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## Feature Article

## The nursing assistants' communication style and the behavioral symptoms of dementia in Korean-American nursing home residents

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## A B S T R A C T

Few studies examined the association between communication style and behavioral symptoms of dementia (BSD). The communication style of Nursing Assistants' (NAs), whose ethnic background is different from the residents, may contribute to BSD. The purpose of this study was to explore the relationship between non-Korean NAs' communication style and BSD in Korean-American (KA) nursing home residents with dementia. Twenty eight NAs and 20 KA residents were recruited from an ethno-specific nursing home. Research assistants observed and recorded NAs' communication style and residents' behavior simultaneously during routine care for 3 days. This study shows a trend that NAs' dementia and culturally appropriate communication style influenced the decreased behavioral symptoms. This finding suggests the need for training for NAs in dementia and culturally appropriate communication.

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## Keywords:

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## Introduction

The population of older adults living in the United States (US) is becoming more racially and ethnically diverse. The number of ethnic minorities over age 65 years is projected to increase up to 28% of all older adults residing in the US by 2030.<sup>1</sup> Consistently, the racial composition of ethnic minority nursing home (NH) residents is rapidly growing. From 2000 to 2007, Hispanic and Asian NH residents increased 43.3% and 44.7%, respectively.<sup>2</sup> Although the prevalence of dementia in ethnic minority NH residents in the United States (US) is unknown, this estimation coupled with the increase in the number of older adults with dementia,<sup>3</sup> will likely lead to a corresponding increase in the number of ethnic minority NH residents with dementia. Among the ethnic minorities, 1.7 million Korean Americans (KA) represent the fifth largest Asian group, with a population increase of 42% from 2000 to 2010.<sup>4</sup> Although the number of KA-NH residents is unknown, it will likely increase with KA population growth.

The KA-NH residents may have different cultural and language background from nursing assistants (NAs), who frequently provide direct care activities, such as bathing and dressing. If the NAs use a different language with different cultural experiences, KA residents

may experience communication challenges such as misinterpretation of the verbal and non-verbal expressions of NAs.<sup>5,6</sup> The need for culturally familiar communication may be pronounced for KA-NH residents who have lower levels of English proficiency and tend to retain their language and culture.<sup>7,8</sup> For example, when NAs instruct in Korean to KA residents, KA residents expect culturally appropriate linguistic and behavioral expressions.<sup>9</sup> In Korean, there are two types of words or phrases with the same meaning which are used differently based on age, which is incorporated in a deep-seated respect for older adults.<sup>10</sup> In other words, the Korean language is spoken in a casual manner (i.e., *Yesamal*) or in a more respectful manner (i.e., *Jondaemal*). When NAs speak to KA residents, the residents expect to hear the polite *Jondaemal* form (words or phrases), otherwise the KA residents may interpret the NAs communication style as disrespectful and impolite. The KA residents with dementia may experience further frustration due to the language and cultural barriers, in addition to their cognitive impairment, that in turn, might elicit or increase behavioral symptoms of dementia (BSDs).<sup>11</sup> The BSDs become a concern for caregivers, and may result in higher rates of staff turnover and medication overuse.<sup>12,13</sup>

Despite the increasing attention to culturally and linguistically appropriate care,<sup>14,15</sup> there is a dearth of studies that have explored culturally appropriate verbal and non-verbal expressions and the resulting influences on BSDs. Only a single case study<sup>16</sup> was available

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in the literature to support the influence of native language on behavioral symptoms of an immigrant resident with dementia. Since language is only one aspect of culturally familiar communication, further studies are needed to examine other aspects of communication (i.e., verbal and non-verbal style, communication traditions, and generational language rules) in ethnically diverse residents.

Considering that ethnic minority NH residents prefer to receive care from those who have familiar cultural background and/or are able to use residents' native language,<sup>17,18</sup> it becomes critical to understand appropriate communication style and its association with BSDs for the residents. The purpose of this study was to explore and describe the association between non-Korean NAs' communication style and behavioral symptoms in KA-NH residents with dementia. The findings may help family caregivers and health professionals to better understand BSDs within the context of social interactions in an ethnically diverse community. It will ultimately improve quality of life of KA-NH residents with dementia.

## Methods

### Sample and setting

After approval from Institutional Review Board, the study was conducted in a single NH, where more than 90% residents were KA older adults. This study used a descriptive longitudinal design.

### Residents

A total of 20 KA-NH residents participated in this study. Inclusion criteria for residents were 1) Korean-American immigrants; 2)  $\geq 65$  years; 3) a diagnosis of dementia according to their medical record and score less than 24 on the Korean version of the Mini-Mental State Examination (K-MMSE)<sup>19,20</sup>; 4) resident in the NH for at least 2 months; 5) anticipated residency in the NH for the duration of the study; and 6) no dose adjustment of the following medications for at least 1 month: anti-psychotics, anti-depressants, anti-anxiety, neuroleptics or sedative-hypnotics. The principal investigator (PI) obtained written informed consent from the family members of 20 among 54 potential participants (35%). Seven (13%) refused to participate and 27 (50%) could not be reached.

### Nursing assistants

A total of 28 NAs were observed in the study. Among 32 potential participants, the PI recruited 28 individuals (87.5%). Four (12.5%) NAs declined participation. Inclusion criteria for NAs were: 1) non-Korean, 2) non-fluent Korean speaker, and 3) anticipated working in the NH through the duration of the study.

### Procedures

The PI reviewed the residents' medical records and administered K-MMSE. NAs were individually interviewed to obtain demographic information.

### Direct observation

The modified Agitated Behavior Rating Scale (mABRS)<sup>21,22</sup> and social interaction coding schemas (Dementia Social Interaction, Culture Social Interaction)<sup>23</sup> were installed on the observational computer software, the Pocket Observer 3.0 (Noldus) in hand-held devices (Panasonic®; Japan). The maximum number of observation per resident could be six over three days (2/day  $\times$  3days = 6). Trained RAs observed NAs/resident dyad interactions during morning care between 8 am and 10 am (e.g., dressing, bathing, combing, grooming, oral care, and transferring out of bed) and afternoon care (e.g., undressing, incontinence care, and transferring to bed) between 3 pm and 5 pm. Three RAs independently observed

and recorded NAs' communication style and residents' BSDs, as unobtrusively as possible. They simultaneously started coding when an NA entered a resident's room to provide care and continued whenever the target behaviors (i.e., communication, BSDs) occurred. While one RA recorded the NA's dementia communication style using the DSI coding schema, the other RA recorded the NA's cultural communication style using the CSI coding schema. The third RA observed and recorded the resident's BSDs using the mABRS. The two RAs, who observed the NAs' communication style, stopped observation when the NA left a resident after completing her/his tasks. The third RA continued to observe and record BSDs for 1 h after the NA left the resident's room. Data were downloaded from the hand-held device to The Observer 5.0 (Noldus) and then transferred to Microsoft Excel to manage the dataset. The cleaned dataset was exported to SPSS 20.0 and/or STATA 12.0 for data analysis.

### Reliability of observations

The RAs had an intensive 8 h training session in standard protocols for using the hand-held device, the coding schemas, and the mABRS until they demonstrated proficiency. RAs were trained for 6 h away from the NH, using videotaped behavior, followed by a 2 h practice observation session at the NH. Definitions for BSDs and communication style codes were clarified using examples. If there were coding differences, they were resolved by group discussion under the direction of the PI. To ensure the inter-rater reliability of behavioral observations, 2 RAs simultaneously recorded communication style (DSI, CSI) for the same NA. The other 2 RAs simultaneously recorded BSDs for the same resident. The inter-rater reliability between 2 RAs reached 0.70 or higher, using Cohen's kappa<sup>24,25</sup> for both communication style and BSDs.

### Measures

#### Demographic information about residents and NAs

Demographic data for residents were abstracted from each resident's medical records including medications, co-morbid medical conditions, age, gender, and marital status. The K-MMSE was used to assess cognitive status. Demographic information was obtained directly from NAs including age, gender, race/ethnicity, primary language, education, and length of time working in the facility.

#### Residents' BSDs

The Modified Agitated Behavior Rating Scale (mABRS)<sup>21,22</sup> was used to measure frequency and intensity of BSDs using direct observation. The mABRS includes 6 six categories of behavior: vocalization, restlessness, escaping restraints, searching/wandering, tapping/banging, and pacing/walking. The ratings are coded on a four-point Likert-type scale for each point, ranging from not present (0) to high intensity (3). For example, intensity ratings for restlessness are: 0 = not present; 1 = low intensity, rhythmic purposeless movements of hands; 2 = medium or moderate intensity, repetitive manipulation of an object, facial distress; 3 = high intensity, large amplitude rubbing or picking. The percent agreement for the presence or absence of BSDs ranged from 85.5% to 96.8% for frequency with kappa values ranging from 0.71 to 0.93 and from 83 to 89.5% for intensity with kappa values ranging from 0.60 to 0.64.<sup>21</sup>

#### NAs' communication style

The Dementia Social Interaction (DSI) coding schema<sup>23</sup> consists of 27 behavioral codes, including 12 dementia appropriate and 15 inappropriate communication styles (Table 1). Inter-rater reliability of the DSI coding scheme varied from 0.73 to 0.83 for

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