebrating an anniversary with the facility are given a new name tag with their name and number of years they have been with the facility. Those celebrating a special anniversary (e.g. 5 years, 15 years, etc) are also given a bonus. One nurse who has been with the facility for 15 years received a $1500 bonus. Staff members are publicly praised and rewarded with $10 gift certificates for meeting certain goals. For instance, if none of the residents on a particular resident wing have urinary tract infections, or falls, the staff of that wing is rewarded. Mr. Williams says, “We have a low staff turnover rate (about 10-15 %). This is so important for us as management and for continuity of care for the residents. We work hard to find ways to keep the staff happy and motivated and use many incentives, such as the bonuses and gift cards, to achieve this.”

Mr. Williams credits the facility staff for the success of the facility. He says because of the good reputation of this facility, he is frequently asked by others, how he does it. Honestly, he says “Number one is the staff. The staff is the foundation of the facility. The culture of the people of the building make it what it is. Frankly, a majority of the staff are Asian, predominately Filipino. Not Asian because we particularly seek Asian staff, but it’s what we get. Either Asian staff
want to work here because this is an Asian facility, or they come because of the reputation of the facility. Having worked with many staff members in the past, the staff here at this facility is different. I attribute much of it to the Asian culture. The Asian work ethic is strong and they work hard, and are proud of the work they do. The Asian culture values the elderly and it shows. They have it instilled in them that the elderly are the most valued members of their families. They would want their own family members treated like this, so this is what they do for their patients/residents. My staff is dedicated to their jobs, and this is the ideal foundation for me to work with.”

There is a certain finesse to balancing the budget of a nursing home facility. As a non-profit facility, this balance lies somewhere between paying for facility upkeep, resident care, and savings for the unexpected. The resident beds are always filled to capacity. They receive several applications for admissions daily. Mr. Williams and Mrs. Lo carefully decide based on the type of room available, the needs of the resident, and payment for care, which residents to admit.

On one particular day, they had 6 residents on Medicare (6%), 53 residents on MediCal (53%), 30 private pay residents (30%), and 11 residents with private insurance coverage (11%). Depending on the resident and their need category, they receive anywhere from $150 to $500 a day per resident. They receive the most reimbursement from Medicare (up to $500 a day) and the least from MediCal (about $150 a day). Though residents who have Medicare generally yield the greatest reimbursement, it is not always in their best interest
to choose them, as their Medicare status is often temporary. They must also consider future reimbursement rates for these residents when they are no longer covered by Medicare. They often have the option to choose to accept private pay residents. Though they do not get reimbursed as much by the private pay insurers as Medicare residents, in the long run, they do not have to consider the issue of future reimbursement rates when Medicare coverage runs out. Mr. Williams explains that they operate the facility with a small profit, with some of the money going towards making facility improvements and the rest in a savings account for emergencies or future projects.

The Asian Community Group continually raises money for the facility. Every year, they receive many donations. In November, they held a craft and bake sale at the facility, from which they collected over $6000 from sales and donations. Every spring, the Asian Community Group hosts an annual fundraiser dinner. Mr. Williams says proudly, “In one night last spring, they raised $70,000; $70,000 in one night. That’s pretty good for one night. We use the money we get from fundraising in a variety of ways. A lot of it goes to remodeling areas of the facility that need updating. Last year we painted the exterior of the facility. This year we have remodeled the garden area. Plans are now underway to remodel the tub room as well as installing in new flooring in the dining room. The Asian Community Group really does an incredible job of raising money for the facility.” The extra money that comes in enables this facility to provide a better environment for the staff and residents.
The Resident

100 residents live at this facility. The average age of the residents is 86; 78% of the residents are female. The average length of stay at the facility is 426 days. 74% of the residents are Asian (Chinese, Japanese, Filipino, and Vietnamese) and 39% are Chinese. Of the Chinese residents, 69% are Chinese-speaking only. A profile of all of the residents in the facility is presented in Table 2.

Most of the residents use a wheelchair to get around in the facility. These residents are generally only able to ambulate short distances with assistance, or unable to ambulate, but capable of maneuvering their wheelchair around the facility. With the exception of the bedridden residents, the rest of the residents are transferred to a wheelchair and wheeled to their destination by the nursing staff. Each morning, residents are expected to be dressed in their own clothes before going into the dining room for breakfast. Residents attend to their daily personal care, with many able to do this independently at the sink in their rooms. Twice a week, the CNAs assist the residents with a shower. As mentioned previously, Sandra is available twice a week at the facility for hair cutting, setting, perming, and coloring. A manicurist also visits the facility weekly. Residents pay out of pocket for these services. A haircut costs $11 and a permanent $50.

Overall, residents are happy about the care they are receiving at the facility. Mrs. Lee says, “I like it here. I’m happy. Everyone is very nice. I don’t know how to explain it, it’s a good feeling I get about this place. For instance, the nurses are very nice when they help me in the shower. I usually get the same
nurses so they really know me and how I like things.” These sentiments were echoed by many of the residents.

Though residents were generally happy about the care they received at the facility, many complained about having to wait for care. This was their biggest complaint, particularly when they called for assistance in getting to the bathroom. There are 15 CNAs working during the day shift and 92 residents who need at least some assistance with toileting. For instance, one day after breakfast Mrs. Lin’s call light was on; I went inside to see what she needed. She told me that she needed to go to the bathroom soon and had the call light on now anticipating that it would take awhile for someone to answer. She knows that she will have to wait, so she is thinking and planning ahead. Mrs. Hom says, “Sometimes it takes a long time to get help. It can take up to 10 to 20 minutes. It’s just that sometimes when you have a stomach ache or something and you need to get to the bathroom fast, you need to get there fast. You can’t really wait. So I say to the nurses, “I have to go to the bathroom, right now. I mean right now.” If I say it like that, they will try their best to get me to the bathroom as fast as they can. It’s an inconvenience, but I really think they are just trying the best that they can. One person can only do so much at one time.” Though residents complain about having to wait for care, they seem to understand that the staff are trying their best, and that they get to them as soon as they are able to.
The Personal Supra-Personal Environment

Residents

The residents, their family and friends, and facility staff and volunteers, constitute the personal supra-personal environment. Of the facility's residents, 39 are Chinese, 32 are Japanese, and 22 are Caucasian.

Residents socialize with each other during meal times in the dining room, during activity hours, and while sitting in the day room or lobby. Many friendships have developed among the residents. Mr. Yee says, “I have made good friends here, like Stan. He’s a good guy. I like him. We like to joke around with each other. He looks out for me. If I forget that it is time for lunch, he’ll come over and say 'Hey, it’s time to go to lunch.'”

Many of the monolingual Chinese residents have also developed friendships with each other. It was not uncommon to come into the dining room and find a group of Chinese residents chatting in Chinese. Mrs. Chow befriended her new next door neighbor Mrs. Lin when she arrived. Mrs. Lin later told me, “I’m so happy that there are so many Chinese people here. At the other nursing home, I did not have anyone else to talk to, there weren’t any other Chinese residents there at that time. I have met a few of the Chinese ladies here. This has been so nice for me. I enjoy being able to socialize with others.”

Not all of the residents socialize with each other. This was particularly noticeable amongst the male residents. Mr. Lee says, “No one seems to like to talk. Most people seem to keep to themselves. There are not a lot of people to talk to.” Mrs. Wilson, the activities coordinator, commented on this and said, “I
think it is sort of the nature of women. They like to do crafty things, and talk and gossip. The men don’t participate in the activities very much and thus these opportunities for socialization are missed.” When asked about socializing with other residents, Mr. Lam replies, “I don’t really. I prefer to be alone. I just like to keep to myself.”

Resident council meetings are held once a month. All the residents are invited to attend. Generally about 15 residents gather together with Mrs. Wilson, the activities coordinator, to discuss any issues they have. They are updated on changes going on in the facility and talk freely about things they like or dislike about the facility. Mrs. Wilson presents the minutes of these meetings during the weekly leadership team meeting, where they can be discussed and addressed.

*Family and Friends*

Families are very involved in the care of their relatives. Mrs. Lo, the director of nursing, says, “All of the residents have family or friends that come to visit.” While visiting hours at the facility are from 10 am to 8 pm daily, they are not enforced. Family and friends may visit at any time. Mrs. Lo she says that on several occasions, particularly for newly admitted residents who are adjusting to the facility or terminally-ill residents, they have allowed family members to spend the night at the facility.

Frequency of visits by family members or friends varies from resident to resident. The majority of family members come to the facility two to three times a week. This is dependent on the working status of family members. Those who are not employed generally visit daily or several times a week. Those who work
generally visit either before or after work several times a week or come on the weekends. Mrs. Chin explains, “My daughter is very busy. She goes to work every day and has children to care for. She tries to come on the weekends when she can. I tell her it is ok, I understand.” Mrs. Lo, the director or nursing, says, “Chinese families as whole, are very involved in lives of their family members. It is very rare for residents not to have at least weekly visits from their family.” Though specific numbers of frequency of family visits were not gathered, it appeared that monolingual Chinese residents received visits more frequently than English-speaking Chinese residents.

Many of the Chinese residents had sons/daughters who visited daily. Mrs. Lam’s daughter, Lisa, is a stay-at-home mom of two school-aged children. Every day after lunch, Lisa comes to the facility. Lisa says, “I come because I like being with my mom. She tells me what is going on around the facility, and I tell her what is happening in my life.” Mr. Wong, a board member and the facility liaison to the Asian Community Group, is at the facility every morning at 7am to help his father and father-in-law with breakfast before he leaves for work. His relatives are able to feed themselves, so he often helps the staff serve breakfast and collects the dishes when residents are finished eating.

Visiting families frequently brought food for their family members. Family members also frequently helped provide personal care, such as bathing their relatives. Many family members came during meal times to help their relatives with their meals. Mrs. Kong had a stroke that left her with right-sided weakness. With great difficulty, she is able to use a specially designed fork to feed herself.
Her daughter, Ruth, came to the facility every day to assist her mother with her lunch. She says, “Mom is able to feed herself, but she is very slow. I try to let her feed herself. I think this will help her hand get stronger, but I do help her when she is really struggling. She gets frustrated sometimes, but I keep encouraging her. I come everyday at lunch so I know that she is eating well for at least one meal a day. I think she eats better when I am here.” Mrs. Kong’s CNA, Janet, says, “I’m so glad Ruth comes every day to feed her mother. She is very encouraging and patient. Mrs. Kong eats more when Ruth is here. I would love to give Mrs. Kong that attention, but there usually just isn’t enough time for me to do that.”

Facility Staff and Volunteers

The staff and volunteers are also an integral part of the residents’ person supra-personal environment. They do not just care for the residents, but socialize with them. As a result of the low turnover rate of the staff at the facility, many of the staff have been working at the facility many years. The nursing staff as a whole know the residents’ habits, preferences, and general demeanor very well. Mrs. Fong, who has dementia, frequently tries to get up out of her wheelchair. She is unsteady on her feet and the staff are always worried that she will fall when she tries to get up out of her wheelchair. She can frequently be found sitting at the table in the nursing station where the ward clerk can keep an eye on her. The staff know that Mrs. Fong really likes shopping. The ward clerk frequently brings fashion magazines for her to look through. Throughout the day, various staff members will come up to Mrs. Fong and say things like, “Mrs. Fong,
I’m looking for a new sweater. Have you seen anything good for me?”

Sometimes Mrs. Fong will say, “Leslie, I found a purse I think you might like.”

Mrs. Fong is doing something that occupies her time and gives her an opportunity to socialize with the staff.

Many people volunteer their time at the facility, usually on a weekly basis. During the week, volunteers help residents during the arts and crafts hour and the popcorn social hour. Teenagers volunteer at the facility, on the weekends, often to help the residents play bingo. Various community groups (e.g. church youth groups, Girl Scouts) come several times a month to put on special activities for the residents. These groups put on performances, organize special craft sessions, or play games with the residents. Residents enjoy socializing with the volunteers and vice versa. Tina, a 17-year old high school junior, volunteers at the facility to meet a community service requirement for a class at school. When asked what she enjoys most about volunteering here she says, “I’m bilingual and speak Cantonese Chinese and English. The Chinese residents who don’t speak English really appreciate having me here, and that makes me feel good. I also really enjoy talking with them. They tell some really interesting stories.”

The Cultural-Psycho-Social Environment

As mentioned previously, the mission of this facility is to provide compassionate and quality care that recognizes the ethnic diversity of its residents, which are predominately Asian. What makes this an “Asian” facility? Mr. Williams, the facility administrator, says, “The food, the religious services, the
activities, and most importantly the culture of the building and its staff and the
culture of its people, the residents.” Mr. Wong, the facility liaison to the Asian
Community Group, says, “There are so many Asians here. We have many
common cultural/religious beliefs, for the most part. We recognize and respect
the commonalities and differences of the culture of the residents.” One resident,
Mrs. Hom says, “I like it here. They have familiar food here, there is a familiar
culture, and Chinese people to socialize with.”

Over 90% of the residents in the facility have their meals in the dining
room. One resident, Mr. Woo, who had just transferred to this facility from
another facility remarked, “What’s different here is that everyone eats in the
dining room. They did not do that at the other facility I was at, so that’s different
here. Everyone at the old place would eat in their rooms.” Mrs. Lo, the director of
nursing says, “With the exception of a few residents, there is no reason why
residents cannot be dressed every day and have their meals in the dining room.
They need to get out of their rooms and be with other people, to socialize.”

Due to space limitations, every resident has an assigned seat in the dining
room during 1st or 2nd dining. There are approximately five residents at each of
the eight tables in the dining room. Approximately 20 residents, who are unable
to feed themselves, sit at one of six horseshoe shaped tables and are fed by
CNAs during 2nd dining, with each CNA feeding three to four residents at a time.
The CNAs patiently feed each resident, often encouraging residents to eat more.
Other than words of encouragement, very little conversation occurs at these
tables.
The kitchen is located right next door to the dining room. An opening between these two rooms allows the CNA’s to bring meals directly from the kitchen to the dining room. There are no meal trays in the dining room. Each resident’s meal is served on an elegant white plate. During mealtimes, the CNAs pass out meals, refill the cups of coffee or juice, and encourage the residents to eat. As residents are eating, the CNA’s talk to each other, but surprisingly there is little dialogue among the residents or residents and staff.

In general, the facility serves Asian style cuisine. Interestingly, there is no Asian food for breakfast. A Western style breakfast is served. Residents are offered: oatmeal, cereal, muffins, toast, pancakes, scrambled eggs, bacon, and hash browns. Though Asian style food is not served at breakfast, the dietitian says that breakfast is the meal where on average the greatest amount of food is consumed by the residents. Asian style entrees are served every day for lunch and dinner. Residents choose from entrees like: broccoli beef, miso soup, sweet and sour pork, stir fry bok choy, sesame chicken, curry chicken, tofu, egg flower soup, and teriyaki chicken. Steamed rice is almost always offered as a choice for lunch and dinner. On special occasions like Chinese New Year, residents enjoy having dim sum.

At each of these meals, residents have a choice between the entrée of the day and an alternate entrée. They are also allowed to write in simple requests, like noodle soup. If the kitchen staff is able to meet their request, they will do so.

Food is so important to the residents at the facility that, Mrs. Brown, the dietary manager says that this is the most talked about topic amongst the
residents at the facility and the one thing that everyone has an opinion about.

Mrs. Lau says, “I lived at another facility before I came here and they served Western food which I don’t enjoy as much. I like the Asian style food. Granted, not all the food is to my liking, but overall it is very good, and plentiful. Sometimes too much. I like having rice to eat at most meals too, which they have here.” Many other residents were also very happy that Asian style food choices were offered at the facility. They particularly enjoyed several of the rice and noodle dishes.

Residents liked the fact that Asian style food was served by the facility. To them, this was an improvement over the Western food commonly found at other facilities. However, residents had many complaints about how the Asian food was prepared. Here are some examples of some of the residents’ comments:

- “My only complaint about living here is the food. I think that the food is the biggest problem here. Good food is so very important.”

- “They offer Asian style food. They really try but it looks and tastes nothing like Asian style food. Sesame chicken, doesn’t taste like sesame chicken. They have roast pork, but it is so dry. They have Chinese vegetables, but they boil it so long that it doesn’t have any taste. You are supposed to boil it first and then stir fry it and add some flavor. The food here does not taste like it is supposed to.”

- “I love chow mein. It’s a pretty simple dish to prepare, but the chow mein they serve here, they don’t use the right kind of noodle. So it does not taste like chow mein.”

- “Not much fruit is offered here, just apples, bananas, oranges, and sometimes watermelon. The fruit is very thinly sliced, and looks like a garnish for the plate. I don’t know if they cut the fruit in such small pieces so people can eat it, but they give so little here. I have to ask my husband to bring fruit for me to eat.”
“The food here is bad. Yesterday we had broccoli beef. They cooked the broccoli so long that it was nearly unrecognizable. The broccoli in broccoli beef is supposed to be green and a little crunchy. Well, theirs was all mush. It looked bad and tasted bad. We had tonkatsu (Japanese style deep-fried pork cutlet) the other day. It looked and tasted nothing like tonkatsu. It didn’t even seem fried. We have resident council meetings every month. People complain about the food, but they don’t listen. I don’t think they are listening to us and nothing is done about it. They will go out and spend $25 on napkins, but I wish they would take all that money and spend they money on preparing good food.”

“A lot of the food goes into the garbage. I think the other residents don’t like it either, because it doesn’t taste good. What a waste of food.”

Juk, a Chinese rice porridge, is frequently eaten by Chinese people for breakfast. It is also commonly prepared for people when they are ill. It is the Chinese equivalent of chicken noodle soup. Interestingly, I did not see it offered to the residents. Mrs. Hong, a resident of the facility for over five years, says, “They used to have juk (Chinese rice porridge) here sometimes, but it is not the juk you and I are used to, a nice and thick porridge. It’s more like a thin rice soup. They do not cook it long enough to be like the juk you are thinking of. I think part of the problem is that they have these preset recipes. I think they have to cook according to the recipe that they have, so it might not come out like it’s supposed to. Many of the cooks are Filipino or African American, so I don’t know if they even know what “real” juk is supposed to be like.” Mrs. Brown, the dietary manager, explains that they used to offer juk every morning for breakfast, but no one ordered it, so they stopped offering it. She says that they will be changing the recipe and are planning to offer it to the residents again soon.

Mrs. Brown, the dietary manager, is responsible for managing the kitchen staff, menus, meals, ordering, and service. She explains that she previously
worked at another facility where the administrators stressed that she had to buy the cheapest of everything possible, in order to save money. She complained that the food was just so bad there. Mrs. Brown says, “Here I have a decent budget. My goal is not to save money, but to try to balance the budget and do the best I can with what I have. Many of the residents here are wealthy and I think, in turn, this facility has money. We have the money to be able to afford better quality food. The Asian Community Group is also very involved with how this facility is doing, some of them have family members here, too, so they stress the importance of us have a decent budget to provide good food for the residents.”

Many family members brought food from home. Some relatives brought food to the facility daily, while others came from several times to once a week. Mr. Woo says, “Almost every day they bring food for me. My son or grandchildren drop off food every morning before they go to work. Otherwise, I wouldn’t get anything to eat. They bring me whatever it was that they were cooking for themselves.” Mrs. Mak’s daughter, Wendy, visits every weekend and always brings her mother’s favorite “no mi fan” (Chinese sticky fried rice). Wendy says, “It’s nice that they have Asian style food here. Even though the food doesn’t always taste that great, my mom likes it better than Western style food, simply because that is what she is used to. But of course, she does prefer that we bring food from home when we can.” Family members bring a variety of foods for their family members, ranging from juk, to noodles, to Chinese vegetables, to a variety of Chinese entrees.
Various activities are offered by the activities department. One particularly popular activity is arts and crafts hour, which takes place every Monday, Tuesday, and Thursday morning. Mrs. Lin, a monolingual Chinese resident, rarely participates in the activities offered by the facility, but never misses arts and crafts hour. She says, “I don’t speak English, so it is hard to participate in activities. But I really like working on the art projects, so I try to follow along by watching. Some of the other ladies who speak both Chinese and English are very helpful and translate for me when necessary.” Mrs. Chu loves to cook and particularly enjoys the cooking class offered every Friday. She says, “I love to cook, but here it is mostly just chopping for us. It’s the best they can do under these circumstances. We chop peppers, onions. We do all the chopping and then Mrs. Wilson, puts everything in the electric skillet and then stir fries it. Sometimes we make casseroles here. A few weeks ago we made smoothies. We had fresh fruit, a lot of fresh strawberries. Oh, that was really good.”

Residents also enjoy playing bingo, music hour, and exercises classes.

The majority of the male residents do not participate in the activities offered by the facility. Mr. Tam says, “They do not really have much that I like to do here. I like sports a lot, so I spend time in the day room watching the sports channel.” Mrs. Wilson, the activities coordinator, explains that they had tried offering “men’s only” activities, like playing cards, but did not have much success with that. One resident Mr. Lee says, “I think doing activities for men is difficult. Most of the men like to watch TV, or some of them read. That’s all they want to do. The men as a group tend to be more reserved, not just here, but in general.
The women tend to like to socialize more, so they want to participate in activities. Well, at least that how I see it.”

As a reflection of the diversity of religious beliefs of the residents, religious services of various denominations are offered at the facility. Catholic services are held every Friday morning. Presbyterian and Baptist services are held twice a month. A Buddhist monk holds a monthly service. All are welcome to any of these services. In fact, several of the residents said that they enjoy listening to the preaching and go to several of the different services.

As mentioned previously, a newly-remodeled garden area is available behind the facility, for the residents to enjoy. Mr. Yip’s son, Dan, comes to visit his father every morning. Every morning they can be found talking and strolling around the garden. Many residents and their families, like the Yips, come to enjoy the garden. Unfortunately, residents are not allowed out of the facility unless they are accompanied by a family or staff member. The facility is not gated and there is concern for the residents safety to be out of the facility alone.

Once a month, Mrs. Wilson, organizes an outing. Residents have the opportunity to go out to a restaurant, to the zoo, or sometimes shopping. The van, owned by the Asian Community Group, can only accommodate six residents and their wheelchairs, so residents who want to go must take turns. Volunteers go along to push the residents in their wheelchairs. Mrs. Lee says, “It’s so nice that they offer these outings, just to get out of here for a little while. Unfortunately, they can only take a few people each time. Over the years
though, I’ve gotten the chance to go to eat in most of the Chinese restaurants and shopping at the mall a few times.”

Some of the activities offered at the facility are geared toward the Chinese residents. For instance, Chinese shows and movies are often shown in the day room in the afternoons. Chinese newspapers, magazines, and books can frequently be found in the day room. During special Chinese holidays, like Chinese New Year, the facility hosts a special dim sum lunch to celebrate the new year. There are many Japanese residents residing at this nursing home. Like for the Chinese residents, Japanese movies, books, and magazines are provided for these residents.

Though not subscribed to by the facility, a copy of the local daily Chinese newspaper can usually be found in the day room. Mr. Yu’s family brings him a copy of the Chinese newspaper several times a week. When he is finished with it, he will put it in the day room for others to read. Interestingly, I also noticed that the residents do not play mah jong, a popular Chinese game, here. Mrs. Wilson explains, “A long time ago, they did try to have mah jong, but it didn’t work out. Not all the residents knew how to play, or could remember all the rules. But the main reason that they do not have it is because most of the residents are not able to reach across the table to get the tiles. Many do not have the use of both hands. It usually takes two good hands to play this game and so it didn’t work out.”
A variety of different activities are offered to the residents. These activities not only give residents something to do, but provide opportunities for residents to socialize with each other and the volunteers.

*End of Life Care*

Residents and their families at this facility generally made health care decisions together. While traditionally, decision-making powers generally fell on the oldest male child of Chinese families and not the resident themselves, this was not the case for residents at this facility. This included decisions made about end-of-life care.

The staff work closely with physicians and family members to support the residents during this time. After death, the body had to be out of the room within 4 hours, a requirement made by the Department of Public Health. Though many of the families consider themselves Buddhist, residents and their families did not adhere to some of the traditional Buddhist rites performed at the end of life, nor during the post-mortem period. Mrs. Lo, the director of nursing, explains that after death families are called, and after their visit, the body is picked up by a pre-selected funeral home.

*Communication*

Communication barriers were the most problematic issues facing monolingual Chinese residents. For the Chinese residents who do not speak or understand English, making their needs known to the staff is difficult. For new residents this transition is especially difficult, as routines and nurse-resident relationships are not yet established. Mrs. Lau, explains, “The first night I was
here, I woke up in the middle of the night with a great deal of pain in my legs. I called the nurse. I pointed to my leg to try to tell her that it hurt and hoped she would give me some pain medication. But she didn’t understand me. Everyone was asleep, so I couldn’t ask someone to help me talk to her, so she left. I didn’t get any pain medication until morning. I was so frustrated.”

Residents’ inability to communicate their needs was frustrating to both the residents and the staff. When residents can’t make their needs known, some react negatively by yelling, banging and/or throwing things. One morning during arts and crafts, Mrs. Chu was looking for her scissors. She was saying over and over again, in Chinese, “Where are my scissors?” Rachel, a volunteer, came by to try to help, but had no idea what she wanted. Mrs. Chu repeated herself, getting louder and louder. Rachel still had no idea what she wanted. I eventually interceded and translated for Rachel. Rachel says, “Mrs. Chu frustrates me. She is very demanding and impatient when she doesn’t get what she wants. Once she even threw something at me. Sometimes I wish I didn’t have to deal with her.” Susie, a CNA, says, “Sometimes residents are frustrated over their inability to communicate. I’ve had things thrown at me, like a pitcher of water. I was not happy about that. But I know they were just angry because I couldn’t understand what they were saying.”

Several strategies were used to bridge the communication barriers between the residents and the staff. Strategies included: 1) using gestures, 2) learning Chinese words, 3) using translation sheets, 4) calling the family.
• Gestures. The most frequently utilized strategy is using gestures to communicate. Mrs. Lin explains, “When I need help, I try to point or gesture. This works pretty well, but can sometimes be frustrating.” Sarah, a CNA, comments, “I’m able to communicate with the residents using gestures. Then of course, there is sometimes a lot of guessing of what they might need or want. Most of the time this works.”

• Learning Chinese words. Many staff members, particularly the LVNs, have learned a few key words in Chinese. The LVNs need to do some assessment of each resident’s condition daily and knowing a few key Chinese words makes communicating a little easier. Residents and particularly their families are often very happy to teach the staff a few Chinese words.

• Translation sheets. These sheets were sometimes posted on the bulletin boards of residents’ rooms. These sheets contain commonly used Chinese and corresponding English words and phrases. They did not seem to be consistently utilized for all of the monolingual Chinese residents. Natalie, a CNA, said, “Sometimes I do use those translation sheets and they do work, but if the sheet is not there, I don’t go out of my way to get one.”

• Calling the family. When the staff have exhausted other means of trying to communicate with the resident, they will call their family to help with the translations. Lina, an LVN, explains, “We rarely do this, but when we
really don’t understand them, I can call the family and they will talk to the resident.”

Though there is a communication barrier, many of the staff work so closely with the same residents, day in and day out, that they get to “know” the residents and have worked out a system to communicate with them. One day I saw Mrs. Chow walking out of the dining room after lunch. As she walked by one of the CNAs, she put the palm of her hand up to her mouth. I didn’t know what that meant. But the CNA understood and picked up a few napkins and handed them to her. Mrs. Chow nodded, took the napkins, and left the room.

About a third of the Chinese residents at the facility are bilingual and speak both Chinese and English. These residents are frequently called upon by both the staff and the monolingual Chinese residents for help in translating. One morning I found Mrs. Chin in the dining room looking all over for a piece of fabric she needed to complete her project. She wheeled herself to Nina, a volunteer, and holding a piece identical to the one she is looking for, hoped she would understand that she would like another piece like the one she is holding. But Nina didn’t understand. Nina said to Mrs. Ho, who is bilingual, “Do you know what she wants?” Mrs. Ho then translated for Nina.

The multi-lingual, multi-cultural staff reflects the diverse community of residents in the facility. The staff can speak several dialects of the Chinese (Cantonese, Toishan, Mandarin), Japanese, Filipino (Tagalog), and Vietnamese language. Unfortunately, only one Chinese LVN, Cathy, currently works here. Cathy is able to speak Cantonese, Toishanese, and some Mandarin. Cathy, who
has been with the facility for 17 years, says, “I’m the only Chinese nurse here now. The others have left, many to hospitals where the pay is better. They have been good to me here, so I am loyal to them.” With Cathy being the only Chinese-speaking nurse, she is frequently being called on to translate. She says, “I am probably the only staff that can translate, I am frequently called upon to translate. I don’t mind doing that, but sometimes it is a burden. It takes me away from the work I need to get done, and frequently get behind in my own work.”

Obviously, what the most unique about the features of this facility is the cultural-psycho-social environment. At this facility residents are served familiar Asian food and have opportunities to participate in culturally-relevant activities with other Chinese residents. Communication barriers exist, especially between monolingual Chinese residents and staff. The strategies utilized to bridge these barriers appear to be quite effective and allow residents a means to communicate with the staff.
Chapter Five

Discussion
An environment that is able to meet the needs of its residents will have a positive impact on their well-being. Individuals seek out environments that are able to meet their needs, but often when they enter nursing homes they are powerless in many aspects of care, and thus either live with a lower sense of well-being, or develop new strategies to cope with the environment (Sperbeck, Whitbourne, & Nehke, 1981). For elderly Chinese individuals, entering nursing homes often means entering an environment with different cultural beliefs, practices, and values. Recognizing a need in the community, the Asian Community Group opened this facility with the hope of bridging these cultural gaps by providing compassionate, quality care that recognizes the ethnic diversity of its residents.

Conceptual Framework: Resident Outcomes

Nursing home residents are part of a complex environmental system (Kayser-Jones, 1992b). Kayser-Jones’ Conceptual Model of Person-Environment Interaction (1998) illustrates the effects that the interaction of multiple factors in the physical, organizational, personal-suprapersonal, and cultural and psychosocial environment may have on elderly nursing home residents. A discussion of the findings of this study will be presented according to these four major components of the environment (see Table 3).

While each major component of the framework will be presented separately, variables from each area are in constant interaction with, and thus influence one another (Kayser-Jones, 1992a). The model indicates, by the two-way arrows, that just as the environment influences its residents, the residents
also have an influence on their environment. As a result of these resident-environment interactions, the resident at the center of the model, cognitively appraises and copes with the situation.

The Resident

At the center of this complex environmental system is the resident. Residents are characterized by their functional status, cognitive status, physiological status, sensory-perceptual capacity, and gait and mobility. Resident characteristics in this study were similar to those found in a study on the sociodemographic and health characteristics of older Chinese on admission to a nursing home (Huang et al., 2003). They found that the typically admitted Chinese resident was an 82 year old widow who was a first-generation immigrant, was admitted from an acute hospital, spoke primarily Cantonese or Mandarin Chinese, and lived with their family (Huang et al., 2003).

The residents at this facility are predominately Asian, and nearly 40% are Chinese. The large number of Asian/Chinese residents creates a certain comfort level for the Chinese residents. They live amongst people who understand their language and culture. The majority of residents, 84%, at this facility were mildly or moderately cognitively impaired, 16% were severely impaired. One study, on nearly 2000 nursing home residents found that 64.8% were mildly or moderately cognitively impaired (Gruber-Baldini, Zimmerman, Mortimore, & Magaziner, 2000). A greater number of residents at this facility functioned at a higher cognitive level than is typically found in nursing homes. More residents at this nursing home were able to socialize and interact with one another.
The Physical Environment

The physical environment includes such characteristics as building design, space, furnishings, color, and lighting. The facility is considered “home” for many of its residents and having a home-like atmosphere is important. The interior design of a facility affects the overall quality of life for residents (Miller, Goldman, & Woodman, 1985). The Asian décor, reflecting the culture of the majority of the residents, can be found throughout the facility. For example, residents particularly enjoyed the lobby. The beautiful and tranquil Asian décor of this room serves as a wonderful sitting area for residents, families, and staff. Physical aspects of the environment, like the Asian décor of the lobby, gives Chinese residents a sense of connectedness to their culture and a peaceful environment conducive for them to sit quietly or socialize with others.

The residents’ rooms are functional with all the requisite furnishings. On the whole, the rooms are kept neat, clean, and tidy. With most of the residents occupying the small semi-private rooms, space is an issue. Residents complained about not having enough space to get around in their room. Resident areas such as the day room and dining room are frequently utilized by the residents. The beautiful décor and functionality of these rooms, much like the family room or dining room of a home, make it a wonderful and relaxing place for them to watch television, read a book, participate in an activity, or have their lunch.

The newly-remodeled and beautifully landscaped garden is a wonderful retreat area for residents. One recent study found that opportunities to go
outside is associated with thriving amongst nursing home residents (Bergland & Kirkevold, 2006). Unfortunately, there is no fence around the facility grounds and there is concern that residents may wander off by themselves. Due to these safety issues, the residents are not allowed to go into the garden alone. The staff, with their heavy work loads, usually do not have time to accompany residents outside. Most family members work during the day and when visiting after work, it is often too dark or cold to go outside. As a result, many residents must wait until the weekends when their families can take them outside. One possible solution might be to install a fence around the facility. With a fence in place, residents could be allowed to visit the garden independently.

When present, one of the first things people notice when entering a nursing home, is the odor. The distinct odor gives residents, family, and friends the impression that housekeeping and resident care standards are not up to par. People have certain standards of cleanliness when choosing facilities to live or work in. Many of the residents and staff said that part of the reason they chose to live or work at this facility was due to the lack of odor and the cleanliness of the environment. Residents are proud that they live in a clean facility, one devoid of “nursing home smells.” A clean environment has been associated with a better quality of life for nursing home residents (Degenholtz, Kane, Kane, Bershadsky, & Kling, 2006). An odor-free and clean environment should be a high priority in nursing homes.

When a facility that is nearly twenty years old, there is always something that needs to be fixed or updated. Fundraising by the Asian Community Group
provides money for improvement or renovation projects in the facility. Last year alone, some of this money was used to repaint the exterior of the facility and landscape the garden. This year the facility plans to remodel the tub room and install new flooring in the dining room. The administration is always striving to create a more beautiful and comfortable physical environment for the residents.

The physical environment of this facility overall is quite impressive. The facility offers its residents the basic amenities (bedroom area, bathroom facilities, resident dining and lounge areas), but what sets it apart from the others is the beauty and tranquility of the Asian-style atmosphere that has been created within this environment. It is apparent that a great deal of thought was given to the décor, taking nearly all of the senses into account. Visually, the Asian style décor is aesthetically pleasing, suits the taste of the Chinese residents, and allows them to connect with their surroundings and their culture. Offensive odors are not present.

The home-like physical environment provides residents with many of the familiar comforts of home. The connection with their physical environment, through the Asian accents in this home-like environment, allows residents to feel more comfortable and “at home”. This is important, as the physical environment has been found to be an important determinant of psychosocial and health outcomes (Sloane et al., 2002).

The Organizational Environment

The organizational environment refers to the philosophy, policies, leadership, staffing, and financing of an institution. Many Chinese elders in
nursing homes experience cultural and language barriers, encounter Western health care practices, and have difficulty adjusting to a new environment (Chan & Kayser-Jones, 2005). This facility is dedicated to providing culturally sensitive health and social services for older Asian adults.

Working in a collaborative environment.

The common goal of both the Asian Community Group and the facility leadership team is to provide quality care for elders residing at the facility. Mr. Wong, the nursing home liaison and board member, and Mr. Williams, the facility administrator, have each stated the importance of working in a collaborative environment. Mr. Williams said that while working in previous facilities, the strict rules and restrictions of the parent company make instituting changes in a facility very difficult. Hence, the turnover rate for facility administrators is often high. Turnover of the nursing home administrators is significantly and negatively associated with communication and teamwork. (Forbes-Thompson, Gajewski, Scott-Cawiezell, & Dunton, 2006). Mr. Williams has been with the facility for over six years. The time that he has been employed at this facility has allowed him to get to know the board members, facility staff, and residents. It has also given him the vision and opportunity to make positive changes for both the staff and the residents.

Staffing - Consistent staff members.

Registry services are not utilized. Current full and part-time staff members fill the gaps in staffing. The benefit to the facility in not using registry staff is that they save money. Residents benefit by having familiar staff members providing
care for them. Staff members benefit by getting the opportunity to earn extra money. The facility employs 5 registered nurses (RN), 16 licensed vocational nurses (LVN), and 49 certified nurses aids (CNA). Finding available staff members amongst the regular employees, to fill gaps is sometimes challenging. There are mornings when they are short-staffed, but they have always been able to fill these gaps in one way or another. For instance, Lisa, an LVN and the director of staff development, had filled in a few times when they were short an LVN.

Inadequate staffing is a significant factor influencing care for nursing home residents (Kayser-Jones et al., 2003). Kayser-Jones et al. (2003) reported that on the day shift, CNAs ratios were 1:8-10. At this facility, the CNAs ratio was 1:6-8. Staff in higher-staffed homes (CNA ratio 1:7.6) have been found to provide better care than lower-staffed homes (CNA ratio 1:9-10) (Schnelle et al., 2004).

Nurse staffing levels at this facility were 3.3 hours per resident day, and they meet the 3.2 nursing hours per resident day requirement in California (Harrington & O'Meara, 2006). The workload is heavy with many of the nurses complaining that they just barely have enough time to get their work done during their shift. What has made it easier for the nursing staff is working with a familiar team of colleagues and having the same resident assignment. The nurses and the residents have the opportunity to get to “know” one another. They do not have to spend time figuring out how to work and get along with each other or residents’ likes/dislikes. Many of the staff, who do not speak Chinese, provide
care for the monolingual Chinese residents. Though they are unable to speak to one another, having known the residents’ for a period of time, they know their preferences.

Staff members at this facility are encouraged to work as a team. The facility has developed creative solutions, which they call “stations”, in an effort to share the workload. During mealtimes, each CNA is assigned a station. This division of work allows some CNAs to assist residents in the dining room and others to assist those needing assistance in their rooms. This solution is beneficial to the residents in that it encourages all who are able, to be up out of bed to eat and socialize in the dining room. It is beneficial to the CNAs because more of the residents eat in the dining room. With the majority of the residents eating in one place, tasks like serving meals, helping residents at meal time, and picking up the dishes, takes less time.

*Incentives – Rewarding staff.*

The leadership team at this facility recognizes the importance of leadership and staff supervision. To achieve good resident outcomes, facilities must have leadership that is willing to embrace quality improvement and group process to see that the basics of care delivery are done for residents (Rantz et al., 2004). The leadership team and various special committees met weekly to review various staff and resident issues. The constant presence of the facility administrator and director of nursing keeps the staff motivated. Bonuses or gifts are used to motivate the staff. Once a month, an all-staff meeting is held by the leadership team. As a part of these meetings, the staff members are singled-out
and publicly praised and rewarded for service to the facility. In an effort to boost staff retention, staff celebrating anniversary dates with the facility are given cash bonuses. Staff members who have contributed to meeting certain goals for their assigned residents, such as decreasing the fall rate or the rate of pressure ulcers are rewarded with gift cards. Financial incentives have been found to lead to improvements on objectively measured qualities of care (Beaulieu & Horrigan, 2005). Mr. Williams says that using financial incentives can get expensive, but that the payoff is worth it. In spending a little money to aid in staff retention or meeting clinical goals, he saves money in the long run. It can be more costly to have to recruit staff or to treat infections or falls. One concern in using financial incentives, especially to meet clinical goals, is the possibility that false documentation can occur. In order to meet goals, staff members might not report all falls or infections. Petersen, Woodard, Urech, Daw, & Sookanan (2006) found that though financial incentives leads to partial or positive effects on measures of quality, unintended effects of incentives can occur. They recommend that continuous monitoring of incentive programs is critical to determine the effectiveness of financial incentives and their possible unintended effects on quality of care.

Asian staff.

The facility serves a predominately Asian elder population. Attracted to working with Asian elders, many Asian staff members choose to work here. Mr. Williams attributes much of the success of this facility to the Asian staff. He says, “Having worked with many staff members in the past, the staff here at this facility
is different. I attribute much of it to the Asian culture. The Asian work ethic is strong and they work hard. The Asian culture values the elderly and it shows. This is the ideal foundation for me to work with.” The public image of Asian Americans is that they find success through the virtues of hard work and uncompaining perseverance (Tseng, Chao, & Padmawidjaja, 2007). These values created a dedicated workforce passionate about providing good care for elders. This influence of the Asian culture positively affects care for the Chinese residents at this facility.

Financial stability.

Financial stability is crucial to the success of a facility. The advantage this facility has over many other facilities, is the level of financial support received from the community. The Asian Community Group and the Asian community work very hard in raising funds for the facility. The money comes from generous donations from individuals and businesses, as well the many fundraisers that are organized each year. This money allows the facility to make improvements and provides amenities for the residents and staff that they otherwise may not have been able to afford.

The organizational environment at this facility is focused on providing quality care for Asian elders in this community. The largest contributing factor to the success of this facility is the strong collaborative relationship between the board members of the Asian Community Group and the facility’s leadership team. Empowering nursing homes to make decisions aids in the change of organizational culture (Scalzi, Evans, Barstow, & Hostvedt, 2006). For Mr.
Williams, the facility administrator, this teamwork has given him the flexibility to try new things in his quest to improve the quality of care for the residents, as well as to provide a good working environment for his staff.

Staffing issues are an important component of the organizational environment. Having consistent staff members who work and socialize with residents on a daily basis, is beneficial to both the staff and residents in many ways. Staff learn residents’ preferences, socialize with them, and are able to bridge many communication barriers. Staff incentives have also been effective in improving the quality of care for residents. The result is that residents are satisfied with the care they receive.

The Personal Supra-Personal Environment

*Socialization with other Chinese residents.*

The personal environment has been defined as the significant others who constitute the major one-to-one social relationships of an individual (e.g. family members and friends) and the supra-personal environment as the modal characteristics of all the people in the physical proximity to an individual (e.g. other residents in the facility, facility staff, volunteers) (Lawton, 1982). Of the residents in the facility, 39 are Chinese, with 27 of them unable to speak or understand English. Mrs. Lin had previously lived in another facility, and had experienced isolation and loneliness due to her inability to communicate in English with the staff and other residents. She now appreciates having other Chinese residents with whom to socialize. Socializing with others increases resident morale and helps residents to pass the time. Increased levels of
socialization with others has even been found to be associated with longer
survival for long-term care residents (Kiely, Simon, Jones, & Morris, 2000).

Interestingly, most of the socialization occurred amongst the women.

Overall, the men tended to be more reserved and preferred to keep to
themselves. Mrs. Wilson, the activities coordinator, speculated that it was easier
for the Chinese women, while participating in various activities, to socialize with
each other. Despite her best efforts, Mrs. Wilson was unable to attract the
Chinese male residents to activity sessions. There appears to be a correlation
between participation in activities, socialization, and friendships developing. It is
important to continue to try to offer activities that may be of interest to the male
residents.

*Cultural expectations – Families are involved in care.*

Chinese families are expected to provide for their family members.

Chinese people have been characterized as having family values that foster
intense interdependent family ties, high filial expectations, and strong
intergenerational cohesiveness (Bond, 1996; Chow, 1996). Ideally, families
preferred to care for their elders at home. Many Chinese elders came to the
facility because their family members either could not manage the level of care
required, or they had to work. Once in the facility, family members continued to
be devoted to the care of their elders. Most family members visited one to three
times a week. It was not uncommon for some family members to spend hours at
the facility daily. This is consistent with the findings from a study conducted on
the number of family visits of residents in a Japanese nursing home. Fukahori et
al. found that nearly 62% of family members visited from one to three times a week, with 11% visiting daily (2007).

Culturally, the expectation had been for family members to care for Chinese elders at home. Yet, more and more Chinese elders are now living in nursing homes. Family members played a big role in their relatives’ lives; they frequently brought Chinese food for their relatives, provided care, advocated for their care, and provided companionship and emotional support. The emotional support received by the residents from their families was important.

Families of monolingual Chinese residents were worried about how their relative would get along in the facility, especially because of the language barrier. Families of monolingual Chinese residents appeared to visit more frequently than the families of English-speaking Chinese residents. This facility provides culturally appropriate food, environment, and activities geared towards Asian residents. Perhaps family members of the English-speaking Chinese residents feel comfortable knowing that their relative is well provided for and cared for in all aspects and don’t feel such a need to visit more frequently.

Though a resident council is available for residents to voice their concerns to the staff, a family council does not exist. Families are very involved in the care of the family members, yet there is not an avenue available for them to sit down as a group to discuss issues they may have with the staff. Participation in a family council can provide mutual support for its members, increase their decision-making opportunities, effect change to improve residents’ quality of life, and yield other benefits (Curry, Hogstel, & Walker, 2007).
The facility staff and volunteers care for and socialize with the Chinese elders; they have a close relationship with the Chinese residents. Residents are assigned the same nurses for at least a period of three months, and even after the period of three months when nurses rotate assignments, the nurse-resident relationship continues to exist. Kayser-Jones (1981) also reported on the importance of enduring relationships between staff and residents. As a result, after a period of time the staff get to know nearly all the residents living in the facility.

Stability of staff is important at both the professional and nonprofessional levels (Kayser-Jones, 1981). Strong bonds and relationship between residents and the staff develop. Over time, for many of the staff, coming to work is not about providing care to strangers, but for people they have come to know and care about. The same holds true for the residents. For instance, Mrs. Lam’s daughter and granddaughter, who is three years old, comes to visit nearly every week. Mrs. Lam knows that Tracy, the CNA, also has a three year old daughter. Frequently, when Tracy is providing care to Mrs. Lam, they talk about all the latest things that the girls are doing and learning. As emotional attachments develop, staff members are more invested in providing good care to the residents. Residents not only benefit from this care, but from the opportunities to socialize with others. Though not through verbal communication, these relationships also exist between the staff and monolingual Chinese residents. Mrs. Lin smiles when her favorite CNA, Sara, comes to help her out of bed. When she is seated in her wheelchair, Mrs. Lin smiles, pats Sara on the back,
and reaches on her nightstand to offer her a piece of candy, which Sara happily accepts. Gaugler (2005) has also found that in facilities where extensive staff rotation did not take place, staff and residents became more closely acquainted, thus providing staff with opportunities to connect socially, and hence the staff members’ feelings of personal responsibility and closeness with residents were enhanced.

A large number of people in the Asian community volunteer regularly at the facility. Many who are bilingual in Chinese and English, provide much needed socialization for the monolingual Chinese residents. They help translate for residents, enabling them to participate in activities they otherwise would not be able to enjoy. Residents enjoy visiting with the volunteers, especially the many young people who volunteer at the facility on the weekends. These young volunteers enjoy listening to and learning from the elders and the elders enjoy the company of these teenagers.

Residents, their family and friends, and the staff and volunteers are all a part of the personal supra-personal environment. In talking with Chinese elders in nursing home facilities in a previous study, residents frequently complained about being lonely (Chan & Kayser-Jones, 2005). Yet, this word never used by the Chinese elders to describe their experience at this facility. Much of this was due to the fact that residents, especially monolingual Chinese residents have other Chinese-speaking residents with whom to socialize. The high level of family involvement in care also greatly influences residents’ experiences in the nursing home. A high level of family involvement shows the Chinese residents
that they are still valued as family members and are given the respect and care so important to elders in Chinese culture.

The genuine sense of caring by individuals, whether it be from other residents, family and friends, or staff and volunteers, contributes to a feeling of community. Mrs. Lee, has been a resident for over five years. She says, “We are like a family here, we are not all related, but we care about each other, just like family. We are very close here, seeing each other every day, talking, laughing, and sometimes even crying. Everyone here supports each other, through the good and the bad.” Research has found that residents with a greater subjective sense of support from their peers and staff reported less depression, more positive affect, and a greater sense of happiness (Carpenter, 2002).

The Cultural-Psychosocial Environment

This facility is unique in that their mission is to provide care for a predominately Asian population. Because of this, accommodations have been made to meet the specific needs of this population. The Chinese elders living at this facility feel more comfortable living in an environment that is sensitive to their culturally-specific needs.

Meals in the dining room.

Meals in many nursing home facilities come on a tray on a dining cart that has been wheeled in from the kitchen. At this facility, over 90% of the residents eat their meals in the dining room. Mrs. Lo, the director or nursing, believes that when possible, all the residents need to be dressed and present in the dining room for their meals. For the staff, it increases their workload because they must
assist the residents in getting dressed and into the dining room. On the other hand, staff workload is decreased at mealtimes as they work their stations thus dividing up their work, and because it is easier to manage meals for residents who are all in the dining room. Being in the dining room for meals, benefits the residents in many ways. Residents, who may otherwise stay in bed all day, are out of bed and dressed, thus decreasing the potential for issues like constipation or pressure ulcers. They eat in the dining room where there are opportunities to socialize with others, which can decrease feelings of isolation, loneliness, or depression. Having meals in the dining room has also been associated with increased food and fluid intake among nursing home residents (Reed, Zimmerman, Sloane, Williams & Boustani, 2005; Simmons & Levy-Storms, 2005). Instead of the institutional-style meal trays, the use of the more visually appealing plates and cups is more home-like, and may contribute to increased meal intakes in these residents.

*Asian food.*

Food is important in the Chinese culture. Many of the Chinese in the United States continue to have predominately Chinese food and are unaccustomed to Western food. Having consumed Chinese food their entire lives, many Chinese elders have difficulty adjusting to Western-style food. Chau, Lee, Tseng, and Downes (1990) found that 95% of elderly Chinese women in the United States consumed Chinese food for lunch and dinner. A major draw to the facility for residents is that Asian style food is served here. For many residents
adjusting to a major life change, that of entering a nursing home, having familiar comforts, such as food, are so important.

The financial status of the facility affects the quality of food that is provided to the residents. Mrs. Brown, the dietary manager, stressed the importance of having an adequate budget to purchase food. She explains that management has been very generous with the food budget, so she is able to purchase very good quality food. The dietary department is also very flexible when it comes to resident food choices, offering alternate entrees daily and even accommodating residents’ write-in requests.

While the Chinese residents appreciated having Asian style food served, they frequently complained about the texture and taste of the food. For many, their biggest complaint about living in the facility was the food. Residents complained that Asian style dishes did not look and taste like they were supposed to. As a result, a great deal of food is left uneaten. The majority of the residents are Chinese and Japanese and most of the cooks are Filipino or African American. Perhaps the cooks do not have a good understanding of what traditional Chinese/Japanese food should taste like. Additionally, because a large number of residents have hypertension and/or diabetes, meals are prepared in large batches accommodating low/no salt and sugar diets. Condiments are then offered to residents who are not on a restricted diet. Residents complained about the food at the resident council, but felt nothing was being done to improve the situation.
Malnutrition affects up to 85% of the 1.5 million nursing home residents in the United States over age 65 (Rowe & Kahn, 1998). Fluid intake among nursing home residents has also been found to be inadequate (Kayser-Jones, Schell, Porter, Barbaccia, & Shaw, 1999). Lack of nursing home resident satisfaction with meals often results in reduced food intake, leading to poor nutritional status, weight loss, functional decline, and depression (Crogan & Evans, 2006). Nearly every Chinese elder I spoke with mentioned their dislike of the facility food. Obviously, it is not possible to cook for such a large group of people and expect everyone to be happy with their meal. However, it is important for the staff and residents to work together on this issue. The residents feel they are not being heard by the staff. Communication between the staff and residents is important. Utilizing the resident council, the dietary committee could meet with residents to hear and discuss their issues.

Family members frequently brought food from home for the Chinese residents. Residents enjoyed the familiar home-cooked foods. However, family members did not bring food to their family members as often as was seen with Chinese elders in other facilities (Chan & Kayser-Jones, 2005). Because Asian style food is served at this facility, family members feel that it is not always necessary to bring food on a regular basis. Though the food might not be to the specific liking of many of the Chinese elders, families may be reassured by the fact that their relatives at least have Asian food to eat.
Activities.

The activities offered at the facility are quite popular and well-attended by many residents. Mrs. Wilson, the activities coordinator, who only speaks English arranges most of the activities. Participation in activities is difficult for the monolingual Chinese residents. In spite of this, these residents attend many of the activities offered and are often assisted by the Chinese/English speaking residents. Interestingly, none of the Chinese women complained of boredom. Activities are offered throughout the day, with the exception of a few hours in the afternoon when most of the residents are napping. Most of the Chinese women gather in the dining room to observe, participate, and or chat during the activity hours. Participation in activities has been associated with decreased use of psychotropic medications, improved nutritional state, and increased family satisfaction (Volicer, Simard, Pupa, Medrek, & Riordan, 2006). Most of the Chinese women welcomed the socialization opportunities created by attendance at activities.

The Chinese men at the facility were generally not interested in participating in the activities offered by the facility. Despite Mrs. Wilson’s attempt at providing “men’s only” activities or activities that she thought might interest the male residents, she was unsuccessful. The men preferred instead, to watch TV or read. Those residents with a military background frequently made connections with one another, as they reminisced about their past. Aside from this, the Chinese men did not seem to socialize very often with others; they preferred to be alone.
The facility offers some activities specifically for the Asian residents in the facility. This includes showing Chinese shows and movies for the Chinese residents, and having Chinese books, magazine, and newspapers available to read. Chinese holidays, such as Chinese New Year, are celebrated throughout the year. The facility’s efforts at providing a home-like environment for their residents shows sensitivity to their cultural needs.

On a monthly basis, Mrs. Wilson, takes a few of the residents on an outing. This popular activity gives residents an opportunity to go out have a meal or do some shopping. For some of the residents who spend weeks or months at a time in one place, this is a welcome opportunity. Being out of the facility, even for just a short period of time, rejuvenates residents, and gives them a chance to reconnect with the outside world.

*Communication.*

Monolingual Chinese residents’ inability to communicate with others in Chinese greatly affects many aspects of their lives. With the exception of the one Chinese nurse, monolingual Chinese residents are unable to communicate verbally with the staff. Their means of communication comes primarily through a few simple English words they have been taught or through physical gestures. If they are not understood, needs can go unmet. This leave residents feeling frustrated, occasionally acting out by yelling, banging, or throwing things. This inability to communicate with others affects how residents feel about themselves and how they feel about being residents in a nursing home.
Improved communication is essential in providing high-quality care (Winn, Cook, & Bonnel, 2004). Strategies used to bridge the communication barriers between the residents and the staff included, using gestures, learning Chinese, words, using translation sheets, and calling the family.

The most utilized strategy is using gestures to communicate. Residents and/or staff gesture to communicate with each other. Initially, there is a lot of guessing on both parts to understand each other, but over time an understanding that certain gestures mean certain things develop. The use of gestures is effective, but limited in terms of the scope of what they can convey.

Many staff members, particularly the LVNs, have learned a few key words in Chinese. The use of gestures is only useful up to a point. Asking a resident if they are short of breath or have pain is difficult to do by gesturing. The use of several key Chinese words allowed the nurses to assess residents with greater accuracy.

Translation sheets, when utilized, can be helpful. However, they were not posted for all monolingual Chinese residents and thus were inconsistently used at this facility. The staff considered it time consuming to use these sheets and preferred to rely on using gestures.

There was only one Chinese-speaking nurse at the facility, an LVN. They do not actively recruit Chinese nurses, and the Chinese nurses they have had in the past have elected to work in hospitals where the pay is better. Cathy carries the burden of translating for the Chinese residents, in addition to her already heavy workload. Quite often, the staff will turn to the Chinese/English speaking
residents for help in translating for the monolingual Chinese elders. This is convenient for the staff, and residents appear happy to be able to help.

Family members of residents were called when the staff had exhausted all other efforts in communicating with residents. While these strategies facilitate communication, communication problems remain. However, the low turnover rate of the staff and consistent staff assignment allows staff to get to “know” the residents. Though communication barriers exist, after a period of time, staff determine and understand the residents likes/dislikes, needs/wants, and are able to meet their needs.

The language barriers at this facility are similar to those experienced by other monolingual Chinese residents in other facilities (Chan & Kayser-Jones, 2005). What is different is how these obstacles are overcome. The fact that they have a consistent staff and resident translators available on-site, allows the monolingual Chinese residents to make their needs known. As a result, being in an environment where they are unable to speak the dominant language, does not lead to loneliness and isolation for the residents.

The transition into a nursing home facility is often a difficult one. Chan and Kayser-Jones (2005) found significant factors that influenced care included: communication barriers, dislike of Western food, and differing cultural beliefs and customs. The cultural-psycho-social environment in this facility is one that is sensitive to the needs of the Chinese elders. Though communication barriers exist, various strategies are used to overcome some of these barriers. The Chinese elders are not able to speak to the staff, but they are generally able to
make their needs known. Asian style food, which is familiar to the residents, is served. The large number of Asian and Chinese residents facilitates socialization, especially amongst the monolingual Chinese elders. Chinese residents feel comfortable in a place where their culture and customs are a part of their environment.

Chinese individuals have needs and preferences in what they expect of their environment. The teamwork between the Asian Community Group, Asian community, and the facility leadership team have created, implemented, and maintained an organizational structure with the goal of meeting the needs of the Chinese elders and the other residents in the facility (organizational environment). This affects the physical and cultural-psychosocial environment, as this team works together to provide a home-like environment sensitive to the needs of the Chinese residents (physical and cultural-psychosocial environment). Chinese elders in the community seeking long-term care are thus drawn to this facility, one in which the organization supports an environment sensitive to the social, psychological, and cultural needs of this population (personal supra-personal environment).

Chinese elders receive care in an environment sensitive to their cultural needs. Because they are in an environment which shares an understanding of common cultural beliefs and values, adaptation to life in the facility is easier, and a greater level of comfort and well-being can be achieved. The overall outcome for the resident is that there is a good person-environment fit, resulting in high resident morale and self-esteem and thus, a high level of resident satisfaction. In
sum, multiple factors in the physical, organizational, personal supra-personal, and cultural psychosocial environment cumulatively contribute to an outcome of a high standard of care and resident and family satisfaction with care.

Implications

The cultural diversity of the elderly population is increasing in the United States, thus increasing in the number of Chinese elders in nursing homes. As residents of nursing homes, Chinese elders experience cultural barriers. They are often faced with adapting to an environment unfamiliar to them, with language barriers, unfamiliar Western food, and differing cultural beliefs and customs. Research on the care of Chinese elders in nursing homes is limited.

This research has shown that positive outcomes occur for Chinese elders in a nursing home providing culturally-specific care. The residents live in a facility providing quality care in an environment supportive of their cultural needs. Chinese elders found comfort in their “home away from home,” thus enhancing and improving their quality of life.

The face of nursing home residents is changing. While ethnic minority groups currently represent about 13% of the nursing home population, they are projected to represent over 35% of the nursing home population by the year 2050 (U.S. Census, 2000b; U.S. Census, 2000c). Cultural barriers exist and can have a negative impact on the quality of life for ethnic minority residents (Chan & Kayser-Jones, 2005). In fact, overt and indirect acts of discrimination from nursing home administrators, staff, and other residents against ethnic elders sometimes occur (Aeschleman, 2000). Cultural sensitivity and cultural
competence toward ethnically diverse residents is important. Nursing homes should strive to create an environment conducive to their needs.

Chinese elders reside in nursing home facilities throughout the United States. It may be feasible for communities with a large Asian population to operate facilities catering to the needs of the Asian community, but what about the others? What can we do to provide culturally sensitive care for them and other ethnic elders? Where do we begin?

Many of the residents and staff said that part of the reason they chose to live or work at this facility was due to the lack of odor and the cleanliness of the environment. Cleanliness of the physical environment is important. A clean and odor-free environment is one that benefits all the residents and staff.

The organizational environment was central to the high quality of care for the residents. Teamwork within the organizational environment was important. Nursing home operators, administrators, and staff should work together towards setting and achieving facility-specific goals. Teamwork amongst all players in the organizational environment not only moves the facility towards reaching their goals, but as goals are being met, can lead to staff satisfaction and thus a decrease in overall staff turnover. Castle and Engberg (2005) found in a study of 526 nursing homes that the average one-year turnover rate was 85.8% for nursing assistants and licensed practical nurses and 55.4% for registered nurses. The relation between nursing staff turnover and decreases in quality of care have been documented (Castle & Engberg, 2005; Hickey et al., 2005).
Rewarding the staff for meeting specific goals was an effective incentive to improve the quality of care provided. In using this rewards system, the staff were motivated to improve care and when successful, were proud for having achieving desired outcomes and were rewarded with a small gift certificate. Though utilizing a rewards system can be costly, the benefits are an increase in the quality of care and an increase in staff satisfaction.

This study has shown that this facility and its low staff turnover rate has positively affected residents in many ways, especially in its effect on decreasing communication barriers between the residents and the staff. The nursing staff have the opportunity to work with residents on a long-term basis and get to know how to best care for each resident as an individual. In spite of the communication barrier, this continuity of care allows them to provide quality care for the Chinese elders, benefiting them both physically and socially. This finding is especially important. Nursing homes with a culturally diverse population may be unable to bridge all the communication barriers between their staff and the residents. Assigning staff to the same residents for a period of time allows nurses to familiarize themselves with the residents and in time help to decrease problems caused by communication barriers.

Family members of the Chinese residents in this study played a big role in their relatives’ lives; they frequently brought Chinese food for their relatives, provided care, advocated for their care, and provided companionship and emotional support. While most family members visited from one to three times a week, it was not uncommon for some family members to spend hours at the
facility daily. It is recommended that nursing home staff work together with family members in providing care for residents. Family visitation should be encouraged. Strategies like having chairs available for family members, or inviting family members to assist in caregiving, or asking family members to participate in activities or special events would help family members become more involved in their relatives’ care. It also provides opportunities for families and their relatives to interact and bond.

Food is an important part in the culture and the lives of Chinese people (Chan & Kayser-Jones, 2005). Though there were complaints about the taste of the dishes offered, residents felt fortunate to have Asian style food every day. Simple strategies like offering rice instead of potatoes would be appreciated by Chinese residents. As mentioned above, the nursing home population is becoming more culturally diverse. Resident menus should reflect their diversity. Offering dishes familiar to the residents of different ethnic groups, like the Chinese, would help increase the amount of food eaten, decrease the amount of food wasted, and prevent weight loss.

All ethnic cultures, including the Chinese, have a unique set of values, beliefs, and customs. It is important for health care providers to learn about and respect different cultural beliefs. This may be challenging when facilities serve residents of many different ethnic backgrounds. One study suggests that a practical approach would be to focus on the issues that arise most commonly due to cultural differences and how they may affect interactions with any resident (Betancourt, 2006).
Chinese residents, being of one culture, act and think alike in many ways. But there is also diversity amongst Chinese residents, especially between Chinese immigrants and the Chinese American population. Many of the Chinese immigrants have retained their native language and cultural practices, while Chinese Americans have acculturated to Western society in varying degrees. Each of these residents is an individual, shaped not only by their culture, but by their own personal life experiences. Though it is important to understand what factors affect Chinese people as nursing home residents, residents should be treated as individuals.

There is a great deal of interest now on culture change in nursing homes. Culture change refers to the systematic efforts to transform the underlying operative values about aging and elders and the work of caregivers in maintaining quality of life for residents and those who care for them (Scalzi, Evans, Barstow, & Hostvedt, 2006). Creating an environment that provides culturally-sensitive care to nursing home residents should be integrated into these plans to transform nursing home environments.

Further quantitative and qualitative studies are suggested. A larger comparative study on Chinese elders living in Western-influenced nursing homes and Chinese elders living in Asian-influenced nursing homes would help us understand how important cultural factors are in the care of Chinese elders. It would also help us to see with greater clarity, which specific factors or issues they deem are most important to their care. Studies on Chinese elders that
measure outcomes, such as hospitalization, weight loss, dehydration, restraint use, and incidence of pressure ulcers are also suggested.

The perceived likelihood of entering a nursing home is one of the most pervasive fears among older people (Biedenharn & Normoyle, 1991). This fear is heightened for ethnic elders, many of whom encounter communication barriers and cultural differences. Understanding their perspectives and beliefs will help us continue to develop and implement strategies to provide a high standard of culturally sensitive care.
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Table 1
Profile of Nursing Home Staff
(N=110)

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<th>%</th>
<th>M</th>
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<td></td>
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</tr>
<tr>
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<td>Age</td>
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<td>Below 20</td>
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(continued)

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Table 2.
Profile of Nursing Home Residents
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<tr>
<td>Marital Status</td>
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<td>Language of Chinese residents (N=39)</td>
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<td>Chinese-Speaking Only</td>
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<td>English/Chinese Speaking</td>
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<tr>
<td>Baptist</td>
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<td></td>
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<tr>
<td>Mormon</td>
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<td>1</td>
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<td></td>
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<tr>
<td>None</td>
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<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
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<td>14</td>
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<td></td>
</tr>
<tr>
<td>Length of Stay (in days)</td>
<td>426</td>
<td></td>
<td>1 to 3457</td>
<td></td>
</tr>
</tbody>
</table>
(continued) n %

**Hospice Care**
- Yes 8 8
- No 92 92

**Primary Diagnosis**
- Cardiovascular Diseases 31 31
- Pulmonary Diseases 4 4
- Gastrointestinal Diseases 7 7
- Renal and Genitourinary Diseases 11 11
- Neurological Disorders 20 20
- Musculoskeletal Disorders 16 16
- Neoplasms 2 2
- Other 9 9

**Cognitive Status**
- Severely Impaired 16 16
- Mildly to Moderately Impaired 84 84

**Pressure Ulcers**
- Stage 1 5 5
- Stage 2-4 0 0

**Activities of Daily Living (ADL)**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Independent</th>
<th>Needs Assist</th>
<th>Totally Dependent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td>1</td>
<td>48</td>
<td>51</td>
</tr>
<tr>
<td>Dressing</td>
<td>5</td>
<td>48</td>
<td>47</td>
</tr>
<tr>
<td>Transfers</td>
<td>7</td>
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<td>24</td>
</tr>
<tr>
<td>Toilet</td>
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<td>47</td>
<td>45</td>
</tr>
<tr>
<td>Eating</td>
<td>40</td>
<td>29</td>
<td>31</td>
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</tbody>
</table>
Table 3
Outcomes Utilizing Kayser-Jones’ Conceptual Model of Person-Environment Interaction

The Physical Environment

<table>
<thead>
<tr>
<th>Major Environmental Factors</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian décor</td>
<td>Provides residents with a sense of connectedness to their culture.</td>
</tr>
</tbody>
</table>
| Cleanliness – lack of odor        | Residents and staff chose to live and work at this facility due in part to the cleanliness.  
|                                   | Residents are proud to live in a clean environment.      |

The Organizational Environment

<table>
<thead>
<tr>
<th>Major Environmental Factors</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working in a collaborative environment.</td>
<td>With the Asian Community Group and facility leadership working together towards common goals, positive changes can be made for both the staff and residents.</td>
</tr>
</tbody>
</table>
| Staffing – consistent staff.      | Nursing staff work with a familiar team of colleagues, eliminating need to “get to know” each other.  
|                                   | Nursing staff “get to know” the residents, both at the professional and nonprofessional levels.                                           |
| Rewarding staff.                  | Provides an incentive and rewards staff who provide quality care.                                                                            |
| Asian staff.                      | Staff have a strong work ethic.  
|                                   | Culture values the elderly.                                                                                                                   |
| Finances - fundraising            | Fundraising money allows the administration to make improvements to the facility and provide amenities for the residents and staff.         |
The Personal Supra-Personal Environment

<table>
<thead>
<tr>
<th>Major Environmental Factors</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Being able to socialize with other Chinese residents.</td>
<td>• Decrease in isolation and loneliness particularly among monolingual Chinese residents.</td>
</tr>
</tbody>
</table>
| • Cultural expectations – Families are involved in care. | • Families bring food.  
  • Families provide care.  
  • Families advocate for care.  
  • Families provide companionship and emotional support. |

The Cultural-Psychosocial Environment

<table>
<thead>
<tr>
<th>Major Environmental Factors</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| • Asian food                | • Since Asian food was preferred over Western food, residents appreciated the Asian style food choices offered at the facility.  
  • Since Asian food was available, families did not feel the need to bring food as frequently. |
| • Chinese activities        | • Chinese television, movies, books, magazines, and newspapers are available for the residents. |
The Cultural-Psychosocial Environment

(continued)

<table>
<thead>
<tr>
<th>Major Environmental Factors</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Communication</td>
<td>- Over time, the use of gestures is effective, but limited in terms of the scope of what they can convey</td>
</tr>
<tr>
<td>- Gestures</td>
<td></td>
</tr>
<tr>
<td>- Learning Chinese words</td>
<td>- Effective particularly for nursing assessments.</td>
</tr>
<tr>
<td>- Translation sheets</td>
<td>- Not always available and inconsistently used when available</td>
</tr>
<tr>
<td>- Staff/Resident Translators</td>
<td>- Effective, though the staff translator was not always available, resident translators were available, frequently utilized, and effective</td>
</tr>
<tr>
<td>- Calling the family</td>
<td>- Utilized when other means of communication were exhausted</td>
</tr>
<tr>
<td>- Consistent staff members</td>
<td>- Consistent staff members who know residents’ preferences minimizing problems associated with the language barriers</td>
</tr>
</tbody>
</table>

- As a result, being in an environment where they are not able to speak the dominant language, does not lead to loneliness and isolation.
Figure 1
Moos’ Conceptual Framework of Specialized Living Environments
Figure 2.

Kayser-Jones' Conceptual Model of Person-Environment Interaction
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Date