

LEVEL OF KNOWLEDGE AND COMMUNICATION OF THE RIGHTS OF RESIDENTIAL ELDER PEOPLE

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Abstract: Many third-age people come to live in the residential environment due to lack of family or home. The residential environment is an environment in which members at the same time have rights and obligations towards the community in which they live. These rights are not always known by the residents due to poor communication with the staff of the residential center. The paper aims to determine on a number of 107 elderly people living in the residential environment the level of knowledge of the rights they have and the level of communication that is established with the staff of the residential centers.

Key words: elderly people, residential environment, rights, communication

Theoretical frame

The situation of dependency

Dependence translates into the loss of autonomy, the need for help from those people. Your ability to maintain your home can be affected, prepare your own food, take care of your own person (hygiene, equip yourself, go to the toilet), move around, etc. Dependence is caused by illness, physical disability, affecting about one-third of people over 75 years of age, mental deterioration that occurs in about 5% of the elderly, or poverty. This situation affects the elderly's quality of life both because of mental discomfort (feelings of embarrassment, futility, sadness, helplessness) and due to the associated costs: medical consultations, payment of home carers, changes in the environment.

Economical situation

Elderly income tends to keep up the age gap: the rich are still rich, even if the income is somewhat diminishing, and the poor become poorer. Most pensioners are the main source of income, and others earn rental income,

economic activities, are helped by children.

The poverty of the elderly enters into wider context of poverty at the level of the integral society, its causes being either individual or structural, depending on what they achieve. The problems faced by the elderly have structural rather than individual origins. In the context of a high population poverty rate, as in Romania, economic growth measures are required, coupled with procurements for supplementing low-income people and ensuring decent pensions for the elderly (Breaz, 2011).

Some of the needs met by social services would be better met by the elderly if they had the financial means to maintain their independence. Most elders deal adequately with the problem of old age if they have financial security and a decent home, which is the benefits to which social policies should give them the most attention.

Discrimination, social exclusion, ageism

There is direct discrimination and indirect discrimination. Direct discrimination is, for example, when age is used to determine what treatment to be done to someone or how much to pay for a service.

The use of chronological age, directly or implicitly, as a measure for services or as the basis for resource rationing, is the most easily identifiable and the most arbitrary form of discrimination of the elderly. It betrays a deeply rooted ageism, implying that elders do not deserve to be treated on equal bases with others.

Indirect discrimination arises from affecting and disadvantaging the elderly by a particular policy or practice by ignoring their needs. The main reasons behind this discrimination are the stereotypes about the elderly and their marginalization in the policy making process. The consequences of indirect discrimination can be as damaging and important as those of direct discrimination and more difficult to identify and evaluate.

Defined as the negative, unfavorable or abusive behavior of individuals or institutions towards the elderly, ageism can also be seen in the way elders perceive themselves and lower their self-esteem and self-esteem. Ageism and age discrimination deprive society of the skills, talents and contribution of a major and growing section of the population, establishing a second-class status that negatively affects the lives of millions of people and helps create a divided and uneven society (Breaz, 2015c).

Ageism is evident in professional practice, in the media and in a wide variety of areas. It is absolutely necessary to change public attitudes and unfavorable images of aging.

Promoting an inclusive society for all will require fewer special measures and will result in the elimination of discrimination against the elderly.

Declining status

With retirement, there are a series of status and role restructurings. The change of status from the employee to the pensioner is steep, which leads to the appearance of a sense of ineligibility and, if new concerns do not occupy the time devoted to service, to boredom.

Different family situations and chronological inconsistency of life events for all the elderly make there a great difference between them. For some elderly families at the age of retirement, home abandonment by adult children is also happening, which doubles depressive feelings, others now appear to grandchildren, which was the opportunity to acquire a new sense of social utility (Breaz, 2015a).

Older people have fewer opportunities to make new friends and depend on long-lasting relationships. As the old man advances, the social network is rising, especially by the death congener, loneliness being as painful as so widespread among the elderly. Some elders become even isolated due to illness, loss of other significant or loss of hearing, vision, mobility.

Loneliness itself is not a problem if it does not lead to a lack of social relations and isolation, situations in which the person is deprived of the company and intimidated, crucial for a healthy and happy life. Studies show that people whose relationship needs are unsatisfied are more dissatisfied with life than those who live with others, more exposed to depression and poor health, have a lower quality of life (Bucur, 2001).

Ethics in an aging society

Over time and space were frequently mentioned unfavorable attitudes towards the elderly. In some cultures, when they become useless for family and society, elders become a problem and often they want death or are killed. In Eschimos, this mentality is implicit in the elders' habit of withdrawing from the community and leaving a boat off the ocean when it feels that it is no longer useful either. It's actually a suicide.

Today's violence against the elderly, such as physical, sexual or moral abuse, including abusive neglect and abandonment, robberies, crimes taking a leading role in crime statistics, and the high number of suicides among them the fact that even at the beginning of the third Christian millennium the elders are not loved, accepted or respected.

Conflict between generations as an antagonism between the young and the elderly is a current issue expressed in the variable intensity manifestation that is encountered in the spheres of social life: in the family, in the workplace, in the street, in the community, in the whole society (Fontaine, 2008).

As any conflict and the conflict of generations is due to the struggle for distributions of limited resources, power, or disputes over some values. The stereotypes and myths of the various age groups (especially children,

adolescents and the elderly) are a factor with significant influences for the accentuation of this conflict, and in this context the contemporary media society, especially television, plays the most important role in the image which it promotes about the groups mentioned, an image most often not in line with reality.

The other direction of ethical approach to aging and old age issues is related to making economic and political decisions. If the first case concerned individual life decisions, here are decisions that affect the community, the society. Issues related to healthcare, pension systems and social services for the elderly are already well known.

Ageism is a concept that multiplies the number of "ism", meaning discrimination against the elderly.

On the agenda of the international bodies, the issue of old age, demographic aging, the rights of the people of vartners is a permanent one, and the principle of non-discrimination based on age, gender, nationality, religion and so on appears in most national and international legal acts, beautiful ideals for tomorrow's society (Breaz, 2017).

The elderly patient always requires a particular situation - putting the doctor in a different situation from that of a young or adult patient - that is, to differentiate normal from pathology. (Neamtu, 2003, p.915)

This particularity derives from the fact that the adult's normal is different from what we consider to be normal in the elderly because the aging process (natural, physiological process) brings about changes in the morphological and functional parameters of the body, changes that are considered physiological for a certain age. In other words, it is important to establish whether we are in the face of an elderly person with changes in "physiological aging" or in front of an "elderly patient". However, differentiation is often difficult because the two processes can coexist, closely complicated, being difficult to separate, which negatively influences the proper assessment of the elderly and the elaboration of the therapeutic measures.

Starting from this difficulty, in practice two aspects can be met:

- or some aspects of normal aging are considered pathological, a situation that is most certainly the most common;

- Some pathological aspects are considered normal, belonging to physiological aging. (Garleanu Soita, 2006)

Roland Cape (apud Breaz 2014) considers that this second situation is also common because of the elderly (relatives, friends) who are trying to convince him that he has to console himself with the idea that full health is in the past and that he must confine himself to being ill and weak, expecting to be even worse before the end. As long as the elderly or even the doctor accepts ongoing pain, dizziness, weakness, fatigue and other symptoms as an integral

part of advanced age, many diseases will remain undiagnosed and untreated.

Therefore, elderly patients should be encouraged to report new and troublesome symptoms as they occur. The elderly will also appreciate the interest of their doctor or caregiver, will trust them, and so will be able to be quiet in situations where the accusations of their physiological involution should not alarm them (perhaps at a very advanced age, a man hardly accepts that the decrease in physical force or vision, for example, is a normal phenomenon). (Neamtu, 2003, p.915)

Summing up the clinical nature of the elderly patient in a few words, one can say that he is an individual whose huge functional reserves during development and maturity are largely lost. In spite of low reserves, most systems continue to operate quite accurately, albeit at a considerably slow pace. It is rarely necessary to prohibit the elderly from undertaking certain activities. The condition is that the activities they carry do not require unusual force or agility. The only necessary limitation to this statement is that the elderly should be warned that many activities require more time to do so and should be encouraged to accept it and not to hurry (Breaz, 2014).

Although morbidity and mortality are constantly increasing with age, many elderly people can enjoy a full and active life. Their proportion declines slowly from about 95% to 65 years to about 85% to 80 years and to 70% or less to 90 years. This means that the advanced age must not inspire fear in most cases, being a period that allows the individual to enjoy every moment, a time when unfulfilled ambitions can be achieved.

Few studies have examined the health of random cohorts of elderly people living in their own homes. One such study was conducted in three districts southwest of Ontario and provides estimates of the proportion of elderly people of different ages who lost some or all of their independence.

Based on an analysis of simple activities (walking, climbing and descending stairs, washed, dressed), this study found that most elderly people retain their completely independent lifestyle to the end. between 65 and 75 years, the incidence of significant disabilities slowly increases from 5 to 10%. Only 80 years later, this increase in the loss of independence reaches 20-30% in the risk population. (Mandrila 2005)

The importance of this simple study is that it draws attention to the false nature of the idea that advanced age is necessarily time of debility and loss of health. Most elderly, if not all, rely heavily on health, more than any other aspect of life, and that's why it is important that this message is spread everywhere and is well understood and accepted. He will encourage the elderly to have hopes for his health, understanding that he expects that disabilities will never necessarily happen.

Elderly people usually imagine a chronic and continuous illness picture,

with reduced capacity and disabilities. It should be emphasized, however, that chronic illness and age do not always go hand in hand. Shapiro finds that more than half of patients with admissions longer than 6 months are under the age of 65 years, as confirmed by studies conducted in London and Ontario hospitals. It is therefore important to distinguish between patients with chronic and elderly illnesses. They may have many health problems, characteristic of the elderly being polyopathy, but in relatively few cases they lead to continuing complex disabilities to result in loss of independence. In other cases, the hope of achieving a satisfactory return to independence is good (Breaz, 2015b).

Elderly patients arise from many chronic conditions of illness (remarkable being vascular atherosclerotic disease, obstructive chronic bronchopneumopathy, delayed diabetes, chronic arthritis). The first and most common of these - atherosclerosis - usually occurs as a series of acute episodes of myocardial infarction, gangrene due to peripheral vascular disease, etc. (Neamtu, 2003, p.915)

Although some individuals become ill in these conditions, most continue to maintain an independent lifestyle, outside occasional acute episodes. It should be added here that including the disabled group is treated with skill and seriousness.

Chronology does not mean that treatment can not be applied to reduce problems and help maintain independence. Ronald Cape believes that in an elderly, the effect of a chronic illness falls broadly into one of the following three possibilities:

- the first is that of terminal disease, and the patient dies in two to three weeks;
- the second is that of the disease that responds to treatment and is properly rehabilitated, and the patient regains his full independence;
- the third possibility is that the disease results in a significant loss of functional ability, so that the individual becomes dependent on the support of others.

American geriatrics considered that elderly people feared this third possibility, so management of elderly illness should avoid this situation as much as possible. This objective can be achieved by having the elderly patient in a continuous rehabilitation program at home or, if necessary, in a day care center with community services in order to encourage and maintain independence, be it only partial. Another problem related to the pathology of the elderly, which we consider to be worth mentioning, is that of a surgical disease at risk of death, for example the discovery of an asymptomatic abdominal aortic aneurysm in an octogenarian, potentially lethal situation, because the rupture of the aneurysm will be close surely causing death (Sorescu, 2005).

Surgery would remove aneurysm and its lethal risk, but on the other hand, such an intervention at a healthy octogenary is striking by a rather high mortality (approximately 19%) and can cause, through the operator's stress and the possible adverse effects of drugs, impairment of mental capacity and individual independence.

Experience shows that most elderly people, if given the opportunity to choose, prefer a short, independent life instead of a long period of disability, when they are dependent on the care of others.

Turning to the importance of rehabilitation, we emphasize that for an elderly the critical part of a disease is the final stage, ie the restoration of mental and physical function to the stage before the disease. There is a difference between the ways in which beings react to disease and re-establish themselves at different ages. Thus, the adult individual affected by a severe acute illness is often remarkably restored, rapidly, his rehabilitation being stimulated by the need to return to family and work responsibilities. In contrast, the prospect of the future for the elderly is not an incentive for its rehabilitation and, without being motivated, it will not make the effort necessary for the rehabilitation process, which inevitably requires persistence from the patient. (Miftode, 2010)

Therefore, the elderly needs careful supervision and permanent support to achieve this goal. He must be convinced (and it is not always simple) that the only way to repair the psychic force and ability is to take responsibility, get up from bed and use the muscles, obviously within acceptable limits, gradually over a period of time.

The effectiveness of rehabilitation programs has been verified over and over again in the UK as well as in North America. This aspect of care must never be out of sight, regardless of illness.

Another aspect of the elderly pathology, which I think deserves to be remembered here, is the special role that preventive geriatric medicine can have. And many examples can be given in this regard. Thus, osteoporosis, considered to a certain extent to the elderly woman due to hormonal deprivation from menopause, presents a maximum risk of fracture around the age of 75-80 years. there are hundreds of thousands of serious bone fractures in the world, attributed to osteoporosis.

The dietary analysis of "middle-aged women shows that for many of them, the diet does not contain enough calcium and although the negative calcification can only be a secondary factor in this multifactorial disease, it plays an important role and is certainly a remedy factor.

Preventive action can also be taken on the other aetiological factors of osteoporosis, through hormonal correction and physical activity, and it is particularly important to maintain a modest physical activity. (Buzducea, 2010)

The results of epidemiological studies strengthen the physician's role in

the primary prevention of cardiovascular disease, which is the leading cause of elderly mortality. The risk factors identified in the Framingham study, which are modifiable or preventable, are: hypertension, high serum cholesterol, smoking, glucose intolerance, left ventricular hypertrophy.

Excessive obesity, hypercholesterolemia, hyperglycemia, over-saturated diets in fat and excessive alcohol consumption (in contrast to the permissible consumption of a glass of wine a day) are the conditions or habits in which the doctor has an opportunity to take an attitude. There are many other opportunities to practice preventative medicine. For example, immunization of the elderly by vaccinations should be accepted as a routine method.

Similarly, administration of postoperative antithrombotic drugs and in all other immobile situations where the risk of pulmonary embolism is feared. Ronald Cape said that "in geriatrics, a preventive effect has greater value than a healing remedy," meaning that the role of prevention is more than 12.5 times greater than treatment (Bodi, 2017)

Dependence in old age

The notion of dependence is integrated with gerontology and geriatrics, of which it is inseparable. It has specific geriatrics, and although it is not a disease, it can be caused by illness, accident, an inborn or gained anomaly, plus the involution process for the elderly. Dr. Constantin Bogdan emphasized in 1997 one of Cardot's statements in 1994: "Old age is not a disease; the great age induces a natural dependence that needs help. " (apud Breaz 2011).

Demographic developments also make it possible to increase incapacity and handicaps in the coming years. The first results of non-incapacitated life expectancy studies are encouraging, which is growing faster than life expectancy. Despite the progress that has been made, many of the elderly become dependent. The problem of elderly dependence is a major public health issue. It determines the needs and services dimensions that are needed, it requires resource allocation in health and social care, supporting families and finding other forms of help.

By qualifying a person's relationship with his or her environment, dependency requires a global and multidisciplinary approach (Buzducea, 2017).

In a preventive way, which refers to the whole population and, in particular, to the younger generation, the goal is to restore the broken balance between the person's abilities (his / her skills) and the living space he / she chooses. For this purpose, it is essential to perform a functional assessment beforehand. It refers to both the physical and psychic skills and the social universe of the person. The means implemented must be well coordinated. These means must pursue a threefold purpose: correction of incapacity; stabilization of the acute functional stage; adaptation of the social environment

to the stabilized functional stage.

Often, many interventions are needed: medical and surgical; social services; home care help services; hosting institutions (day centers, night shelters) (Breaz, 2011).

It is, therefore, important to always have the patient's good knowledge of the case in order to respond to the situation (Neamtu, 2003. p.920)

Dependency refers to the loss of autonomy of the third person, the need for help from other people. Dependence may be provisional or definitive depending on the evolutionary potential of each disease being diagnosed. (Bucur, 2001, p. 915)

The needs of the third-age dependents partly or totally dependent may be socio-medical, psycho-affective, and these are established on the basis of a national assessment of the needs of the elderly, which provides the criteria for inclusion in dependency grades. Law 17, 2000)

Institutionalization of third-age people raises a series of problems (the appearance of a common sense in the community, loss of independence, intimacy and familiarity, minimizing family ties, friends and neighbors, discontinuing involvement in different organizations, altering normal social activities , aggression, anxiety, abandonment, hyperprotection) and cause reactions from the elderly (adaptive disorders, depression, confusional states, isolation, hostile silence, increased irritability, aggravation of organic suffering) and some needs: the need to be considered as part of society: the need to use time in as satisfying conditions; the need to be recognized as a person with distinct individuality and the need to manifest one's own personality; the need for health care; the need to stimulate menta faculties; the need for spiritual services; the need for communication (Sorescu, 2005, p. 60-87)

Loneliness and social isolation at third age.

Loneliness and isolation of the elderly and beyond, generates the need for belonging, to have a life characterized by sense and dignity. The elderly person remains the only one, and the assistance received from receiving social services does not respond to this problem given the fact that the social and emotional problems of the instincts are less recognized in comparison with the material. Third-age people have fewer opportunities to engage in new friendships and tend to depend on long-term relationships in their previous lives. The more the person advances, the more his social network is rare, especially through the death of his acquaintances.

Loneliness itself is not a problem unless it leads to a lack of social relations and isolation. Robert Lauder's studies have highlighted that people whose need for relationship is unfulfilled, are more dissatisfied with life than those living with others, are more exposed to depression, and have a healthier and lower quality of life . (Sorescu, 2005, p.43)

Beyond the precarious material state of the elderly, it faces acute problems, such as the abandonment of active social roles, poor health, loneliness, dependence, the feeling that the elderly is generally a "burden for society, which is why most of them become victims of the abuses of their peers, often even from the ones they gave their lives, the first to have the duty of respect and care.

Regarding the abandonment of these people, Dr. Constantin Bogdan points out that it manifests itself in several forms. Since 1992, inspired by the phrase "street children," he has reported what has turned out to be a reality - the "street elders" (an important part of the category called "boschetari"). Without shelter, begging, scrambling through the garbage, these elders of nobody with biographies hard to decipher (because they hide the causes of their tragic becoming, either present difficult to check stories, or have memory disorders, certain degrees of intellect damage, other forms of mentally disabled, often without identity papers, etc.), because of the polymorphism of the causes that sent him to the street, these "elders of the street" often go unnoticed (apud Breaz, 2015a).

The reasons they came to the street are diverse and the probability of them getting back into families is very low.

Hypotheses

H1: We assumed that vartic people do not know the rights they can benefit from within the residential centers and are aware of their obligations within the centers.

H2: We assumed that older people have more difficult access to the services provided in the centers and have difficulties in dealing with the staff of the center.

Lot studied

The sample comprised a total of 107 subjects, beneficiaries of services from residential centers, between the ages of 55 and 81. The age and sex distribution of the elderly is shown in Table 1 and Figures 1 and 2.

Table 1. Distribution by function of sex and age of studied group

Age	65 yaers	68 years	69 years	70 years	74 years	78 years	79 years
female	10	2	6	3	15	10	10
male	3	12	17	14	6	8	1

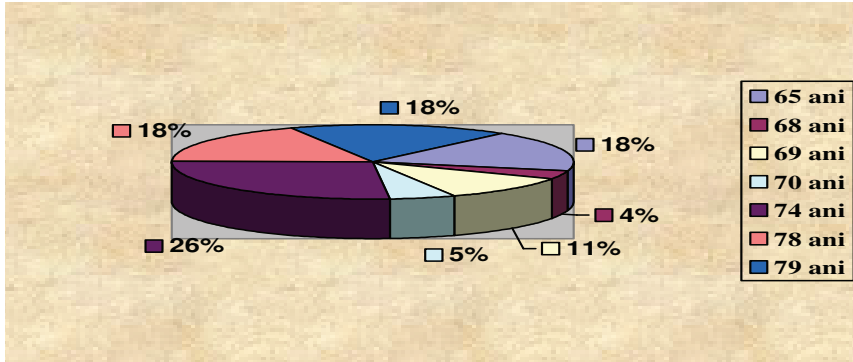


Figure 1. Distribution by age of women

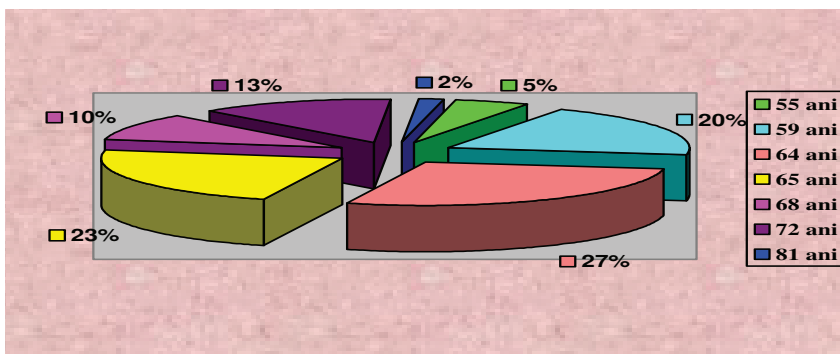


Figura 2. Distribution by age of men

Methodology

An interview was conducted with all the subjects of the batch, which reached the points of interest for us from the formulated assumptions.

From the perspective of constructivism, interviewers and interviewees are always actively engaged in constructing their meanings. Instead of treating this fact in terms of an obstacle that blocks the correct collection of descriptions of facts or experiences, the way of constructing meaning becomes the main research problem of constructivists (Silvemar, D., 2004, p.106).

S-a efectuat un interviu cu toti subiectii lotului, care atingea punctele de interes opetyru noi din ipotezele formulate.

Results and discussions

Speaking about the rights they have under the law in force, only 20

people have been told of the interviewed group.

Another 20 beneficiaries know that they have certain rights but do not know them; 35 beneficiaries claim that they have not been brought to their attention and the rest of the beneficiaries, in the number of 31 assistants, consider that they have only obligations that they do not know. Here we can see the degree of information peculiarity as well as the training of qualified staff (see Figure 3).

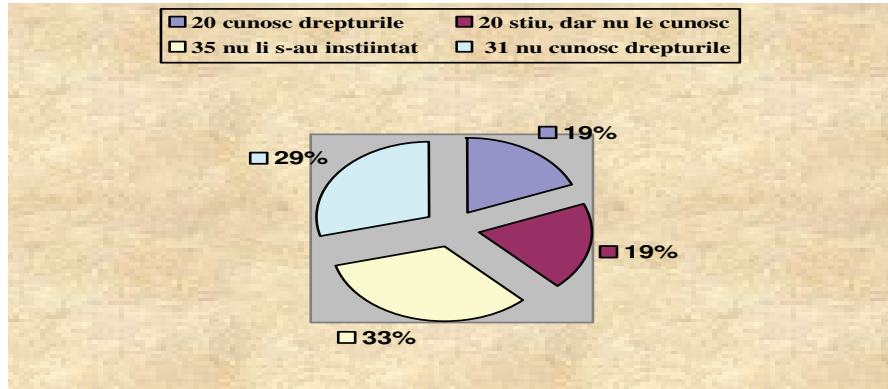


Figure 3. Knowledge of rights and obligations by the beneficiaries

The first hypothesis is verified in practice: the elderly in residential centers do not know their rights and their obligations towards the center. The conclusion of this is that most of the institutionalized elderly people do not want to communicate with the staff of the centers, but the latter does not have the high degree of trust. See Figure 4).

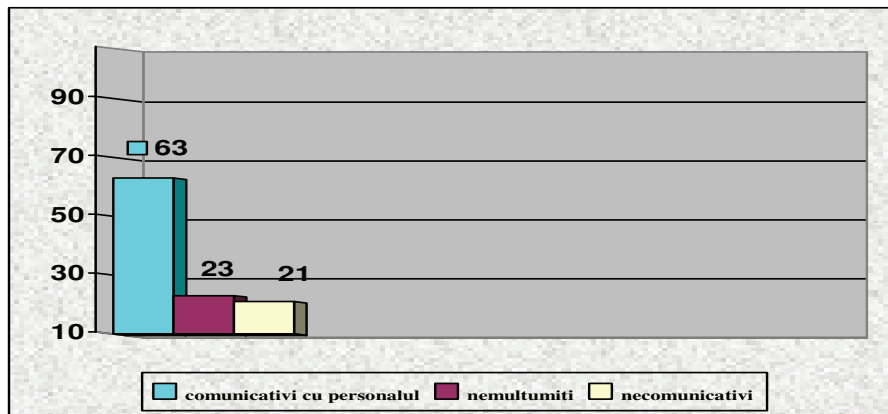


Figure 4 Beneficiaries and the linkig of the staff with them.

In the group of the interviewed persons, 63 beneficiaries communicate very well with the roommates and the center staff, for 23 beneficiaries the communication with the staff is hampered by its behavior, and 21 beneficiaries are not open to the communication.

Following the interviews applied both in residential homes for the elderly belonging to the Community Assistance Directorate, as far as the Department for Social Assistance and Child Protection in Arad County, it was found that elderly men communicate less with their family, friends or close relatives, and women communicate more easily with others.

Relationships with the center staff are not very open and this impedes the elderly attitude towards the residential institution. Recent research from the literature highlights this aspect of the relationship between the elderly and staff in the residential centers (Breaz, 2015c).

Conclusions

Both of the hypotheses formulated at the beginning were validated by practical research. In the research it was found that the number of beneficiaries of these residential services is alarmingly high, the causes being usually lack of material support, moral or lack of housing. The family does not empathize with the situation and problems of the elderly, so communication with it is deficient.

Most elderly people attend religious services, but few visit their friends. It is alarming that the staff is not qualified and that the qualified person is not "motivated" to take care of the seas. Qualified staff are not prepared for an experience around the elderly, the latter not knowing their rights and obligations provided by the legislation in force and mentioned in the Center's internal regulations.

Following the interview with the batch of beneficiaries, there was some misinformation and misinformation about their rights and obligations. The staff having an import role in this respect, found a lack of interest towards the beneficiaries regarding the implementation of the Center's internal regulations.

The suggestion on this issue is to involve the staff in "continuous improvement", that is to say, his participation in perfecting courses.

For those who do not want, among the beneficiaries, to maintain contact with the family, the proposal of some counselors in this respect and their careful monitoring.

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