

THE IENE 3 TOOLS REPORT

LEARNING TOOLS FOR INTERCULTURAL EDUCATION OF HEALTHCARE PRACTITIONERS IN EUROPE

Edited by

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Introduction to the report

This report documents information on the development and evaluation of the three learning/teaching tools which represent the key outputs of the IENE 3 Project. The report begins with a document on the methodology for creating the learning/teaching tools and it is followed by the presentation of the three tools and the data from their evaluation.

The three tools cover the following topic areas of intercultural education:

- Tool 1 – Compassion
- Tool 2 – Courage
- Tool 3 – Intercultural Communication

The following countries participated in the IENE 3 Project:

- United Kingdom, Middlesex University (Co-ordinator)
- Romania, Edunet
- Netherlands, ROC Albeda College
- Italy, Azienda Ospedaliera Universitaria Senese
- Germania, Volssolidaritat Gera
- Turkey, Marmara University Hospital

The key personnel involved in this project were:

- Middlesex University, Prof Irena Papadopoulos, Alfonso Pezzella and Laura Foley
- Edunet, Victor Dudau and Adrian Dudau
- ROC Albeda College, Annemiek, Xandra and Angela
- Azienda Ospedaliera Universitaria Senese, Claudia Rustici and Cristina Masoni
- Volssolidaritat Gera, Fedrike Jung and Rena
- Marmara University Hospital, Fatma Çırpı and Serpil Tural

Each partner country produced one tool per each topic area. In total, eighteen tools are presented in this report together with their evaluation data.

This report is also available on the project website at www.ieneproject.eu

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Methodology For Creating The Learning / Teaching Tools For Compassion, Courage, And Intercultural Communication

by
Professor Irena Papadopoulos

Introduction
This paper deals with the methodology to be used in the development of learning /teaching tools for compassion, courage, health inequalities, and intercultural communication. The **first section** provides a definition of what the term 'tools' means for this project. The **second section** provides the guiding values and principles of the methodology, whilst the **third section** presents the model for the development of culturally competent and compassionate health care professionals. This model will be adapted to provide some key content for the other three areas which we will develop tools (courage, health inequalities, and intercultural communication). The **fourth section** provides the components of a tool. The **fifth section** provides a template that can be used in the development of the tools. The **final section** provides a step-by-step summary of the methodology.

**Please note that for the benefit of clarity, I refer to a 'tool' as one activity whereas 'toolkit' is a package containing a collection of tools.*

1. **What do we mean by 'tools'?**
Learning tools are 'materials' which students use on their own or with others to learn about a topic, to develop their cognitive (thinking), psychomotor (practical) and affective (emotional) competencies. Learning tools may be identified or developed by the students or the teachers (sometimes referred to as teaching tools). Because every individual learns in a different way, teachers use a variety of learning/teaching tools, to respond to the diversity of learning styles. For example, tools could be a book, a picture, a power point presentation, a diagram, a quiz, a visit, a podcast, a song, a video, a computer game, a website and so on.

The following list can be used as a checklist for learning/teaching tools. Not all learning tools will meet all criteria. But generally speaking the more criteria a learning tool meets, the stronger the tool.

A good tool:
- Contains customised steps to help students progress through their learning goals;
- Provides observable evidence of learning;
- Clarifies what students know and don't know;
- Allows the teacher to see/hear (and intervene) when students don't understand;
- Leads to and connects with other tools in the process of meeting larger /higher level learning goals;
- Helps students synthesize knowledge and meaning;
- Provides building blocks that enable students to step into and through difficult concepts or processes to reach predetermined learning goals;
- Provides pathways that lead to depth and clarity in learning;
- Adds to the meaning-making in the classroom.

Modified from a list provided by the Perpich Center for Arts Education
http://www.mnartseducation.org/docs/03/_pdf/03_01.pdf

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2. Guiding values and principles of the methodology

Taken from the United Nations human rights declaration, the overall **guiding value** of our methodology is:
'All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood'.
(http://www.un.org/cyberschoolbus/humanrights/declaration/1.asp)

Further, the values of the IENE3 team, which were expressed during a values workshop which used 'compassion' as the vehicle for the value clarification exercise at the beginning of the project, are compatible with the following:

Effective 'values education':

- helps students to understand and to be able to apply values such as care and compassion;
- pursues excellence by requiring the students to do their best;
- purses and protects the common good where all people are treated fairly for a just society;
- pursues freedom in order to protect the rights of self and others;
- pursues honesty and truth;
- helps the students achieve consistency between their words and deeds in accordance with moral and ethical conduct;
- promotes the respectful treatment others;
- promotes personal responsibility and accountability of one's own actions and the resolve of differences in a non-violent and peaceful ways;
- promotes the understanding and tolerance of others and their cultures, the acceptance of diversity and the inclusion of others.

Adapted from: National Framework for Values Education in Australian Schools, DEST 2005, p 5,
http://www.valueseducation.edu.au/verve/_resources/Values_PLP_intro.pdf

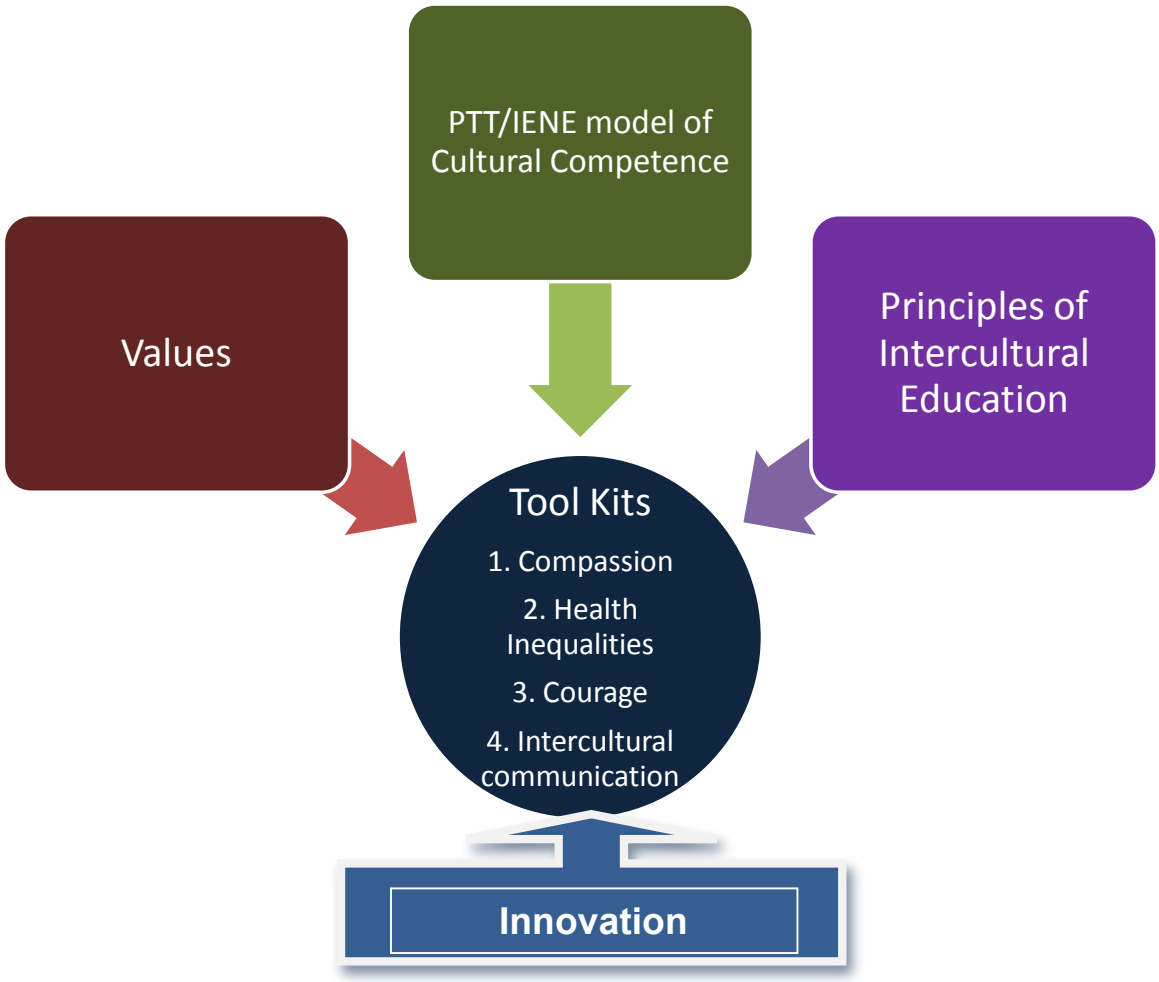
The principles which inform the methodology derive from the previous work on the Papadopoulos, Tilki and Taylor model of transcultural nursing and cultural competence (1998, 2006) and the Intercultural Education of Nurses in Europe (IENE1 & IENE2 projects), as well as other principles of intercultural education which can be found in the literature. These are:

- Respecting the cultural background and identity of the learner by relating learning to their previous knowledge and experiences
- Providing equal access to learning by eliminating discrimination in the education system and by promoting an inclusive learning environment
- Promoting learning which encourages the understanding of personal values and the development of self -awareness, both of which form the basis for reflective communication and co-operation across cultures and social boundaries
- Promoting a critical approach regarding the power linked to the production and use of knowledge to either oppress or emancipate people
- Encouraging the establishment of peer learning communities for support and the exchange of knowledge and experiences
- Tolerating language imperfections by providing language support and/or by allowing extra time for people to express themselves
- Avoid over-dependence on oral learning methods and use visual and other interactive and culturally appropriate learning approaches
- Emphasising realism. Intercultural learning is a life long process
- Promoting courage. Thinking outside the box and speaking out against injustice.

Whilst the above principles will inform and guide the development of the IENE3 tools, an **additional principle** is that the tools should have an element of innovation. The Collins dictionary defines 'innovative' as:
novel, new, original, different, fresh, unusual, unfamiliar, uncommon, inventive, singular, ground-breaking, transformational.

Figure 1 summarises the above.

Fig. 1: Values and Principles for the development of learning/teaching tools.



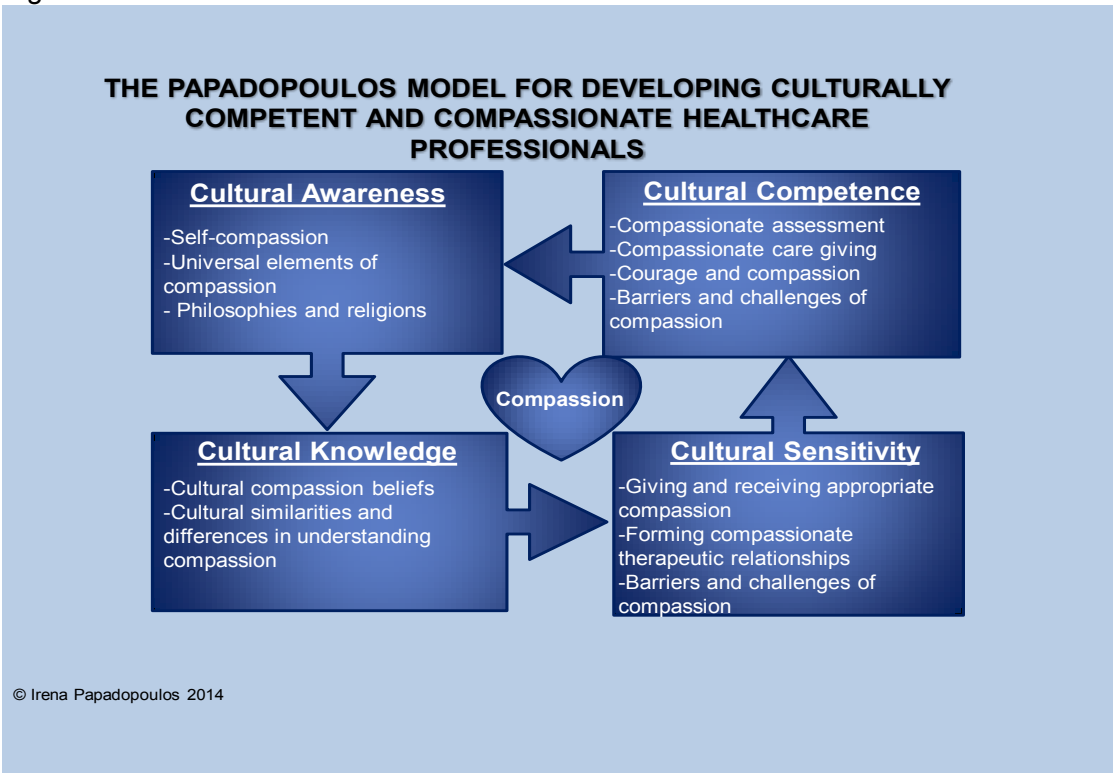
3. The model for the development of culturally competent and compassionate health care professionals

The proposed model uses the construct 'compassion' to propose the overall methodology for the development of tools (Fig. 2). The construct under development is placed in the centre of the four boxes each containing the main construct of the PTT/IENE model. In each box a small number of sub-constructs are proposed, about which learning / teaching tools could be developed. The proposed sub-constructs could be added to or replaced with relevant others. In this way each sub-construct is considered not only for in own sake but, importantly, it is considered from the cultural perspective. For example, in order to start on the process of

becoming a culturally competent and compassionate health professional, a student should be encouraged to reflect on the meanings, understandings, expressions, etc of compassion from their own cultural point of view. A variety of learning /teaching tools can be developed to address the other sub-constructs.

By replacing 'compassion' with 'courage' in the centre of the diagram, we can identify relevant sub-constructs for 'courage' and then develop the learning/teaching tools, and we repeat this process with 'health inequalities', and 'intercultural communication'.

Fig.2:

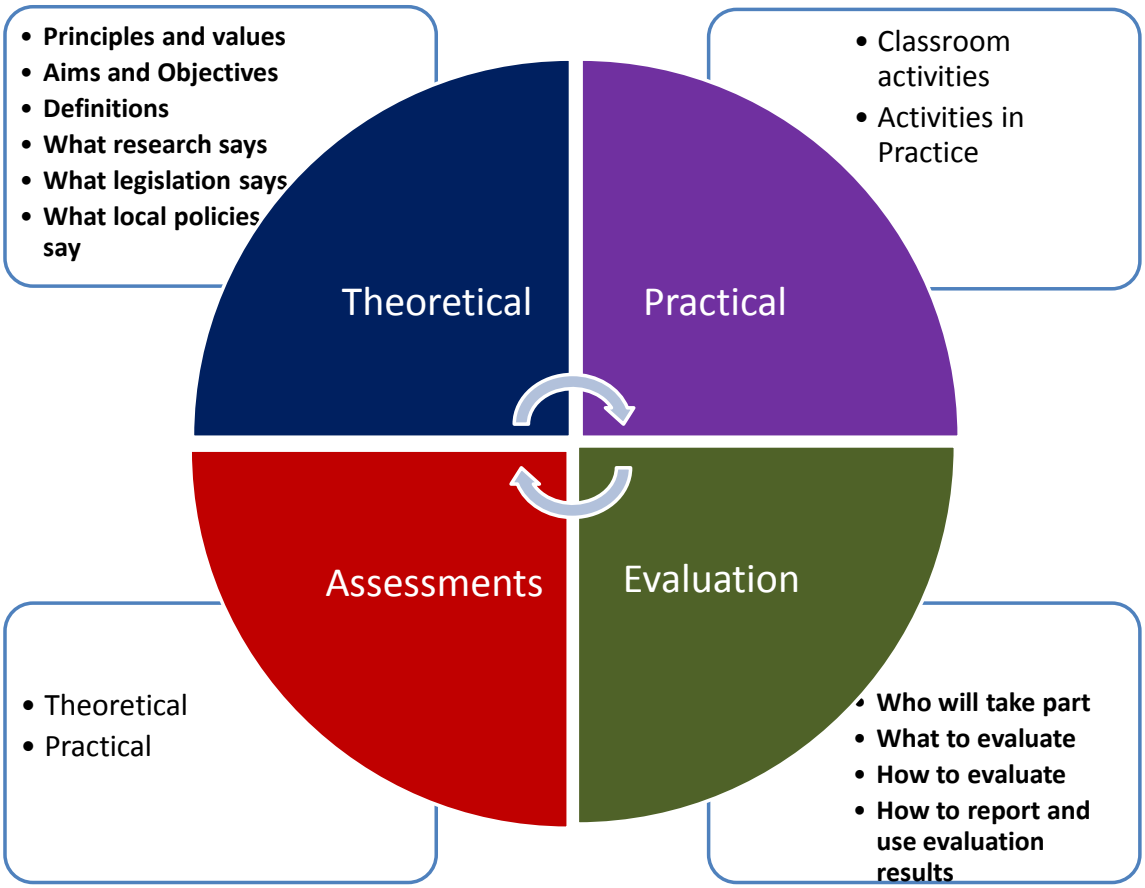


4. The components of a learning/teaching tool

Figure 3 identifies the main components which we can use for the development of the learning/teaching tools. These are:

- the theoretical component
- the practical component
- the assessment component
- the evaluation component

Fig. 3. Components of a tool



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5. Template for the development of the tools

(Please use one template per tool and use as much space per section as needed)

THEORETICAL ASPECTS OF THE TOOL

5.1 Title of the tool

5.2 Articulate the principles and values relevant to the tool

5.3 Overall aim for the tool

5.4 Learning outcomes *(up to six)*

5.5 Relevant definitions and terms *(to be added to the IENE glossary)*

5.6 What the research says on the topic *(add at least 6 research references with a brief summary for each and relevant URLs)*

5.7 What the legislation/treaties/conventions says on the topic *(add 2-3 local and 2-3 European and 2-3 International with brief summaries and relevant URLs)*

5.8 What local policies say (*add 2-3 policies from your institution and those organisations you work with)*

PRACTICAL ASPECTS OF THE TOOL

(please note that a tool can be either classroom based or practice based)

5.9 Classroom activities *(provide the summary here. The full activity with teacher instructions and specific materials to be used e.g a game-board, a power point presentation, etc can be attached as a separate document which will be uploaded on the IENE website)*

5.10 Activities in Practice *(provide a summary with full instructions and materials to be used in a separate document as above)*

TOOL ASSESSMENT*
(Please note that a tool does not need to have both theoretical and practical assessment. Use whichever is relevant)

5.11 Theoretical assessment.

5.12 Practical assessment.

**in this paper the term 'assessment' refers to those activities used by teachers and students to confirm what they (the students) have learnt which demonstrates whether they have achieved the learning outcomes of the tool. The term 'evaluation' may be used instead of the term 'assessment'.*

EVALUATION

5.13 Please suggest who should take part in the evaluation and why.

5.14 'What' to evaluate *(for example: the quality of the materials used in the tool, the relevance between learning outcomes and the content of the tool, the user-friendliness of the tool, etc)*

5.15 How to evaluate the 'what' *(5.14).*

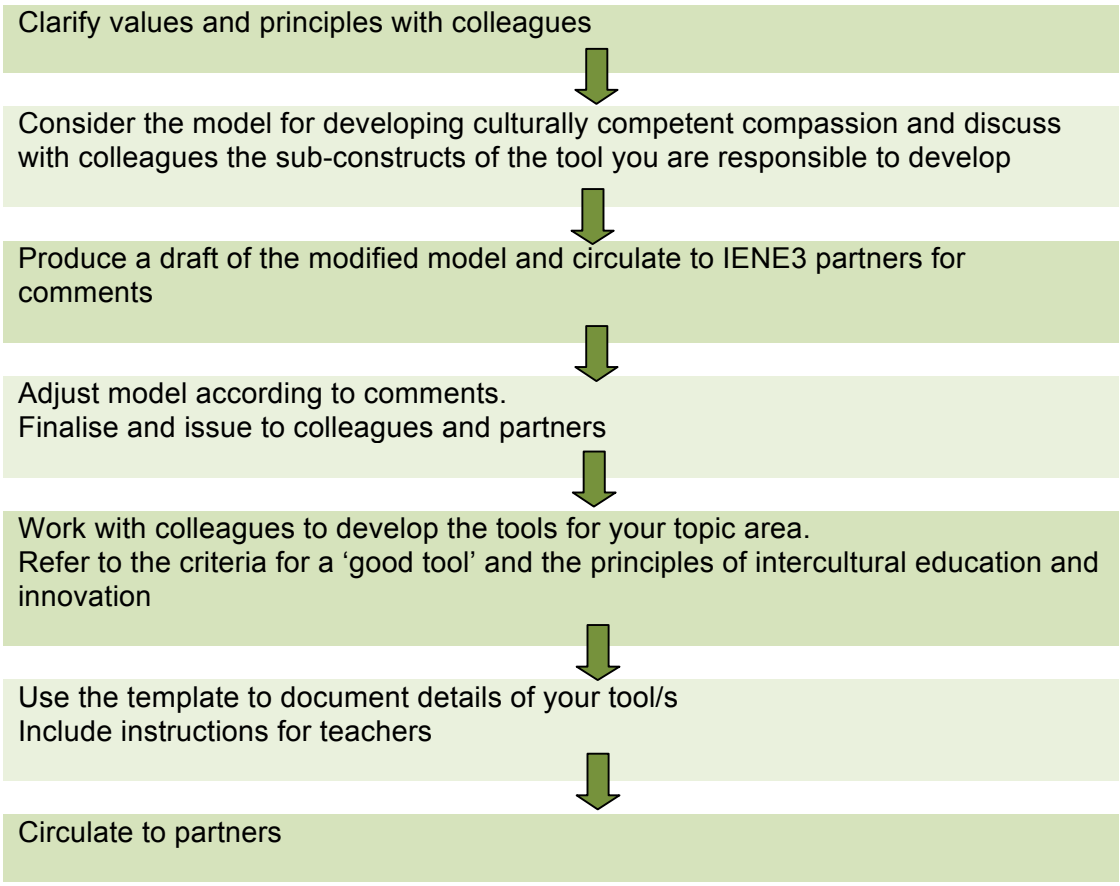
5.16 How to report and use the evaluation results.

AUTHORSHIP

5.17 Provide the names of the people who led the development and those who assisted in any of the many ways that colleagues do.

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Fig. 4 Summary: The seven steps of the IENE3 tool methodology



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Toolkit One

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The Middlesex University Compassion Tool & Evaluation

by

Dr Gina Taylor and Professor Irena Papadopoulos

COMPASSIONATE HEALTH AND SOCIAL CARE

THEORETICAL COMPONENT

Principles and Values

Compassion has its roots in religious ideologies and it concerns sharing the suffering of others. Thus, the principles that underpin this tool are:

- Shared learning
- Valuing experience
- Building on what is already known
- Equality of access
- Exploring similarities and differences
- Tolerance
- Fostering curiosity
- A commitment to life-long learning

The tool is also informed by the following values:

- Respect
- Dignity
- Equity
- Human rights
- Acceptance
- Inclusion
- Empathy
- Professionalism

Aims

When you have worked through this tool, you will be able to:

- Articulate the need for the focus on compassion in current nursing practice;
- Discuss the meaning of compassion from different viewpoints: your own, patients' and their families'; colleagues' viewpoints;
- Reflect on your own practice in relation to the provision of compassionate care that is safe and effective for a variety of different patients;
- Identify strategies to nurture your own practice in this respect.

Relevant definitions and terms/ What the research says

In England, compassion has risen to prominence in the media and policy circles following reports of unsatisfactory care of patients (Straughair, 2012a; Dewar, 2013; Price, 2013), which identified cruelty and neglect, unnecessary suffering, degrading and inhumane treatment (Staughair, 2012a) of people with learning disabilities (at Winterbourne View) and

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mostly frail elderly patients and patients who were nearing death (at Mid Staffordshire NHS Foundation Trust) (Hehir, 2013). Concern has been raised that nurses have lost sight of basic, compassionate care (Price, 2013).This emphasis on compassion is set in an increasingly complex healthcare context (Dewar, 2013). These reports suggest that the most frail, vulnerable and powerless people in society are most at risk of receiving poor care. Good care and compassion are often reserved for 'attractive' people (CAREIF, 2013).

Kim (Kim and Flaskerud, 2007) draws on her own experience of being a patient (in USA) and contrasts health professionals who demonstrated efficiency and clinical expertise with those who demonstrated connectedness and understanding but not particularly extraordinary skills. However, caution should be exercised in viewing two types of nurse – the efficient nurse and the caring nurse. Compassion is a relational concept and thus cannot be considered within a vacuum. Compassion arises in nursing encounters with patients, so there is a need to consider compassion alongside expertise. Within nursing literature, compassion is often discussed within the context of what 'good care' looks like, and so much of the literature is about good nursing practice, for example, care that is 'safe and effective but also compassionate' (Adamson and Dewar, 2011, p43).

In their work on developing a culture of compassionate care, Cummings and Bennett (2012) note that:

- Nurses generally come into contact with their patients and their families when they are at their most vulnerable and when *'care, compassion and clinical expertise matter most'.* (2012, p6);
- The focus on compassion is part of a wider drive to improve the quality of care;
- Values at the heart of the vision for nurses, midwives and care-givers are underpinned by 6 Cs:

- Care
- Compassion
- Competence
- Communication
- Courage
- Commitment

Cummings and Bennett define compassion, in the draft vision, as follows:
'Compassion means care given through relationships based on empathy, kindness, trust, respect and dignity, regardless of the circumstances and seeing the person behind the condition' (p10).

Alongside this nurses need to connect compassion with the very best technical care and the highest levels of knowledge.
The revised definition in the completed vision defines compassion as follows:
'*Compassion is how care is given through relationships based on empathy, respect and dignity – it can also be described as intelligent kindness, and is central to how people perceive their care'* (NHS Commissioning Board, 2012, p13).

So, providing compassionate care means being able to use the best available evidence to support nursing actions. Rather than seeing compassion as something that can be taught and learnt in a vacuum, it is important to link the nurturing of compassion to all nursing activities. As Dewar and Christley (2013) argue, rather than being one of the six values, compassion is at the heart of the other 5 values. Compassion is what unifies the other 5 values. For example, compassion requires empathy, courage and commitment to gather insight into patients' experiences and represent them to others in authority (Price, 2013).

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Definitions – How has compassion been defined in research studies?

Compassion is a concept that is difficult to reduce to a key set of measurable elements, but there is now a plethora of literature relating to compassion, both across Europe and the Atlantic.
The term means 'to suffer with', from the Latin *com* (together with) and *pati* (to suffer) (Schantz, 2007). Compassion has its origins in religious ideologies (Armstrong, 2011; Straughair, 2012a; CAREIF, 2013). Compassion is a central focus of many spiritual and ethical traditions, from Buddhism to Confucianism to Christianity (Goetz et al).
Certain elements that contribute to compassion can be found in the literature. These include:

- Humanity
- Respect
- Being non-judgemental
- Kindness
- Empathy
- Fellow-feeling
- Sensitivity to patients' experiences
- Being moved by another person's suffering
- Witnessing another person suffering and experiencing a subsequent desire to help (Goetz, Keltner and Simon-Thomas, 2010).
- Not only acknowledging suffering, but also acting toward alleviating it (Schantz, 2007)
  This is important to note, that in nursing practice compassion entails more than being aware of suffering in others. It entails acting on that awareness: many authors agree that compassion goes beyond recognition of suffering to having an active desire to alleviate another's suffering (CAREIF, 2013); *'... the capacity to perceive, feel and act towards suffering'* (CAREIF, 2013).

Dewar (2013) identified key dimensions of compassionate care:

- It is a subjective experience
- The quality of the relationship is important
- It relates to the needs of others
- It recognises suffering and vulnerability
- It requires emotional connection and interpersonal skills
  Cingel (2011) engaged in qualitative research which analysed in-depth interviews with nurses and patients in order to determine 'What is the nature and significance of compassion for older people with a chronic disease in nursing practice?' Cingel conducted interviews with 30 nurses and 31 patients with a variety of chronic diseases in the Netherlands, and was able to describe compassion as a process comprising 7 dimensions:

- Attentiveness
- Listening
- Confronting: verbalisation of suffering – acknowledging and valuing by the nurse
- Involvement
- Helping: assisting with activities of daily living that the patient can no longer perform
- Presence: being there
- Understanding
  This is broadly similar to Proctor's (2007) claim that compassion entails:
- Active listening

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- Ensuring patient dignity
- Anticipating anxiety
- Acting to prevent or ameliorate suffering

While Curtis (2013, 2014) suggests that the origins of compassion are thought to be innate and learned in relation to compassion towards people we know and care about, the origins of compassion for strangers are not so certain. Compassion is an 'other-orientated state' (Goetz, Keltner and Simon-Thomas, 2010). Compassion is likely to be most intense in response to the suffering of individuals who are self relevant, i.e. those who are most important to one's wellbeing, for example, offspring, relations, friends, partners, people who share similarities, group members; and goal relevant, i.e. a general value that all people should have equal rights and opportunities (Goetz, Keltner and Simon-Thomas, 2010). Goetz et al further argue that analysis of the evolution of compassion suggests that appraisal processes that give rise to compassion entail an assessment of 'deservingness', whereby undeserved suffering should elicit compassion. This entails making judgements about the degree to which an individual is responsible for his or her suffering. It is important to be aware of these processes in order to consciously suspend judgements in nursing practice. For Schantz (2007) compassion entails notions of doing good and justice in which there is no place for making judgements about people's deservingness of compassion.
The primary function of compassion is to facilitate cooperation and protection of the weak and those who suffer (Goetz, Keltner and Simon-Thomas, 2010).

'Compassionate nursing practice can be defined as comprising: the enactment of personal and professional values through behaviour that demonstrates the emotional dimension of caring about another person and the practical dimension of caring for them, in a way to recognise and alleviate their suffering.'

(Curtis, 2013a: 3)

So, what can we gather from this literature to use in the formation to learning and teaching tools? Curtis, Horton and Smith's (2012) study identified the following components of student socialisation in compassionate care:

- Personal exposure
- Theory exposure
- Practice exposure

PRACTICAL COMPONENT

In order for you to learn about compassion from practice, it is important to start a reflective diary. In this diary, you should record incidents of receiving and giving compassion.

1. Awareness

You must be able to care about yourself to be able to care for others. The ability to remain compassionate in practice is strengthened by the quality of support you receive. It is important to understand the experience of giving and receiving care.

Activity 1.1: Your own experiences of compassion

We know that compassion is a subjective feeling, so it is important to consider your own feelings about compassion.

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1. Think about a time when you were suffering in some way, maybe you were stressed about something. Was someone kind to you? Did someone convey compassion for you? How did you feel?
Make some notes about what helped you to feel better.
What would be your own personal definition of compassion?

2. Reflect on your own experience in the care giving process – be aware of thoughts and feelings.
Why did you choose nursing as a career? Maybe you chose nursing because you wanted to help people, to contribute to the alleviation of suffering.
To what extent do you feel able to uphold the values you held when you chose nursing as a career?
Are there any barriers that are hindering your ability to provide care with compassion?

Activity 1.2: Other people's experiences of compassion

The Centre for Applied Research and Evaluation International Foundation (CAREIF) is an international mental health charity based at the Centre for Psychiatry, Barts and The London School of Medicine and Dentistry, Queen Mary University of London. The document '*In Conversation with Compassion and Care'* (CAREIF, 2013) contains a selection of narratives relating to thoughts on compassion and care from people from a range of backgrounds. Read this document in order to get some idea of the scope of the concept:
http://www.careif.org/downloads/Events/careif%20Compassion%20and%20Care%20PDF.pdf

2. Knowledge

Activity 2.1: Understanding the concept of compassion

Read the following article in order to enhance your knowledge and understanding of compassion:
Staughair, C. (2012) Exploring compassion; implications for contemporary nursing.Part 1. *British Journal of Nursing,* 21(3): 160-164
We know that compassion takes place in a relationship. Benevolence towards others is widespread and studies suggest that suffering and need elicit compassion universally (Goetz et al).

However the ways in which compassion functions – the reduction of suffering and the formation and maintenance of cooperative relationships – almost certainly vary across cultures (Goetz et al). Goetz et al hypothesise the possibility that cultures that are very interdependent may have a tendency to feel compassion for in-group members; while independent cultures may have a tendency to feel compassion for out-group members. However, this hypothesis remains unproven. As a general rule, cultures vary in their outward displays of emotion.

Kim and Flaskerud (2007) discuss similarities and differences in cultural expression of compassion. Western patients and nurses are more likely to say and acknowledge what they are feeling, providing an opening for the nurse to express compassion. In the East patients do not express their feelings openly to health professionals and for the nurse to try to express feelings for them might be unwelcome in what is considered a professional, not a personal, relationship. However, this is a huge generalisation and you must always be alert to individual differences.

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You also need to be alert to gender roles in the giving and receiving of compassion. In many cultures, compassion may be considered a feminine trait and be confined women's roles. While being alert to differences, it is important to focus on the commonalities and *'... meet people across borders as fellow human beings ...'* (CAREIF, 2013)

Activity 2.2: Similarities and differences in giving and receiving compassion

Seek out opportunities to gain experience with different patients and in different settings and situations. Record your experiences in your reflective diary. As time goes by, you will be able to reflect on these experiences in order to build up your repertoire of responses to patients in a range of situations.
Remember Cummings and Bennett's (2013) definition:
'Compassion means care given through relationships based on empathy, kindness, trust, respect and dignity, regardless of the circumstances and seeing the person behind the condition' (p10).

While nurses must be compassionate towards all their patients, we know that vulnerable and powerless people are most at risk of receiving care that is not compassionate. Vulnerable people include people who are elderly, have learning disabilities, have mental illness, do not speak English, have recently arrived in the UK, or are socially excluded.
Does your experience suggest any cultural differences? Any gender differences? Any differences in relation to age? Any differences in relation to socio-economic status?
While it is important to note differences and similarities, do not try to categorise your patients too much – an older person will have a gender, a culture and could possibly have a learning disability or mental illness.

3. Sensitivity

We know that compassion involves interpersonal skills.
Compassionate communication includes respect for, and interest in, patient experience (Price, 2013). This means being sensitive to the patient experience. It will also entail making adjustments to meet the needs of your individual patients.

Activity 3.1: What matters to patients

Ask patients what they found helpful. Record your findings in your reflective diary.
What are the similarities and differences in your individual patients' responses? Make two lists – one of the similarities and one of the differences.
How will you adjust your practice as a result of what your patients are telling you?

4. Competence

Price (2013) argues that compassionate care requires expertise – understanding of experiences, concerns and expectations of patients, relatives, lay carers.
We know that being compassionate entails respect for fell human beings and being non-judgemental. But it also entails the ability to anticipate suffering, to recognise suffering, to be moved by suffering, and then an active desire to alleviate suffering.

Activity 4.1: compassionate care that is also safe and effective

During your nursing practice, identify a role model – a nurse about whom you can say 'That is the sort of nurse I want to become'.
What is it about this nurse's practice that you admire?

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What does he or she do that has inspired you?
How does he or she relate to patients, convey compassion, ensure care is safe and effective?
How would you describe his or her professional values?

Activity 4.2: Your professional practice

Use your reflective diary to look back over the incidents you have noted and your responses in these situations. How do you feel that your own practice is developing?
Critically analyse your own practice. Do you feel you are acquiring the skills to engage in compassionate care that is safe and effective?
Are there any barriers to delivering compassionate care that is safe and effective?
Feelings of compassion should increase when the individual feels capable of coping with the target's suffering (Goetz et al).
In order to be able to engage in the levels of involvement with patients that may be required in therapeutic compassionate professional nursing relationships, it is crucial that you are supported in your practice.
You should be able to discuss your progress with your mentor who should support you.
Compassion needs to be shown towards colleagues as well as yourself and your patients and their families. Think about the effect of your own practice on other members of the team.

Activity 4.3: Doing good and justice

Being compassionate also means being able to advocate on behalf of your patients. This requires courage and commitment.
Are you developing the skills and confidence to take on this role?
What help might you need?
Sadly, sometimes you will experience dissonance when you are not able to put the theory you have learnt into practice – this is often due to variability in practice.
Think about the help you might need to develop and maintain resilience in order to overcome these difficulties and to maintain your professional status.

ASSESSMENT COMPONENT

Formative assessment:
Reflective account – incident from practice – identifying what has been learned and learning needs.
Summative assessment:
Critical analysis of a case study.
Structured essay.

EVALUATION COMPONENT

1. Self-evaluation: the learner should evaluate how the tool has assisted learning and what has been learned. This stage of evaluation should focus on use of the reflective diary and the development of awareness of compassion.

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2. Peer evaluation: peer learning groups should discuss their use of the tool: how it has assisted learning and what has been learned. This stage of evaluation should focus on knowledge gained regarding compassion and what it might mean for different people in different situations.

3. Teacher evaluation: teachers should evaluate the tool through observing classroom activities that demonstrate students' developing skills in delivering compassionate care, focusing on how they relate to patients' suffering.

4. User group evaluation: it is important to involve patients (or former patients) in the evaluation of this tool. User groups could be approached to invite them to comment on the tool. In areas where users are involved in classroom teaching activities, user group members can be invited to evaluate the tool's effectiveness in helping students towards competence in compassionate care, through observing and taking part in classroom activities that require students to identify patients' suffering, to acknowledge it, be moved by it, and articulate ways of alleviating it.

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Straughair, C. (2012b) Exploring compassion: implications for contemporary nursing. Part 2. *British Journal of Nursing*, 21(4): 239-244

Useful websites

CAREIF (2013) In Conversation with Compassion and Care. http://www.careif.org/downloads/Events/careif%20Compassion%20and%20Care%20PDF.pdf

Cummings, J. and Bennett, V. (2012) *Developing the culture of compassionate care. Creating a new vision for nurses, midwives and care-givers.* NHS Commissioning Board www.commissioningboard.nhs.uk/2012/10/17/comp-care-jc/

NHS Commissioning Board (2012) *Compassion in Practice. Nursing, Midwifery and Care Staff. Our Vision and Strategy.* www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf

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The Middlesex University Compassion Tool Evaluation

CRITERIA	FULLY MET	PARTLY MET	NOT MET
a) Contained customised steps to help students progress through their learning goals	99%	1%	
b) Provided observable evidence of learning	98%	2%	
c) Clarified what students knew and did not know	99%	1%	
d) Allowed the teacher to see/hear (and intervene) when students did not understand	100%		
e) Led to and connected with other tools in the process of meeting larger /higher level learning goals	94%	6%	
f) Helped students synthesize knowledge and meaning	100%		
g) Provided building blocks that enable students to step into and through difficult concepts or processes to reach predetermined learning goals	98%	2%	
h) Provided pathways that led to depth and clarity in learning	100%		
i)Adds to the meaning-making in the classroom	100%		

NB: When the percentages do not add up to 100%, this indicates that some participants did not rate the specific item/s.

1. I am a student / qualified healthcare participant — 20
2. I am a teacher/trainer — 3
3. I am a patient —

Students' Comments:

This should be embedded in the programme

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The Edunet Compassion Tool & Evaluation

by
Victor Dudau, Lucia Babu and Pusa Barbulescu
Romania

VALUES OF CULTURALLY COMPASSIONATE CARE

THEORETICAL COMPONENT

Principles and Values

This tool is both for students to learn on their own or with others about the topic of the compassion and for teachers, to develop to nurses competent and compassionate care. It is based o n the Methodology for creating the learning/teaching tools for compassion, courage, health inequality and intercultural communication , prepared by Prof. Irena Papadopoulos, in the framework of the project Tools for Intercultural Education of Nurses in Europe (IENE 3).

This paper, developed by a team of psychologists, trainers from EDUNET Organization and nurses teachers at "EDUNET" Nurses School, integrates practices with contemporary psychology and scientific research on compassion.

This Learning Tool includes:
a) Classroom activities such as presentations, exercises, study cases, discussion and experience sharing;
b) Real-world "homework" assignments to practice compassionate in actions, to develop loving kindness, empathy and compassion in relationships with patients.

Aims

The tool "Values of culturally compassionate care" is aiming to develop the culture of compassion for nurses and other healthcare professionals, in order to provide excellent healthcare and well-being of patients.

Learning outcomes

At the end of this training, the participants:
- will have a new vision about the culture and the values of compassion in care;
- new knowledge about the attributes necessary in developing compassion;
- sensitivity of cultivating compassionate relationships and avoid barriers to compassionate care;
- increased skills needed to deliver cultural compassionate care, empathy and kindness in therapeutic relationships;

Relevant definitions and terms/ What the research says

Compassion is "sympathetic pity and concern for the sufferings or misfortunes of others" http://www.oxforddictionaries.com/definition/english/compassion

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Compassion is how care is given through relationships based on empathy, kindness, respect and dignity. Compassion has two main valences: the affective feeling of caring for one is suffering and the motivation to relieve that suffering" (Hoffmann, 2011) It is 'a deep awareness of the suffering of another coupled with the wish to relieve it' (Chochinov, 2007).

Compassion includes 'empathy, respect, a recognition of the uniqueness of another individual, and the willingness to enter into a relationship in which not only the knowledge but the intuitions, strengths, and emotions of both the patient and the physician can be fully engaged' (Lowenstein 2008).

Relating terms: sensitivity, sympathy, empathy, distress tolerance, non-judgement, motivation, respect, dignity, human rights. Sensitivity is the capacity to be sensitive and maintain open attention when others need our help. Sympathy is the ability to be moved emotionally by other's distress. Distress tolerance is the ability to bear difficult emotions both within ourselves and in others. Empathy is the ability to recognise another human being feelings, make sense of their feelings and response emotionally to them. Non-judgement means not judging a person's pan or distress, but simply accepting and validating their experience.Motivation is the commitment to try to be caring, supportive and helpful to others.

For more information, see the IENE glossary http://ieneproject.eu/glossary.php.

What the research says

1. Irena Papadopoulos (2006),Transcultural Health and Social Care: Development of Culturally Competent Practitioners. The book provides research-based information on culturally competent care of vital importance to all health and social workers in multi-cultural communities.

2. Intercultural Education of Nurses in Europe, www.ieneproject.eu
   A multilingual website which develop a new model for intercultural education of nurses (PPT/IENE Model), addressing nurses and healthcare professionals working in contact with patients with different cultures and languages .
   Made by EDUNET, 2014 3 TOOLS FOR INTERCULTURAL EDUCATION OF NURSES IN EUROPE (IENE3)

   3. Allys Coe-King, Paul Gilbert (2011), Compassionate care: the theory and the reality, available at http://www.connectingwithpeople.org/node/45
   Outlines the development of an emerging new approach to compassion and acknowledges some of the current barriers to delivering compassionate care.

   4. Joan Halifax (2013) G.R.A.C.E. for nurses: Cultivating compassion in nurse/patient interactions, available at http://www.upaya.org/wpcontent/uploads/2013/12/GRACE-FOR-NURSES2781-10448-1-PB.pdf
   An innovative model for cultivating and expression of compassion embedded in the experience of the practice of nursing.

   5. Compassion in Practice, available at http://www.england.nhs.uk/nursingvision/
   A new vision and strategy to develop the culture of compassionate care for nurses, midwives and care-givers, drawn up Jane Cummings, the Chief Nursing Officer for England (CNO) at the NHS Commissioning Board, and Viv Bennett, Director of Nursing at the Department of Health.

   6. Tools for Intercultural Education of nurses in Europe,

http://ienetools.wordpress.com/
A project aiming to increase the skills of nurses and health care professionals for providing culturally competent and compassionate care to patients

What does national legislation and international/European treaties and conventions say on the topic?

1. The Directive 2005/36/EC of the European Parliament on the recognition of professional qualifications
http://ec.europa.eu/internal_market/qualifications/policy_developments/index_en.htm

2. Professional standards for nurses
http://oamrvaslui.ro/Standarde_profesionale.pdf

3. Curriculum for Qualification of General Nurses (Romanian Education Ministry nr. 2713/29.11.2007).

4. The practicing midwifery and nursing profession (Romanian Government Emergency Ordinance no. 144 of 28 October 2008)
http://oamrvaslui.ro/oug144.pdf.

5. The Ethic Code of the practitioner midwife and nurse in Romania
http://www.oamr.ro/despre-noi/codul-de-etica-si-deontologie/

What do local policies say?

General nurse and midwife are required to show a faultless conduct towards ill, always respecting its dignity. (Article 5 of The Ethic Code of the practitioner midwife and nurse in Romania). Upon receipt of the Order of Nurses, Midwives and Nurses in Romania, registered practitioner nurse and midwife take the oath to exercise profession with dignity, to respect human being and his rights, to not discriminate patients by nationality, race, religion, political affiliation or social status.

PRACTICAL COMPONENT

Classroom activities: Teaching sessions on general principles and values of compassion

SESSION 1: Key attributes of compassion

Activity/Method Resources needed Time

The participants will consider the theory of compassion, examine the PTT/IENE Model of Cultural Competence and the Model for developing culturally competent compassion in healthcare professionals and will identify the core attributes necessary in developing compassion and skills needed to deliver cultural compassionate care.

Trainer Instructions

- Presentation of the Papadopoulos Tilki and Taylor model of cultural competence

- Information sheet
- 45 minutes

SESSION 2: The values of compassion:

Activity/Method Resources needed Time

Exercise 1: Selecting Values game

The participants will consider the benefits of delivering compassionate, extract a list of value for compassion (respect, tolerance, dignity, human rights etc) and consider the importance of these values.

Trainer Instructions
- Cards or A5 sheets papers (10 per person participating in the game)
- Pencil or pen for each participant
- 45minutes

SESSION 3: Barriers to compassionate care

Activity/Method Resources needed Time

Exercise 2: Study case

The participants identify the barriers to compassionate care and consider strategies for and minimising these barriers.

Trainer Instructions
- "The Death of Mr Lazarescu " movie available at http://www.youtube.com/watch?v=dw320TF6BL4
- Work sheet: Compassionate and uncompassionate behaviours of the medical staff to Mr. Lazarescu
- 90 minutes

ACTIVITIES IN PRACTICE : Becoming compassionate

Activity/Method Resources needed Time

Exercise 3: Roles playing of building therapeutic relationships based on the compassion values: learners' interactions with patients, family and team members showing sensitivity, empathy sympathy, commitment followed by debriefing and feedback.

Trainer Instructions
- Work sheet: First steps to become compassionate

Resources:
- PTT presentation
- Information sheet with relevant definitions and terms
- Work sheet: Compassionate and uncompassionate behaviours of the medical staff to Mr. Lazarescu
- Work sheet : First steps to become compassionate

ASSESSMENT COMPONENT

Practical assessment.

Practical skills and capacity of building therapeutic relationships based respecting compassion values will be assessed. Once the classroom training sessions has been completed, the group will practice their newly learnt knowledge & skills. The activities in practice allow the trainees to put their theory into practice.

The minimum acceptable standards are:
- Showing sensitivity, empathy, sympathy and commitment in interactions with patients, family and team members
- Promoting values of respect, tolerance, dignity and rights of patients.

Each trainee is to be assessed against the provided assessment sheet, which is to be completed by the trainer / assessor.

In this paper the term 'assessment' refers to those activities used by teachers and students to confirm what they (the students) have learnt which demonstrates whether they have achieved the learning outcomes of the tool. The term 'evaluation' may be used instead of the term 'assessment'.

While assessing, the trainer compare their practices with the standards, indicating whether they are complying with our standards or not, by making written notes on the Assessment Sheet.

When the assessment has completed, the trainer gives feedback to the trainees on their Performance. The Assessment Sheet can be forwarded to the training department, in order for the trainees to receive a certificate.

Resources: Assessment Sheet

EVALUATION COMPONENT

The participants in piloting the tool (student nurses and registered nurses) will take part in the evaluation.

The evaluation criteria are :
- Does tool helps students progress through their learning goals?
- Is it practical and easy to use by both teachers/trainers and students?
- Is it relevant, innovative and important to students learning pathway?

Evaluation will be made through a questionnaire containing a set of questions following with what extend the learning tool meet the criteria above. The report on the evaluation will be shared to the trainers' team who will conduct a meta-analysis of results, to identify the main themes which will guide the revision of the tool.

Resources : Evaluation Questionnaire

The Edunet Compassion Tool Evaluation

CRITERIA	FULLY MET	PARTLY MET	NOT MET
a) Contained customised steps to help students progress through their learning goals	94%		6%
b) Provided observable evidence of learning	90%	2%	8%
c) Clarified what students knew and did not know	84%	4%	12%
d) Allowed the teacher to see/hear (and intervene) when students did not understand	100%		
e) Led to and connected with other tools in the process of meeting larger /higher level learning goals	84%	6%	10%
f) Helped students synthesize knowledge and meaning	74%	6%	20%
g) Provided building blocks that enable students to step into and through difficult concepts or processes to reach predetermined learning goals	92%		8%
h) Provided pathways that led to depth and clarity in learning	100%		
i)Adds to the meaning-making in the classroom	92%	6%	2%

NB: When the percentages do not add up to 100%, this indicates that some participants did not rate the specific item/s.

4. I am a student / qualified healthcare participant — 50

5. I am a teacher/trainer — 27

6. I am a patient —

Students' Comments:

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The Azienda Ospedaliera Universitaria Senese Compassion Tool & Evaluation

by
Antonella Gorelli, Maurilio Pallassini and Claudia Rustici
Italy

THE PILGRIM

THEORETICAL COMPONENT

Principles and Values

The growth project explained below uses the instruments and the approach of issues that have an emotional impact on employees, and thus capable of capturing the attention and therefore favouring improvement in behaviour and the approach with patients from different cultures.

Principles and value of the tool on compassion are:
Sharing, Equality, Tolerance, Listening, Empathy, Respect, Modesty.

Aims

Reaching a true globalization (in practice and not only words) from a professional aspect but also affecting the population.
The acquisition of knowledge, capabilities and behaviours geared towards multiculturalism and compassion.

Nurses will be aware of the importance of compassion. The tool gives the opportunity to better understand what are the needs of nursing profession and on how nurses can provide a more compassionate care to patients.

Learning outcomes

1. Increase motivation
2. Develop competence and capabilities
3. Help health care workers to modify their behaviour to be better in their profession
4. Go through the tool the nurses will have reflected on the meaning of compassion and they will be able to put their knowledge into practice.
5. To be able to integrate patients in assistance

Relevant definitions and terms/ What the research says

- Listening: listening is a neurological cognitive regarding the processing of auditory stimuli received by the auditory system
- Participation: the state of being related to a larger whole
- Support: the act of helping someone by giving help, encouragement, etc.
- Integration: the process of becoming a full member of a group or society and becoming involved completely in its activities

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What the research says

1. Br J Clin Psychol. 2014 Mar;53(1):6-41. doi: 10.1111/bjc.12043.
The origins and nature of compassion focused therapy.
Gilbert P.
Author information:
Mental Health Research Unit, Asbourne Centre, Kingsway Hospital, Derby, UK.

Compassion focused therapy (CFT) is rooted in an evolutionary, functional analysis of basic social motivational systems (e.g., to live in groups, form hierarchies and ranks, seek out sexual, partners help and share with alliances, and care for kin) and different functional emotional systems (e.g., to respond to threats, seek out resources, and for states of contentment/safeness). In addition, about 2 million years ago, (pre-)humans began to evolve a range of cognitive competencies for reasoning, reflection, anticipating, imagining, mentalizing and creating a socially contextualized sense of self. These new competencies can cause major difficulties in the organization of (older) motivation and emotional systems. CFT suggests that our evolved brain is therefore potentially problematic because of its basic 'design,' being easily triggered into destructive behaviours and mental health problems (called 'tricky brain'). However, mammals and especially humans have also evolved motives and emotions for affiliative, caring and altruistic behaviour that can organize our brain in such a way as to significantly offset our destructive potentials. CFT therefore highlights the importance of developing people's capacity to (mindfully) access, tolerate, and direct affiliative motives and emotions, for themselves and others, and cultivate inner compassion as a way for organizing our human 'tricky brain' in prosocial and mentally healthy ways.

PRACTITIONER POINTS:
The human brain is highly evolved for social processing and these mechanisms are being increasingly well understood and integrated into psychotherapy. Among the most central processes that regulate emotion and sense of self are those linked to social roles such as status, sense of belonging and affiliation, and caring. Many psychological difficulties are rooted in social relational problems especially in feeling cared for by others, having a caring interest in others, and having a caring, affiliative orientation to oneself. Helping clients in these domains can address problems of moods, problematic behaviour and a range of shame and self-critical linked difficulties.

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PMID: 24588760 [PubMed - in process]

2. Pract Midwife. 2014 Jan;17(1):20-2.
Why caring counts. Scotland M.

This article introduces the 'compassionate focused' approach to midwifery (Gilbert 2009) and outlines its relevance to midwifery. This psychological model provides us with a theoretical and research basis to underpin what we already know at an intuitive level--that when you show care and compassion to a woman in labour, you improve birth outcome. Psychology tells us that compassion is fundamental to good midwifery and can help us in our efforts to increase normality and improve the experiences of women during the perinatal period. In this article, I suggest how the compassionate focused approach can be applied to our understanding of good midwifery.

PMID: 24520590 [PubMed - indexed for MEDLINE]

3. Nurs Stand. 2013 Nov 6-12;28(10):46-50. doi: 10.7748/ns2013.11.28.10.46.e7828.
A critical analysis of Compassion in Practice.

Dewar B(1), Christley Y.
Author information:
University of the West of Scotland, Hamilton.

Compassion in Practice is a policy introduced in England to develop a culture of compassionate practice among healthcare staff. There is widespread recognition and agreement of the importance of compassionate practice, and the policy offers a vision underpinned by a desirable set of values. In this article, the significance of a coherent vision is explored and is followed by discussion of the need to anchor the policy vision in values that are important to healthcare staff. The policy's approach to vision and values may generate tensions, which are also examined and discussed.

PMID: 24191834 [PubMed - indexed for MEDLINE]

4. J Nurs Educ. 2013 Nov;52(11):645-8. doi: 10.3928/01484834-20131014-06. Epub 2013 Oct 14.
Webster D.
Promoting therapeutic communication and patient-centered care using standardized patients.

This article describes an assignment designed to incorporate the Quality and Safety Education for Nurses (QSEN) competency of patient-centered care into a simulation activity aimed to improve therapeutic communication skills in psychiatric nursing. During this pilot activity, students engaged in an interaction with an actor trained to portray an individual with mental illness. Students viewed their video-recorded interaction to identify communication techniques used and completed a self-evaluation examining their strengths and areas for improvement. Faculty and actors provided feedback to students during a faculty-led debriefing held to discuss the use of therapeutic communication and care focused on the knowledge, skills, and attitudes necessary to provide quality patient-centered care. Desired learning outcomes included the demonstration of therapeutic communication and assessment skills, empathy and caring, and addressing patient values, preferences, and beliefs.

PMID: 24127180 [PubMed - indexed for MEDLINE]

5. J Christ Nurs. 2013 Oct-Dec;30(4):234-7.
Develop student compassion through service-learning.
Brown E.
Author information:
Widener School of Nursing, Chester, PA, USA.

Compassion is the ability to be sympathetic along with the desire to remedy distress and offer help. The art and science of nursing speaks to the need of having compassion toward those nurses serve, especially when different from the nurse. This article examines the concept of service-learning as a teaching strategy and way of developing compassion in today's nursing students.

PMID: 24282881 [PubMed - indexed for MEDLINE]

6. Nurs Outlook. 2013 Jan-Feb;61(1):e9-14. doi: 10.1016/j.outlook.2012.06.018. Epub 2012 Aug 9. On the humanities of nursing.
Lazenby M.
Author information:
Yale University School of Nursing, New Haven, CT 06536-0740, USA.

mark.lazenby@yale.edu

The author contends that the present state of nursing research, as focused on studies that produce the sort of positivistic evidence espoused by the evidence-based medicine movement, emphasizes something other than the goals of nursing. This emphasis has distorted nursing practice by focusing on the ostensibly quantifiable. Using Virginia Henderson's classic definition of nursing and the work of the philosopher Martha Nussbaum, the author argues for the centrality of the human experience in the practice and the research of nursing.

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PMID: 22884719 [PubMed - indexed for MEDLINE]

7. Psychol Psychother. 2011 Sep;84(3):239-55. doi: 10.1348/147608310X526511.
Epub 2011 Apr 13.
Fears of compassion: development of three self-report measures.
Gilbert P(1), McEwan K, Matos M, Rivis A.
Author information:
(1)Mental Health Research Unit, Kingsway Hospital, Derby, UK. p.gilbert@derby.ac.uk

OBJECTIVES: There is increasing evidence that helping people develop compassion for themselves and others has powerful impacts on negative affect and promotes positive affect. However, clinical observations suggest that some individuals, particularly those high in self-criticism, can find self-compassion and receiving compassion difficult and can be fearful of it. This study therefore developed measures of fear of: compassion for others, compassion from others, and compassion for self. We also explored the relationship of these fears with established compassion for self and compassion for others measures, self-criticism, attachment styles, and depression, anxiety, and stress.
METHOD: Students (N= 222) and therapists (N= 53) completed measures of fears of compassion, self-compassion, compassion for others, self-criticism, adult attachment, and psychopathology.
RESULTS: Fear of compassion for self was linked to fear of compassion from others, and both were associated with self-coldness, self-criticism, insecure attachment, and depression, anxiety, and stress. In a multiple regression, self-criticism was the only significant predictor of depression.
CONCLUSION: This study suggests the importance of exploring how and why some people may actively resist engaging in compassionate experiences or behaviours and be fearful of affiliative emotions in general. This has important implications for therapeutic interventions and the therapeutic relationship because affiliative emotions are major regulators of threat-based emotions.

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8. Irena Papadopoulos (2006), Transcultural Health and Social Care: Development of Culturally Competent Practitioners.

Presenting the evidence-based knowledge in the area of transcultural care, this book is designed to meet the needs of health & social care practitioners who must change their practices to comply with national policies & the expectations of a multicultural public.

What the legislation/treaties/conventions says on the topic

Decreto Ministeriale 14 settembre 1994, n°739

Regolamento concernente l'individuazione della figura e del relativo profilo professionale dell'Infermiere. Gazzetta Ufficiale del 9
gennaio 1995, n°6.
In: http://www.ipasvi.it/archivio_news/leggi/179/DM140994n739.pdf

Codice Deontologico dell'Infermiere.
Approved by Comitato Centrale della Federazione IPASVI by resolution n.1/09, January 10, 2009 and from Consiglio Nazionale
dei Collegi IPASVI in the meeting of January 17, 2009.
In: http://www.ipasvi.it/norme-e-codici/deontologia/il-codice-deontologico.htm

Commentario al codice deontologico dell'Infermiere.
Edited by Federazione Nazionale dei Collegi degli Infermieri IPASVI.
In: http://www.ipasvi.it/norme-e-codici/deontologia/commentario.htm

The international code of ethics for nursing by the International Council of Nurses (ICN)

The international code of ethics for nursing adopted by the International Council of Nurses in 1953. Revised in 2012.
In: http://www.cnai.info/index.php/estero/icn/codice-deontologico

Code of Ethics for Nurses – American Nurses Association (ANA)
The Code of Ethics for Nurses was developed as a guide for carrying out nursing responsibilities in a manner consistent with quality in nursing care and the ethical obligations of the profession. In: http://www.nursingworld.org/codeofethics

ANA Position Statements on Ethics and Human Rights
The position statements from ANA regarding Ethics and Human Rights.In:
http://www.nursingworld.org/MainMenuCategories/

EthicsStandards/Ethics-Position-Statements. Of particular interest: Cultural Diversity in Nursing Practice. This statement describes the features of an operational definition of cultural diversity as it is expressed in nursing practice, education, administration and research.
In: http://www.nursingworld.org/MainMenuCategories/EthicsStandards/Ethics-Position-Statements/prtetcldv14444.html

International Council of Nursing Fact Sheet: ICN on Health and Human Rights
ICN Nursing Matters fact sheets provide quick reference information and international perspectives from the nursing profession on current health and social issues. In
http://www.icn.ch/images/stories/documents/publications/fact_sheets/10b_FS-Health_Human_Rights.pdf

What local policies say

Delibera n° 697 del 14 luglio 2003 della Giunta Reg ionale della Regione Toscana. Il Patto con il cittadino: repertorio di impegni per la Carta dei servizi sanitari con relativi indicatori e standard.
In: http://www.usl7.toscana.it/index.php/amministrazione-trasparente/servizi-erogati/standard-di-qualita
Carta dei Servizi - Azienda Ospedaliera Universitaria Senese: carta dei diritti e dei doveri degli utenti
In: http://www.ao-siena.toscana.it/carta_diritti_utenti.htm

THEORETICAL COMPONENT

Classroom activities

1. PTT/IENE Model introduction and discussion on skills need to be a nurse.
2. Reflection on the definition of compassion in different culture: readings and discussions.
3. Welcome pathway of patients from different culture, the importance of their own approach to the illness.
4. Value of the relationship between the foreign patient and the healthcare provider.
5. Different concepts of health and disease - different representation of the body.

Activities in Practice

1. Listening to the song “"Fiume Sand Creek", De Andrè – reflections on the cruelty of a battle and the lack of values.
2.The importance of the value of compassion and practical demonstrations.
3. Showing pictures that demonstrates compassion.
4. Real case studies: discussion and practical demonstration of the working groups: emotions and cultures

ASSESSMENT COMPONENT

Theoretical assessment*

Teachers: anthropologist, clinical educationalist, tutors (nurses, obstetricians and representation of foreign associations) will create a questionnaire (open-ended questions) to identify what has been learned. Participants, 20 nurses working in different wards, will answer individually and later they will discuss together on the various responses.

Participants will be divided into two groups and elaborate two projects on how nurses can show and deliver compassionate care to patients. The components of the groups will be trainers for the next courses on the basis of the developed projects.

20 groups of 15 health-care workers from wards that are more impacted by foreigners (emergency, urgent medicine, gynaecology, orthopaedics, paediatrics, and later all other wards) and 5 students from the three-year degree programme in nursing will participate in the following editions of the course.

**in this paper the term ‘assessment’ refers to those activities used by teachers and students to confirm what they (the students) have learnt which demonstrates whether they have achieved the learning outcomes of the tool. The term ’evaluation’ may be used instead of the term ‘assessment’.*

This project has been funded with support from the European Commission
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Practical assessment

Evaluation through systematic observation (low degree of structure) carried out directly by the teachers for the full duration of the toolkit. The survey for the exploration of learning outcomes produces a true and complete description of the conditions in which it occurs.

EVALUATION COMPONENT

The evaluation of the toolkit is carried out by the learners, teachers and patients (in the following courses). The evaluation is oriented to the recognition of the originality of the techniques and new contents learned in relation to estimates the effects in the employment context.

'What' to evaluate

Effective achievement of learning goals (theoretical and practical)
Quality of the theoretical content
Quality of teaching activities and facilitation
Relevance and quality of materials used
Time Management

A questionnaire will be administered in order to understand if the tool allows students to do a self-evaluation on what they have learned and to show how they deliver compassionate care.

During group works participants will discuss on their knowledge about compassion and how deliver compassionate care in different situations. Teachers will observe the behaviours of nurses during the demonstrations.

How to evaluate the 'what'

Satisfaction questionnaire administered at the end of the toolkit will be fill in by patients.
At a distance of two months will be conducted a re-evaluation of effective achievement of learning goals. (theoretical and practical)

How to report and use the evaluation results.

Reassessment of contents, methods and materials used in the toolkit.
A report on the evaluation will be created by teachers and the results will be useful to make changes to the tools, if needed.

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The Azienda Ospedaliera Universitaria Senese Compassion Tool Evaluation

CRITERIA	FULLY MET	PARTLY MET	NOT MET
a) Contained customised steps to help students progress through their learning goals	96%	4%	
b) Provided observable evidence of learning	88%	12%	
c) Clarified what students knew and did not know	81%	19%	
d) Allowed the teacher to see/hear (and intervene) when students did not understand	92%	8%	
e) Led to and connected with other tools in the process of meeting larger /higher level learning goals	84%	16%	
f) Helped students synthesize knowledge and meaning	86%	14%	
g) Provided building blocks that enable students to step into and through difficult concepts or processes to reach predetermined learning goals	82%	18%	
h) Provided pathways that led to depth and clarity in learning	94%	6%	
i)Adds to the meaning-making in the classroom	90%	10%	

NB: When the percentages do not add up to 100%, this indicates that some participants did not rate the specific item/s.

7. I am a student / qualified healthcare participant — 15

8. I am a teacher/trainer — 5

9. I am a patient —

Students' Comments:

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The Volkssolidaritat Compassion Tool & Evaluation

by
René Hildebrandt, Karin Senf and Friederike Jung
Germany

LIFE HISTORY TOOL

THEORETICAL COMPONENT

Principles and Values

• care is a process
• heartiness
• humanity
• heart geniality
• patient is a own personality
• empathy

Values of the tool
• equality
• dignity
• tolerance and acceptance

Aims

The patient should feel comfortable and establish confidence to the nurse, so that the care/ therapy could be successful.
Only if the nurse knows his patient well, that means: preferences, his life history, peculiarity, wishes and so on, he could commit himself to the patient in care and could care in a compassionate way.

Learning outcomes

When you have worked through this tool, you will be aware to:
1. Every patient is different and the contact to him releases individual feelings/reactions. This could lead to that the patient feels comfortable or bad.
2. Knowledge of my patient helps me to care in a compassionate way.
3. Feelings, opinions, peculiarity of the patient must be respected in care.
4. Maybe I have to reveal something of me so that the patient is open and tells me even intimate facts, e.g. personal hygiene.

Relevant definitions and terms/ What the research says

Related to compassionate care in Germany researchers and scientists speak about empathy. Empathy and compassion are often used synonymously. For a long time empathy was understood as a inherent ability. Either you were empathic or not. According to the new scientific state of knowledge it‘s assumed that empathy could be learned and also be taught.

Compassion:
Sympathy to the suffering, need or similar of others. (www.duden.de, German language dictionary)

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Empathy:
Willingness and ability to empathise the attitude of other people. (www.duden.de). Empathy marks the ability and willingness to realise thoughts, emotions, motives and attributes of personality of another person and to understand them. Part of empathy is also the reaction to feelings of others, e.g. pity, sorrow or pain, or a impulse of help. Basis of empathy is self-awareness, the opener we are for our own emotions the better we could interpret feelings of others. Thus empathy doesn‘t play only a role regarding other people but is also important in aspect to self-empathy. (www.de.wikipedia.org)

What the research says

“Empathie in der Pflege“ („Empathy in Care“), Claudia Bischoff-Wanner 2002
Bischoff-Wanner determines that empathy in care got lost in the past because of several reasons, but also that empathy has a central role in care. Thereby Bischoff-Wanner talks about cognitive empathy: The way/mechanism of social cognition contains all efforts, that must be done for understanding the psychological constitution of another person. Understanding what others feels (affective empathy = to feel what another feels).
Relevance of empathy in care is about its positive therapeutic effect. In addition it was empirically proven that health carers who commit an empathic relationship to their patients feel less emotional overstrained in difficult situations.

What does national legislation and international/European treaties and conventions say on the topic?

The code of social law XI (Social Sozialgesetzbuch (SGB)), regulates all care instructions in Germany § 2 Self-determination

(1) The services of care insurances should help persons in care of help to conduct a selfdipendent and self-determined life which accords to human dignity even if they need help. The help services should be aligned to recover or maintain the physical, psychological and mental forces of the person in need of care.
(2) Persons in need of care can choose between facilities and services of different organisations. According to the law of services („Leistungsrecht“) their wishes regarding the design of help, if appropriated, should be fulfilled. Also if persons in need of care wish a same-gender care it should be considered if possible.
(3) Religious necessities of persons in need of care should be considered. On their demand they should have inpatient treatments where they could be assisted by reverends of their religious denomination.
(4) These rights according to the passages 2 and 3 have to be indicated to persons in need of care.
§ 3 Priority of Ambulant Care
The care insurance should support with her services prior the ambulant care and willingness of care from relatives and neighbours, so that persons in need of care could stay as long as possible at their homes. Services of semi-residential care and short term care have priority to the residential care.
Source: http://dejure.org/gesetze/SGB_XI

What do local policies say?

Care guidelines of the Volkssolidarität contains following relevant contents (complete in annexe)
• Our service offer applies to all help seeking persons whatever philosophy of world, colour of skin, disease, handicap or age. According to the code of ethics of the elderly and medical

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care we are looking for and carry out ways of supporting, maintaining and recovering health and wellbeing respectively relief of pain together with the patient, his relatives and physicians as well as departments and centres.
• To consider the persons in need of care as holistic, coequal and equal with all his experiences and personality and not just the problematic part of him.
• Quality and orientation to the persons assisted by us. Warmness, humanness and heartiness are key aspects in the realisation of our work.

PRACTICAL COMPONENT

Practical activities

Every student or nurse get the questionnaire of the life history tool. The trainer/mentor-nurse supplies and explains its use and meaning starting with the overall aim:
The patient should feel comfortable and establish confidence to the nurse, so that the care/ therapy could be successful.
Only if the nurse knows his patient well, that means: preferences, his life history, peculiarity, wishes and so on, he could commit himself to the patient in care and could care in a compassionate way.
The completion of the questionnaire is a process and occurs in many sensitive conversations with the patient over a long period. (No discharging of the form!)
Mentioning of the learning aims:
1. Every patient is different and the contact to him releases individual feelings/reactions. This could lead to it that the patient feels comfortable or bad.
2. Knowledge of my patient helps me to care in a compassionate way.
3. Feelings, opinions, peculiarity of the patient must be respected in care.
4. Maybe I have to reveal something of me so that the patient is open and tells me even intimate facts, e.g. personal hygiene.
The scheduling of care has to occur based on the life history tool.
The questionnaire enables every nurse/health carer to adapt themselves to the patient so that they can care in a compassionate way.

ASSESSMENT COMPONENT

Theoretical Assessment
Practical Assessment
Both are possible for the piloting. Now we do only a theoretical assessment. Later there will be practical assessments by the mentor-nurses with students.
1. Students will be present when mentor-nurse completes questionnaires with patients.
2. Students can train the completion among themselves.
3. Students will be assisted by a mentor-nurse doing their first questionnaire.

EVALUATION COMPONENT

• Whole nurse staff of the Volkssolidarität Gera and maybe also the staff of the Volkssolidarität Jena.

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• What should be evaluated?
Quality of questionnaire
Will learning aims be achieved?
Usability
• Evaluation with the standardised data sheet
• Results should be used for improving the questionnaire and its use. Questionnaire can be shared with other divisions of the Volkssolidarität.

Name: Surname:
Date of Birth: Place of Birth:
Interviewed Person:
e.g. patient himself, child, marriage partner, partner, siblings
Religion / Belief / Principles:
Nationality / Culture Group / Ethnic
Minority:
Nurse-gender: O female O male O equal
Life Occurrences:
e.g. married, where and how was living, pets, job/work, children
Personal Habits:
Alimentation:
liking / wishes
aversions
Personal Hygiene:
liking / wishes
aversions
Clothes:
liking / wishes
aversions
Preferred Times
e.g. for eating, getting up/going to bed
Hobbies/Interests:
Specifics:
Medical supports:
Precaution
e.g. authorization, patient‘s provision, wishes for dyeing
Please define briefly for yourself what is your understanding of “compassionate care“.
.....
.....
.....
.....

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The Volkssolidaritat Compassion Tool Evaluation

CRITERIA	FULLY MET	PARTLY MET	NOT MET
a) Contained customised steps to help students progress through their learning goals	60%	24%	10%
b) Provided observable evidence of learning	44%	40%	10%
c) Clarified what students knew and did not know	28%	48%	10%
d) Allowed the teacher to see/hear (and intervene) when students did not understand	14%	62%	10%
e) Led to and connected with other tools in the process of meeting larger /higher level learning goals	54%	30%	10%
f) Helped students synthesize knowledge and meaning	84%	2%	10%
g) Provided building blocks that enable students to step into and through difficult concepts or processes to reach predetermined learning goals	22%	62%	10%
h) Provided pathways that led to depth and clarity in learning	84%		10%
i)Adds to the meaning-making in the classroom	26%	10%	10%

NB: When the percentages do not add up to 100%, this indicates that some participants did not rate the specific item/s.

10. I am a student / qualified healthcare participant — 10

11. I am a teacher/trainer — 30

12. I am a patient — 10

Students' Comments:

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The Albeda College Compassion Tool & Evaluation

by
Marga Hop

COMPASSION IN CARE

THEORETICAL COMPONENT

Principles and Values

Compassionate care is an important principle in all fields of healthcare. In the care of psycho-geriatric patients, compassion is an important core value in terms of providing qualitatively good care.
The ability to have or show compassion is tested regularly in interaction with psycho-geriatric patients. The situations in which a caregiver administers care are often unpredictable and greatly challenge the imagination, empathy and creativity of the caregiver. In our view, acting with compassion also requires a caregiver to have self-compassion. An awareness of one's own core values, emotions and feelings in complex and unexpected situations is the cornerstone of the ability to provide compassionate care.

In this lesson, we want students to learn to respond with compassion towards others in situations where physical aggression plays a role, and to understand how that is based on awareness and compassion for one's own values and feelings.

Educational principles:

- Exploration of experiences
- Exploration of the concept of compassion
- Self-reflection
- Collaborative learning
- Stimulation of curiosity
- Practicing methodology

The tool is also informed by the following values:

- Caring
- Compassion
- Justice
- Integrity
- Accountability
- Equality

Aims

The objective of the workshop is focused on the first segment; Cultural Awareness in the context of compassionate care as per the Papadopoulos, Tilki Taylor Model. We focus specifically on interaction with psycho-geriatric patients.

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Learning outcomes

- Students can describe compassion.
- Students understand that an awareness of their own feelings/experiences can promote the compassionate care of others.
- In a situation involving an unexpected physical reaction/aggression from a psycho-geriatric patient, students are capable of responding from a place of awareness of their own emotions.
- Students can name the triggers that might cause a psycho-geriatric patient to grab and hold onto the caregiver.
- Students know methods and techniques to extricate themselves in a way that demonstrates self-compassion and compassion for the patient.
- Students are able to apply the aforementioned methods and techniques in practice situations.
- Students reflect on the workshop and describe the role of self-compassion and compassion in the techniques learnt.

Relevant definitions and terms/ What the research says

Self-Compassion: An Alternative Conceptualization of a Healthy Attitude Toward Oneself; Neff K., 2003.

In the article, “Self-Compassion: An Alternative Conceptualization of a Healthy Attitude Toward Oneself” Neff, K., 2003 explains how self-compassion ensures that people do not sweep the difficulties/shortcomings, negative emotions etc. they have experienced ‘under the carpet’ and do nothing about them. According to her insight, self-compassion and associated mindfulness are instruments that enable some one to learn from negative thoughts or mistakes and to turn them into compassionate attention/care for clients. Neff is convinced that a lack of self-compassion breeds avoidance behaviour and passivity.

We believe, in our vision and our approach that Compassionate Care starts with you and is reinforced by her vision. The following extracts from her article support that.

Extracts derived from the article:
Self-Compassion: An Alternative Conceptualization of a Healthy Attitude Toward Oneself” Neff, K., 2003.

“The definition of ‘‘self-compassion’’ is related to the more general definition of ‘‘compassion.’’ Compassion involves being touched by the suffering of others, 86 K. Neff opening one’s awareness to others’ pain and not avoiding or disconnecting from it, so that feelings of kindness toward others and the desire to alleviate their suffering emerge (Wispe, 1991). It also involves offering non-judgmental understanding to those who fail or do wrong, so that their actions and behaviours are seen in the context of shared human fallibility. Self-compassion, therefore, involves being touched by and open to one’s own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one’s suffering and to heal oneself with kindness. Self-compassion also involves offering non-judgmental understanding to one’s pain, inadequacies and failures, so that one’s experience is seen as part of the larger human experience

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Some may fear that having too much self-compassion leads to passivity, but this should not be the case when feelings of self-compassion are genuine. While having self-compassion requires that one does not harshly criticize the self for failing to meet ideal standards, it does not mean that one's failings go unnoticed or uncertified. Rather, it means that the actions needed for optimal functioning and health (and having compassion for oneself means that one desires well-being for oneself) are encouraged with gentleness and patience. Thus, self-compassion should not imply passivity or inaction with regard to weaknesses observed in the self. Rather, it is the lack of self-compassion that is more likely to lead to passivity. When the self is harshly judged for its failings in the belief that self-flagellation will somehow force change and improvement, the protective functions of the ego will often act to screen inadequacies from self-awareness so that one's self-esteem is not threatened (Horney, 1950; Reich, 1949). Without self-awareness, these weaknesses will remain unchallenged. By giving compassion to oneself, however, one provides the emotional safety needed to see the self clearly without fear of self-condemnation, allowing the individual to more accurately perceive and rectify maladaptive patterns of thought, feeling and behaviour (Brown, 1999).

At the same time, self-compassion requires that individuals do not avoid or repress their painful feelings, so that they are able to acknowledge and feel compassion for their experience in the first place. Thus, a compassionate attitude toward oneself requires the equilibrated mental perspective known as mindfulness (Bennett-Goleman, 2001; Epstein, 1995; Gunaratana, 1993; Hanh, 1976; Kabat-Zinn, 1994; Langer, 1989; Nisker, 1998; Rosenberg, 1999). Mindfulness is a balanced state of awareness that avoids the extremes of over-identification and disassociation with experience and entails the clear seeing and acceptance of mental and emotional phenomena as it arises. Martin (1997) writes that mindfulness is ''a situation in which the sense of self or self-esteem maintenance softens or disappears'' (p. 292), allowing for a non-judgmental, receptive mind state in which one's thoughts and feelings are observed for what they are, not in terms of how they impact one's self-concept. Mindfulness is a spacious, flexible mind-set that is not attached to any particular point of view (Langer, 1989), yielding greater insight into one's experience. In many ways, mindfulness is similar to the open, non-judgmental attention stance understood to facilitate therapist-client interactions, variously described as detachment (Bohart, 1993), decentring (Safran & Segal, 1990), presence (Bugental, 1987), or evenly suspended attention (Freud, 1958), but in this case applied to one's own experience. (page 86- 88)

http://self-compassion.org/wptest/wp-content/uploads/2014/10/SCtheoryarticle.pdf

What does national legislation and international/European treaties and conventions say on the topic?

Beroepscode Verpleegkundige en Verzorgende beroepen

Beroepscode Verpleegkundige en Verzorgende Beroepen (code of conduct)
In addition to the principles of the profession, the Beroepscode van Verpleegkundigen en Verzorgenden (code of conduct) describes the relationship between the Nurse and the patient, other caregivers and the community.

In article 2, relationship with the patient; it states that every patient has the right to care, and specifically states that ethnic origin, nationality, culture, age, gender, sexual orientation, race, religion, ideology, political conviction, socio-economic status, physical or mental disability, nature of health issues or lifestyle may not influence whether and what care someone receives. [article 2.1]
The caregiver is central and the nurse upholds the interests of the patient. [article 2.2]

Provision of care is tailored as far as possible to the needs, standards and values, cultural and ideological views of the patient [article 2.3]

In article 3, the relationship with other caregivers is described, with specific reference to the nurse protecting the patient against unethical, incompetent, unsafe or otherwise lacking provision of care from other caregivers.[article 3.6]

Nationale Beroepscode van Verpleegkundigen en Verzorgenden [The Code; Standards of conduct, performance and ethics for Nurses]
http://www.venvn.nl/Portals/20/publicaties/20070112beroepscodeposterdef.pdf

Quality of Health Facilities Act
The Quality of Health Facilities Act (KWZ) describes the individual responsibilities of care institutions to provide a qualitatively high standard of care within the global context.

Four quality criteria are described; 1. Responsible care 2. Quality- focused policy
3. Quality assurance systems, and 4. An annual report.
Institutions are required to develop policies in relation to these 4 items. The Inspectorate supervises implementation.
In real terms, this means institutions are accountable for the provision of care and responsible for the quality and training of personnel.
http://www.igz.nl/onderwerpen/handhaving_en_toezicht/wetten/kwaliteitswet_zorginstellingen

Individual Healthcare Professions Act (BIG Act)

Professionals practicing independently are subject to the Individual Healthcare Professions Act [BIG Act]
This legislation defines the framework for the training requirements with which a Nurse must comply, as well as a nurse's individual responsibilities in terms of activities carried out. A nurse may only conduct activities in which he/she is competent and qualified. It demonstrates professional courage when a nurse indicates not to want to conduct an activity because he/she feels unqualified, or asks questions in response to an order from a doctor because this is unclear or inappropriate.
Listening to one's own feeling/judgement and making the right decision from a place of reflection is an aspect that can be approached based on the theory of self compassion/mindfulness.

http://www.igz.nl/onderwerpen/handhaving_en_toezicht/wetten/wet_big/

PRACTICAL COMPONENT

The lesson requires no preparation. During the lesson, you work on the subject with your fellow students and the tutor. The lesson comprises 2 sessions of 50 minutes.

The objective of the lesson is ***to create awareness*** of the meaning of professional compassion and self-compassion in care (PTT Model of Cultural Awareness), particularly in relation to psycho-geriatric patients.

In this lesson, you learn how to respond with compassion in situations where there is an unexpected physical reaction/aggression from a client and extricate yourself so that the situation is manageable for both parties.

Activity 1:

The tutor explains the format of the lesson with the aid of the PowerPoint presentation, followed by the role-play exercise below:

Two tutors enact a scenario in which, in order to get attention, a client grabs the arm of the caregiver/nurse who is busy distributing medication, and will not let go (n.b. wrist technique)
Role-play
Role-player 1 is the nurse/caregiver:
Act as if you are becoming irritated at being grabbed, but do not react yet. Thus, allow yourself to be grabbed.

Role-player 2 is the client:
Hold on tightly: his/her issue requires attention. A call needs to be made immediately to the client's son to make a new appointment to visit.
The role-play stops here.

The tutor then leads a classroom discussion based on the following questions

- What do you do in this situation?
- What is your non-verbal response?
- What is your verbal response?
- How do you monitor the client?
- Why do you think the client is grabbing you?
- How do you monitor your own feelings?
- What are your thoughts in this situation?
- Do you have experience of this?
- How do you look after yourself if this happens to you? Where can you get help?

During the discussion, it is important to ensure that students consider their own and one another's safety, particularly in situations where they have responded/managed the situation inappropriately. The aim of the discussion is to explore these situations, to become aware of

the emotions/feelings that led to the undesirable response and to create an opportunity to turn the same emotions/feelings into other, desirable and compassionate behavior.

Outcome:
Students have considered the situation and can apply it to their own experiences.
They can relate it to their own feelings experienced in this situation or other familiar situations.

Activity 2
The tutor explains the concept of compassion.
The COM-passion for Care Charter describes the concept of compassion in detail: the ability to treat others as you wish to be treated yourself.
Being friendly, generous and forgiving, being hospitable, helpful and attentive, being curious and responsive, being fully engaged, empathetic and in contact, respectful, understanding and cognizant requires courage, self-reflection and self-compassion.

The lesson makes use of the 'compassion-for-care' BLOG. The attached blog can be (read) out if desired, to make the connection between general compassion and the subject of this workshop.

Activity 3
Role-play continued
The tutors demonstrate the appropriate technique for extricating oneself with compassion.
In order to extricate oneself with compassion, it is important to make contact with the psycho-geriatric patient. You make eye contact; you speak to the patient and ask to be let go. At the same time, you consider your personal safety and your feelings. You apply mindfulness, are completely in the moment, focus on yourself and the other party. From that place, you apply the technique you learnt to extricate yourself. From that place of autonomy, you are capable of extricating yourself with compassion.
Wrist technique: Note the way in which the patient has grabbed hold of you; note the position of the thumb. In this case, the thumb is on top. For your own safety, adopt the safety stance. Meanwhile, speak to the patient, make contact.
If the patient does not let go of you, hold your fingers tightly and pull your hand upwards. Do this quickly, but do not use too much force. It is more important to use the correct technique. You extricate yourself by moving your arm and hand in the direction of the thumb. The thumb is weaker than four fingers, therefore it is easier to extricate oneself this way than via the direction of the fingers.
Once you are loose, take a big step backwards, keep looking at the patient. Continue the conversation if necessary. Stay in the moment, concentrate on the patient and yourself.
After the incident, speak to your colleagues and manager about the situation. Seek help for yourself if you require it.

Activity 4
The tutor selects a number of techniques (see activity 5) and explains the theory behind the techniques, such as making and maintaining eye contact, asking to be let go, noting where the door is, adopting the safety stance (personal safety) and noting thumb position. See also activity 3.

Note: during the explanation, keep using the words: courage, compassion, taking care of yourself. In the explanation, keep reinforcing the connection between these concepts and care of the client.

Activity 5

Students practice 'extrication techniques' themselves

1. **Warm up:**
   The practice starts with a warm up session for the students:
   - Wrist exercises: turning the hands.
   - Arm exercises: swinging, swimming, etc.
   - Head exercises: turning the head, shrugging the shoulders, etc.

2. **Structured practice**
   The tutors demonstrate a technique and provide a step-by-step explanation on what to look for when applying the technique. Then, the students practice in pairs, or groups of three. *(Use techniques and protocols available in own practice where possible)*
   - Grabbing the arm, with the thumb of the patient placed on top of the wrist of the caregiver
   - Grabbing the arm, with the thumb of the patient placed on the underside of the wrist of the caregiver.
   - The patient grabbing both arms of the caregiver with the thumbs placed on top. Then grabbing both arms with the thumbs facing downwards.
   - Door handle; the lower arm is grabbed with both hands, with the thumbs on 1 side.
   - Handgrip; the hand is gripped.
   - Grabbing the hair at the front of the caregiver's head.
   - Grabbing the hair at the back of the caregiver's head.
   - Grabbing the caregiver's ponytail.

Practicing 'at random'

Practice the techniques in random order
The group is split into two rows. The tutor stands behind 1 row. These students cannot see the tutor. The tutor demonstrates to those students that can see her/him, which technique to use. Thus, the students do not know how they will be grabbed. They then have to extricate themselves using the techniques they have learnt. After practicing 4 techniques, the rows switch places.

Activity 6

Use the following questions to reflect on what has been learnt:

1. Have you learnt enough about the techniques and how to apply them in practice?
2. What is it like creating space for one's own feelings during these exercises? And to apply mindfulness?
3. What does compassion mean to you?
4. Do you have self-compassion? Give an example.

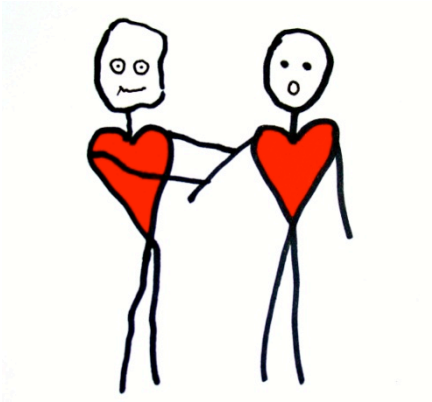
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5. How can you ensure that you act with self-compassion?
6. What do you do now if a patient or client grabs you unexpectedly? What do you do, what do you say? What do you need to consider?
7. How do you take care of yourself if this happens to you? Where can you seek help?
8. Do you feel you can apply compassion your work situation? Why can you, or why can you not?
9. What skills do you need to develop to able be apply compassion effectively?

Students discuss the questions in pairs, after which the class engages in a group discussion. To round off the lesson, refer to the "Compassion for Care" BLOG in which students can read more about the concept and the application of compassion in care.
http://www.compassionforcare.com/

A dementia blog is attached for inspiration.

Dementia Blog



A vacant mind is compensated by knowledge of the heart.
People with dementia often have a rich emotional life, a world of experience.
Paula Irik, mental health caregiver

Imagine we encounter an older client that gets a fright and grabs hold of us firmly. The client is visiting us with a health complaint and also has Alzheimer's disease. What do we know about this? How can we treat someone who has a form of dementia with compassion? Clients with dementia regularly end up in care. They do not always receive the approach their illness requires, sometimes with disastrous consequences. Which healthcare professionals are equipped to deal with people with dementia?

Ignorance can be a barrier to insightful contact. Knowing what we should or should not do or say prevents a great deal of harm. Asking a question directly after being introduced, or approaching the person from behind can be extremely unsettling for a patient with dementia. Approaching a person with dementia calmly from the front, making eye contact, introducing yourself and explaining what you are going to do in a friendly manner can provide reassurance.
How can we interact with a client if we are grabbed hold of? Once we understand that a client is communicating a message via such behaviour, we respond differently. We can remain calm, engage with the other person and try to decipher and verbalize the message, for example pain (often overlooked), fear, or panic. At the same time, we exercise self-

compassion and check whether the other party is pushing our boundaries. If we are grabbed in a painful way, or we feel threatened, then personal safety is the priority. Training helps us see people with dementia differently.

Compassion

1. Questions to reflect upon: What do you know about dementia? What are your thoughts about it? Do you feel sympathy, shame, disillusion, or something else? What would it be like for you if everything and everyone were unknown to you, over and over again? What would you do if you were in pain, but were unable to verbalize it because of the dementia? What would you do if you needed attention and did not know how to ask for it? What can you learn from this?
2. Questions to reflect upon: What do you do if a patient or a client unexpectedly grabs you? What do you do, what do you say? What do you consider? Do you have experience of this? How do you take care of yourself if this happens to you? Where can you get help?
3. Team discussion: What are your thoughts on this view of dementia: 'A fate worse than death.' How does your perception of someone with dementia affect your professionalism? In your contact with clients, is the focus on dementia? Why is it, or why is it not? How do you deal with this as a team? What are the views of other team members towards dementia? What can you learn from one another?
4. Team discussion: What is your communication strategy in relation to people with dementia? Who has knowledge of this? Who has experience of this? Whom can you approach with questions about this subject? Click here for a few practical tips.
5. Viewing tips: the power of music in dementia with Oliver Sacks, the power of touch in dementia.
6. More information:

- E-learning: How can you as a caregiver ensure that people with dementia feel comfortable? How can you prevent misunderstood behaviour in people with dementia? And if this behaviour occurs anyway, how do you manage it and how do you deal with it? These questions are addressed in the Learning about dementia e-learning course, from June 2014 via the Trimbos Institute.
- Experience Alzheimer's via the Alzheimer Experience
- Alzheimer Nederland
- Innovatiekring Dementie

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The Albeda College Compassion Tool Evaluation

CRITERIA	FULLY MET	PARTLY MET	NOT MET
a) Contained customised steps to help students progress through their learning goals	98%	2%	
b) Provided observable evidence of learning	98%	2%	
c) Clarified what students knew and did not know	94%	6%	
d) Allowed the teacher to see/hear (and intervene) when students did not understand	98%	2%	
e) Led to and connected with other tools in the process of meeting larger /higher level learning goals	83%	7%	
f) Helped students synthesize knowledge and meaning	98%	2%	
g) Provided building blocks that enable students to step into and through difficult concepts or processes to reach predetermined learning goals	98%	2%	
h) Provided pathways that led to depth and clarity in learning	96%	4%	
i)Adds to the meaning-making in the classroom	92%	8%	

NB: When the percentages do not add up to 100%, this indicates that some participants did not rate the specific item/s.

13. I am a student / qualified healthcare participant — 41

14. I am a teacher/trainer — 7

15. I am a patient —

Students' Comments:

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The Marmara University Hospital Compassion Tool & Evaluation

by
Serpil Tural
Turkey

THE LEARNING OF COMPASSION

THEORETICAL COMPONENT

Principles and Values

According to most of our society, compassion has its roots in religious beliefs and it means sharing the suffering of others; at the same time the most people believe compassion is based on being human.

The principles of the compassion are:

- Sharing with others
- Caring about others
- Help
- Equality
- Love
- Solidarity
- Tolerance

Values of the tool:

- Empathy
- Respect
- Dignity
- Equity
- Human rights
- Acceptance
- Inclusion

Aims

Having abilities for compassionate care

Learning outcomes

1. To learn the need of compassion in nursing;
2. To be self-awareness,
3. To have compassionate care to patients,
4. To have compassion satisfaction in this respect.
5. To learn the importance of compassion in nursing practice,
6. To understand the patient/client/family as a person.

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Relevant definitions and terms/ What the research says

Teaching students or nurses what compassion means is simple. It's defined as the desire to help someone who's in distress. Compassion, in other words, is a feeling and an act, and the best way to teach it is to put it into action. *www.connectionsacademy.com Compassion satisfaction* is most often felt by both students and teacher.

Compassion literally means, "to suffer together." Among emotion researchers, it is defined as the feeling that arises when you are confronted with another's suffering and feel motivated to relieve that suffering.

Compassion is not the same as empathy or altruism, though the concepts are related. While empathy refers more generally to our ability to take the perspective of and feel the emotions of another person, compassion is when those feelings and thoughts include the desire to help. Altruism, in turn, is the kind, selfless behaviour often prompted by feelings of compassion, though one can feel compassion without acting on it, and altruism isn't always motivated by compassion. While cynics may dismiss compassion as touchy-feely or irrational, scientists have started to map the biological basis of compassion, suggesting its deep evolutionary purpose. This research has shown that when we feel compassion, our heart rate slows down, we secrete the "bonding hormone" oxytocin, and regions of the brain linked to empathy, caregiving, and feelings of pleasure light up, which often results in our wanting to approach and care for other people.

Compassion Code:
S*hare fairly*
C*ommunicate with Care*
H*elp Build Trust*
O*penly Welcome Everyone*
O*ffer Respect to All*
L*isten with Interest*

http://teachingcompassion.weebly.com/teaching-ideas-and-strategies.html

While care and compassion has always been the philosophy that has underpinned our teaching curriculum here at Sheffield Hallam University, we have enhanced this by introducing augmented reality (AR) into our teaching.

AR introduces simulations by overlaying computer-generated images via a tablet computer, such as an iPad, on to a training manikin. The student holds the tablet up to the manikin from the bedside and will see a live display of the room they are in but the head and shoulders of the manikin will be overlaid with the video of an actor posing as a patient. The age and sex of the patient is communicated via the video along with their clinical condition and it is down to the trainee to react appropriately to that patient's needs. The students are currently tested on patients with breathing difficulties, chest pains and other generic conditions, and we are continually adding to our range of scenarios as we progress with this piece of technology.

The purpose of this innovation is to enable students to see the real patient while rehearsing both clinical and non-technical skills on a human patient simulator. We see the way in which students address their patients, interact with them and develop that all important nurse-patient relationship. In doing this, the essential skills of demonstrating care, compassion, empathy and dignity towards a patient can be realistically assessed, allowing us, as tutors, to give feedback on a student's performance and patient communication.

http://www.theguardian.com/healthcare-network/2013/jul/15/augmented-reality-enhance-care-compassion

What the research says

In Turkey, compassion is defined in limited researches. The ability of being compassionate is evaluated to be good nurse or one important characteristics of the nurse. The student nurses pointed out in the research that " the maternal attitudes of the nurses shows that compassion and benevolence can be considered as important qualities for nursing care in Turkey".(1) Nursing focuses on meeting physical, social and emotional health-care needs of individuals, families and society. In health care, nurses directly communicate with patients and try to empathize with them. Nurses give care under emotionally intense conditions where the individual undergoes pain. Results indicated that there is a correlation between self-compassion and emotional intelligence and that emotional intelligence, which includes the individual perceiving one's emotions and using the knowledge one gained from them to function while directing thoughts, actions and professional applications, has positive contributions to the features of nurses with developed self-compassion.(2) Qualified nursing care is based on empathy, respect to other ideas and feelings, compassionate, kindness. (3)

What the research says on the topic

Three Insights from the Cutting Edge of Compassion Research
http://greatergood.berkeley.edu/article/item/three_insights_from_the_cutting_edge_of_compassion_research

A recent gathering of compassion researchers reveals new discoveries about how and why humans help each other.

1. Compassion is push-pull

It turns out that feeling safe is a precondition to activating biological systems that promote compassion. In the face of another person's suffering, the biological mechanisms that drive our nurturing and caregiving can only come online if our more habitual "self-preservation" and "vigilance-to-threat" systems (e.g. fear, distress, anxiety, hostility) are not monopolizing the spotlight.

In the other direction, having a genetic disposition and life history that's led to a strong sense of social support, trust, and safety around people puts your "self-preservation" impulses at ease and opens the door for you to feel compassion. How, then, can we relax vigilant, self-preservation systems so that our compassionate biology can more readily get into gear?

University of Wisconsin researcher Helen Weng suggests the secret lies in the brain's frontal lobes, which her studies show do a better job of calming alert signals from the amygdala (the brain's almond shaped threat detector) when people complete a brief course in compassion. This means that we can actually train our brains for compassion. When Charles Raison, another presenter, and his colleagues at Emory University also evaluated the effects of a compassion training course, they found lower stress hormones in the blood and saliva of people who spent the most time doing the compassion exercises.

But what's *in* compassion training, one might ask? How does it boost the frontal lobes and attenuate stress hormones?

2. Compassion hinges upon mindfulness

The regular practice of mindfulness—moment to moment awareness of your body and mind—turns out to be a common theme across programs for training compassion, including those based at the University of Wisconsin, Emory University, CCARE, the Max Planck Institute in Leipzig, Germany, a consortium of clinicians in the United Kingdom, and, of course, 2,000 years of Buddhist tradition.

The opposite of mindfulness is sometimes referred to as "mindwandering"—reflexively thinking about what has happened, might have happened, or could or should happen. This very common non-mindful habit has been shown by Harvard researchers Matthew Killingsworth and Daniel Gilbert to decrease happiness. Judson Brewer, a psychiatrist at Yale University, has shown that mindwandering involves a predictable brain area (the posterior cingulate cortex), and that people can phase out activation in this brain area by practicing mindfulness.

Compassion, data suggest, comes more readily if people can be more openly aware of the present moment as it is occurring, particularly in the presence of other's suffering, without reflexive thinking or judgment.

2. Brains like helping the group more than helping the self

Studies using ontogenetic, a technique for making populations of living brain cells fire, and fMRI, which measures how much oxygen neurons are using, show that the brain's pleasure systems also play an important role in compassion. For example, extending compassion toward others biases the brain to glean more positive information from the world, something called the "carryover effect." Compassionate action—such as giving some of one's own earnings to charity—also activates pleasure circuits, which some people call "the warm glow."

In the words of Dr Jamil Zaki, a professor of psychology at Stanford, "humans are the champions of kindness." But why? Zaki's brain imaging data shows that being kind to others registers in the brain as more like eating chocolate than like fulfilling an obligation to do what's right (e.g., eating Brussels sprouts). Brains find it more valuable to do what's in the interest of the group than to do what's most profitable to the self.

Why practise compassion?

http://greatergood.berkeley.edu/topic/compassion/definition#why_practice

Scientific research into the measurable benefits of compassion is young. Preliminary findings suggest, however, that being compassionate can improve health, well-being, and relationships. Many scientists believe that compassion may even be vital to the survival of our species, and they're finding that its advantages can be increased through targeted exercises and practice. Here are some of the most exciting findings from this research so far:

- Compassion makes us feel good: Compassionate action (e.g., giving to charity) activates pleasure circuits in the brain, and compassion training programs, even very brief ones, strengthen brain circuits for pleasure and reward and lead to lasting increases in self-reported happiness.
- Being compassionate—tuning in to other people in a kind and loving manner—can reduce risk of heart disease by boosting the positive effects of the Vagus Nerve, which helps to slow our heart rate.

- One compassion training program has found that it makes people more resilient to stress; it lowers stress hormones in the blood and saliva and strengthens the immune response.
- Brain scans during loving-kindness meditation, which directs compassion toward suffering, suggest that, on average, compassionate people's minds wander less about what has gone wrong in their lives, or might go wrong in the future; as a result, they're happier.
- Compassion helps make caring parents: Brain scans show that when people experience compassion, their brains activate in neural systems known to support parental nurturance and other caregiving behaviors.
- Compassion helps make better spouses: Compassionate people are more optimistic and supportive when communicating with others.
- Compassion helps make better friends: Studies of college friendships show that when one friend sets the goal to support the other compassionately, both friends experience greater satisfaction and growth in the relationship.
- Feeling compassion for one person makes us less vindictive toward others.
- Restraining feelings of compassion chips away at our commitment to moral principles.
- Employees who receive more compassion in their workplace see themselves, their co-workers, and their organization in a more positive light, report feeling more positive emotions like joy and contentment, and are more committed to their jobs.
- More compassionate societies—those that take care of their most vulnerable members, assist other nations in need, and have children who perform more acts of kindness—are the happier ones.
- Compassionate people are more socially adept, making them less vulnerable to loneliness; loneliness has been shown to cause stress and harm the immune system.

How to Cultivate Compassion?

We often talk about some people as being more compassionate than others, but research suggests compassion isn't something you're born with or not. Instead, it can be strengthened through targeted exercises and practice. Compassion training programs, such as those out of Emory University and Stanford University, are revealing how we can boost feelings of compassion in ourselves and others. Here are some of the best tips to emerge out of those programs, as well as other research:

- Look for commonalities: Seeing yourself as similar to others increases feelings of compassion. A recent study shows that something as simple as tapping your fingers to the same rhythm with a stranger increases compassionate behavior.
- Calm your inner worrier: When we let our mind run wild with fear in response to someone else's pain (e.g., What if that happens to me?), we inhibit the biological systems that enable compassion. The practice of mindfulness can help us feel safer in these situations, facilitating compassion.
- Encourage cooperation, not competition, even through subtle cues: A seminal study showed that describing a game as a "Community Game" led players to cooperate and share a reward evenly; describing the same game as a "Wall Street Game" made the players more cutthroat and less honest. This is a valuable lesson for teachers, who can promote cooperative learning in the classroom.

- See people as individuals (not abstractions): When presented with an appeal from an anti-hunger charity, people were more likely to give money after reading about a starving girl than after reading statistics on starvation—even when those statistics were combined with the girl's story.
- Don't play the blame game: When we blame others for their misfortune, we feel less tenderness and concern toward them.
- Respect your inner hero: When we think we're capable of making a difference, we're less likely to curb our compassion.
- Notice and savor how good it feels to be compassionate. Studies have shown that practicing compassion and engaging in compassionate action bolsters brain activity in areas that signal reward.
- To cultivate compassion in kids, start by modeling kindness: Research suggests compassion is contagious, so if you want to help compassion spread in the next generation, lead by example.
- Curb inequality: Research suggests that as people feel a greater sense of status over others, they feel less compassion.
- Don't be a sponge: When we completely take on other people's suffering as our own, we risk feeling personally distressed, threatened, and overwhelmed; in some cases, this can even lead to burnout. Instead, try to be receptive to other people's feelings without adopting those feelings as your own.
- Compassion is not sympathy, empathy, or altruism, although each plays a part. The compassionate person feels the emotional state of another and takes steps to be with them in that state. *www.squidoo.com/**teach-kids-compassion***

PRACTICAL COMPONENT

Take a quiz for personally to measure your compassion level
http://greatergood.berkeley.edu/quizzes/take_quiz/13

Activity: Show Compassion for Your Students

Activity: Talk about Compassion with Your Students

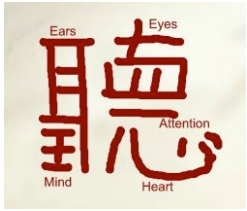
Have conversations with your students to help them understand what other people might be experiencing and feeling.
Have them imagine what it would be like to be in that person's shoes. These could be people at school or the conversation could extend to people in other parts of the world, e.g people experiencing war or natural disasters.

Activity: Act with compassion:
Having the class volunteer, or partake in activities that help the community or others

Activity: Visit to Elderly Care Home or Orphanage with Your Students

Activity: Read about Compassionate People

- *Martin Luther King Jr*
- *Mother Teresa*
- *Mohandas Gandhi*



Activity: Teach Students How to Listen
Activity: Take photographs or find photographs that demonstrate compassion.

Activity: Document a compassionate project on video.

Activity: Draw or paint a story of compassion:

References
(1) Nermin Ersoy, Ph.D. , Insaf Altun, MSN.
Kocaeli University Medical School , Dept Medical Ethics & Medical History, 41900 Derince, Kocaeli ,TURKEY *Eubios Journal of Asian and International Bioethics* 8 (1998), 72-75.

(2) Relationship between self-compassion and emotional intelligence in nursing students.Emine Senyuva, Hülya Kaya, Burçin Işik, Gönül Bodur International Journal of Nursing Practice. 10/2013; DOI:10.1111/ijn.12204 Source: PubMed

(3)-Tortumluoglu G, Bayat M, Sevig Ü. Evaluation of person by using the model of “Giger and Davidhizar”

The Marmara University Hospital Compassion Tool Evaluation

CRITERIA	FULLY MET	PARTLY MET	NOT MET
a) Contained customised steps to help students progress through their learning goals	70%	30%	
b) Provided observable evidence of learning	74%	26%	
c) Clarified what students knew and did not know	70%	30%	
d) Allowed the teacher to see/hear (and intervene) when students did not understand	100%		
e) Led to and connected with other tools in the process of meeting larger /higher level learning goals	86%	14%	
f) Helped students synthesize knowledge and meaning	66%	34%	
g) Provided building blocks that enable students to step into and through difficult concepts or processes to reach predetermined learning goals	48%	44%	8%
h) Provided pathways that led to depth and clarity in learning	38%	52%	10%
i)Adds to the meaning-making in the classroom	84%	16%	

NB: When the percentages do not add up to 100%, this indicates that some participants did not rate the specific item/s.

- I am a student / qualified health care participant [50]
- I am a teacher/trainer [ ]
- I am a patient [ ]

Students' Comments:
Sometimes it is very difficult to understand the patient from a different culture, the tool will help us.

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Toolkit Two

Lifelong Learning Programme

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The Middlesex University Courage Tool & Evaluation

by
Gina Taylor and Irena Papadopoulos
United Kingdom

COURAGE IN HEALTHCARE PRACTICE: AN INTRODUCTORY TOOL

THEORETICAL COMPONENT

Principles and Values

In England, attention to courage in nursing practice has risen as a consequence of reports of unsatisfactory care of patients, including inhumane and degrading treatment. These reports raised concern that nurses have lost sight of basic, compassionate care. It is suggested that courage is necessary if nurses are to challenge unsatisfactory care.
Courage is described as a moral value which enables individuals to recognise when something is wrong and to have the desire and capacity to respond appropriately. The principles that underpin this tool are:

- Shared learning
- Valuing experience
- Building on what is already known
- Equality
- Exploring similarities and differences
- Tolerance
- Fostering curiosity
- A commitment to life-long learning

The tool is also informed by the following values:

- Caring
- Compassion
- Trustworthiness
- Integrity
- Fairness
- Justice
- Respect
- Responsibility

Aims

When you have worked through this tool, you will be able to:

- Articulate the need for the focus on courage in current nursing practice;
- Discuss the theoretical underpinnings of courage, and the meaning of courage from different viewpoints;
- Reflect on your own practice in relation to the ability to display courage;
- Reflect, in a reasoned manner, on when it might be desirable to be courageous;
- Identify strategies to nurture confidence and courage in your own practice.

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Relevant definitions and terms/ What the research says

You will be familiar by now with the six 'Cs' of caring developed by Roach (1993; 2002). Roach asked the question *'What is a nurse doing when he or she is caring?'* and structured the responses into specific caring behaviours – the six 'Cs':

- Compassion: making an attempt to experience what the patient is experiencing.
- Competence: having the knowledge, experience and technical skills for the situation.
- Confidence: maintaining trusting relationships; showing respect for patients and their families.
- Conscience: advocating on behalf of patients; respecting patients' rights; adhering to ethical codes of practice.
- Commitment: placing patients at the forefront of care; adhering to professional obligations.
- Comportment: professional demeanour.

Pusari (1998) added courage to these 'Cs' in order to *'further the moral and ethical dimensions of Roach's work'* (Pusari, 1998, p156-7). We are concerned here with courage. We can see how the addition of courage fits in with Roach's caring behaviours, if we consider her definitions. A compassionate and competent nurse is likely to be confident in her/his practice (Pusari, 1998) and will have the confidence to maintain respectful, trusting relationships with patients. Conscience is a state of moral awareness (Roach, 1993): the nurse's conscience will tell her/him when something is not right – when a patient is being treated unjustly, raising the need to advocate on a patient's behalf and to adhere to ethical codes of practice. A commitment to professional obligations and professional behaviour will prompt the nurse to recognise that something should be done to address unjust treatment. Mayeroff (1971) describes how caring entails commitment, and indifference or neglect can result in guilt. *'Guilt tells me that something is wrong'* (Mayeroff (1971, p45). This is where courage is essential to allow the nurse to respond to the needs of patients and to act appropriately.

You will be familiar with the work of Cummings and Bennett (2012) for the NHS Commissioning Board, relating to developing a culture of compassionate care. Six fundamentals of nursing are identified:

- Care
- Compassion
- Competence
- Communication
- Courage
- Commitment

'Courage enables us to do the right thing for the people we care for, to speak up when we have concerns and to have the personal strength and vision to innovate and to embrace new ways of working'.
(NHS Commissioning Board, 2012, p13)

So, as Hawkins and Morse (2014, p267) point out, courage differs from compassion – it enables risk-taking actions.

What the research says

Lindh et al (2010) undertook a theoretical analysis of 'courage', asking two primary questions:

- How is courage understood from a philosophical perspective?

- How is courage expressed in nurses' actions in nursing practice?

  1. In answering the first question, the authors identified four philosophical views of courage within available literature:

  Courage as an ontological concept
  According to this view, courage is an inherent characteristic of being human. As human beings, we need courage to make day-to-day decisions. If a human being does not fulfil his/her moral duties or obligations, guilt may be experienced.

  Courage as a moral virtue
  The role of courage in ethics and moral life can be found in the work of Aristotle (384-322 BC), who viewed courage as a moral virtue (Lindh et al, 2010). A virtue is concerned with moral excellence, uprightness and goodness (Oxford English Dictionary). You might have heard people say '*Patience is a virtue'.* A moral virtue motivates people to do what is right and moreover to want to do what is right. For Aristotle, courage concerns the ability to respond appropriately to fear, and to face fear with confidence. Thus, in exercising courage, individuals should *'refrain both from cowardice and foolhardiness and instead should act in accordance with practical wisdom'* (Lindh et al, 2010, p559). In this respect, cowardice and foolhardiness can be viewed as being located at opposite ends of a continuum – the courageous person will find a balance somewhere between these two extremes and exercise courage wisely.

  Courage as a property of an ethical act
  'Moral courage is grounded in compassion, sensitivity and recognising other people's suffering' (Lindh et al, 2010, p561). It is further concerned with recognising when something is wrong, and feeling the responsibility to respond. The opposite of moral courage would be a reluctance to get involved when someone is being unjustly treated.

  Courage as a creative capacity
  In having the courage to challenge the status quo, something new can be brought into being and so courage can bring about change.

  2. How is courage expressed in nurses' actions in nursing practice?
  In terms of the expression of courage in nursing practice, Lindh et al (2010) found courage to be essential for *'nurses' way of being'* (p562), and important for facing the challenges of day-today practice. Some studies found that nurses can feel vulnerable – some nurses feared losing their jobs if they spoke up, some student nurses were worried about the implications for their assessments if they spoke up. Some studies described nurses as being sensitive to patients' needs and fair treatment. Some nurses felt responsible for acting on unjust treatment and some had the courage to intervene to stop poor care. Several studies linked courage to opportunities for improving the quality of care.

  Thorup et al (2012) engaged in interviews with 23 experienced nurses from Sweden, Finland and Denmark in order to explore how courage contributes to the ability to engage in professional care. Their particular concern was with ethical formation, which they believed to be influenced by personal and professional life experiences and is developed over time. In terms of their personal experiences, nurses felt that their own vulnerability and suffering could either help them to understand their patients' situations (act as an '*eye-opener'*), or inhibit their ability to engage in meaningful care (create a '*blind spot'*). Concerning professional experiences, nurses recognised the vulnerability and suffering of patients within the healthcare system, accompanied by a loss of autonomy and independence. Nurses felt that courage is needed to:

- Help patients face their own vulnerability and suffering;
- 'Bear witness' to patients' vulnerability and suffering, that is engaging in a meaningful nurse-patient relationship;
- Provide professional care.

Nurses felt that courage allows the provision of meaningful care, but nurses must be prepared for repercussions, for example, the risk of abandonment by the professional community. Nurses need courage to challenge their own professional group on ethical issues. Therefore, courage is required to develop the skills needed for ethical formation: both are influenced by personal and professional life experiences and develop over time. However, Thorup et al argue that having the courage to raise ethical issues and initiate ethical discussion gave nurses a sense of credibility. Courage also helps nurses to venture into areas of uncertainty:
'...willingness to walk alongside the patients on their journey to overcome their suffering, no matter where the road leads'.
(Thorup et al, 2012, p433)

Against the background of the requirement for compassion in day-to-day nursing practice, Curtis (2014) explored student nurse socialisation in compassionate practice. Curtis used grounded theory for this investigation and conducted in-depth interviews with 19 student nurses. Students were aware of the requirement to become compassionate practitioners in order to fulfil professional and educational expectations, but they raised concerns about their ability to engage in and maintain compassionate practice. The students' insightful responses demonstrated awareness of the need to maintain professional boundaries, of the need to avoid inappropriate levels of emotion in nurse-patient relationships and the need to get the balance right, and of the need to cope with, and manage, the demands of emotional labour. Curtis (2014, p223) concluded that:
'For student nurses to cope with the complexity of compassionate practice and its inherent emotional demands, they need to develop professional wisdom and courage.'
This can be developed through small group discussion and reflection in and on practice

Definitions
As with compassion, definitions of courage vary, but there are some common components. In terms of nursing practice, courage is probably best understood through the analysis of nursing literature undertaken by Hawkins and Morse (2014), which described courage as
' ...an inner strength or moral virtue fundamental to an individual's capacity for caring behaviours or compassion, or the ability to cope' (p265-6).

The following elements were identified:
- Courage is preceded by vulnerability, threats (to self or others) and challenges;
- Courage is manifested in advocacy on behalf of the patient and actions (such as taking a stand) despite fear of retribution – the nurse intercedes on behalf of the patient;
- Courage is a developmental process that can be taught and learned, not only as one's moral duty, but also one's professional role;
- The consequences of courage include acting in the best interest of the patient, for example, by alleviating suffering;
- Courage can effect change, increase ethical sensitivity and self-actualisation, and mitigate moral distress;
- The absence of courage or courage in its excess form may give rise to moral distress, incivility (arrogance), and patient suffering. This may equate to a lack of professional integrity and personal commitment to moral action.
(Hawkins and Morse, 2014, p266)

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Hawkins and Morse conclude with the definition:

'Despite fear for self and others, courage is ethical-moral "risk-taking" action(s) with the intent to ensure safe patient care'.

PRACTICAL COMPONENT

In order for you to learn about courage, it is important to start a reflective diary. In this diary, you should record your thoughts and feelings about the need for, and display of, courage in nursing practice.

1. Cultural Awareness and Courage

Having looked at some of the literature relating to courage, it is important that you explore your own thoughts and feelings, and experiences of courage.

Activity 1.1: What does courage mean to you?
Can you think of anyone who you would describe as displaying courage?
What did this person do or say? What were the circumstances in which courage was manifested?
Why do you think this person was courageous?
You might have thought of someone famous like Nelson Mandela; Stephen Sutton, the teenager who died from bowel cancer and faced his illness so bravely and engaged in fund-raising; William Pooley, the nurse who worked in Sierra Leone and contracted, and recovered from, the Ebola virus; or maybe you thought of a nurse who refused to bow to organisational pressure and stood up for what is right for her/his patients.

Activity 1.2: Other people's views of courage
Talk to your family, friends and colleagues about courage – are their thoughts on courage similar to yours or different?

Activity 1.3: Your own degree of courage
Do you feel that you are a courageous person?
Do you stand up for what you believe is right?
Do you want to stand up for what you believe is right, but do not feel confident to do so?
How do you respond to peer pressure? Remember, this could be pressure to conform to high standards of care, or pressure to make short cuts and thus put patients at risk.
Courage can be developed over time, and in nursing practice the development of courage requires knowledge, experience and confidence, as well as compassion. Where do you feel you are at now in relation to courage? What activities and support do you feel you need in order to develop your courage?

Activity 1.4: Developing moral courage muscles
In this brief article, Thompson (2014) likens developing courage to strengthening muscles. Read through the article:
Thompson, R. (2014) Developing moral courage muscles: patient's lives depend on it!
http://www.nursetogether.com/developing-moral-courage-muscles-patients
At the very least, you should come away with the notion of the 'mother' question. '*Would I want my mother to be treated like this?'*
Thompson writes about making decisions based on ethical and moral values – we will come to this later.

2. Cultural Knowledge and Courage

Activity 2.1: Enhancing your knowledge and understanding of courage

In order to enhance your knowledge and understanding read the following article:
Curtis, K. (2014) Learning the requirements for compassionate practice: student vulnerability and courage. *Nursing Ethics,* 21(2): 210-223
Curtis provides some valuable insights into the demands on student nurses and how they cope with these demands.

Activity 2.2: 'If people know what they should do, why don't they do it?'

Gallagher, A. (2011) Moral distress and moral courage in everyday nursing practice. *Online Journal of Issues in Nursing*, 16(2):1 http://dx.doi.org/10.3912/OJIN.Vol16No02PPT03
In this article, Gallagher asks the question *'If people know what they should do, why don't they do it?'* You should reflect on the possible answers to this question.

3. Cultural Sensitivity and Courage

The development and display of courage involves interpersonal skills and teamwork.

Thompson (2014) states:

> When faced with a moral dilemma we have 3 choices:
> 1. say nothing
> 2. speak up but not handle it well
> 3. speak up and handle it well

Speaking up and handling it well requires nurses to develop their assertive communication skills.
However, as well as developing interpersonal skills, addressing a moral dilemma requires the development of reasoned arguments. You might like to think about using a framework to help you work through moral dilemmas that require a decision to be made.

Activity 3.1: Ethical decision-making: the DECIDE framework

Consider the decision-making framework developed by Thompson et al (2006):

> **D**efine the problem: clarify the problem; what is causing concern?
> **E**thical review: use the ethical principles of respect for autonomy, beneficence, non-maleficence and justice to aid the clarification of the problem.
> **C**onsider options: what can be done? Is there evidence to support your concern (for example, evidence in relation to effective or non-effective care or treatment)?
> **I**nvestigate outcomes: what are the likely outcomes of the various options?
> **D**ecide on action: make a decision based on the above process.
> **E**valuate results: and learn from the experience.
> (Thompson et al, 2006, p322-4)

By using this framework to articulate your concern, you should be able to convey your concerns to your colleagues in a manner that demonstrates that you have given serious consideration to the problem.

Nurses can experience 'moral distress' when they find themselves in situations where they feel unable to do the right thing (Gallagher, 2011). This implies that they know what should be done but feel inhibited, possibly by organisational constraints. As Gallagher points out, it

is not necessarily the case that sufficient moral courage will allow a nurse to speak up and challenge unacceptable practices. Organisations are not always supportive.
Gallagher (2011) demonstrates how problems can arise at different levels:

- Individual nurse (micro level)
- Organisation (meso level)
- Political (macro level)
-

Activity 3.2: Analysis of challenging healthcare situations

Re-visit Gallagher's article to explore examples of challenging healthcare situations, and the consideration of these from different viewpoints.

Gallagher, A. (2011) Moral distress and moral courage in everyday nursing practice. *Online Journal of Issues in Nursing*, 16(2):1 http://dx.doi.org/10.3912/OJIN.Vol16No02PPT03

4. Cultural Competence and Courage

Use your reflective diary to look back over the incidents you have noted and your responses to these situations. How do you feel your own practice is developing?
Critically analyse your own practice. Do you feel you are acquiring the skills to challenge unjust care and treatment?

Activity 4.1*: Examples of unjust care and treatment*

Focus on a few incidents that gave you cause for concern. These might have entailed:

- Witnessing food being removed from a frail elderly patient before he/she had time to eat it, or was not helped to eat, or the food was not within reach anyway.
- Failure to make reasonable adjustments for the special and individual needs of a patient with learning disabilities.
- Failure to take account of diversity and the cultural needs of a patient.

How did you respond to these situations at the time you witnessed them?
Would you do anything different now?
The public inquiry into the failings of the Mid Staffordshire NHS Foundation Trust (Francis, 2013) heard harrowing stories from patients' relatives which included:

- Patients being left in excrement in soiled bed clothes for lengthy periods;
- Assistance not being provided with feeding for patients who could not eat without help;
- Water being left out of reach;
- In spite of persistent requests for help, patients not being assisted with their toileting;
- Wards and toilet facilities being left in a filthy condition;
- Privacy and dignity, even in death, being denied;
- Triage in A&E being undertaken by untrained staff;
- Staff treating patients and those close to them with what appeared to be callous indifference. (Francis, 2013, p13)

Activity 4.2: The Francis Report

You can look at the 'Francis Report': www.midstaffspublicinquiry.com/report

This is a lengthy report consisting of 3 volumes, but you can find examples in this of report of the poor care that initiated the focus on compassion and courage in England.
We have seen that an ethical decision-making framework can help you to decide if an incident needs intervention and to clarify the problem. Think about how you would have responded in one (or more) of the situations. Try framing your argument by using the **DECIDE** framework.

Following the outcome of the public inquiry into the failings of the Mid Staffordshire NHS Foundation Trust, attention has been paid to raising concerns and whistleblowing.

Activity 4.3: NMC guidance on raising concerns
Visit the NMC website, watch the video and read through the guidance on raising concerns.
www.nmc-org.uk/Nurses-and-midwives/Raising-and-escalating-concerns/

Make sure you are aware of your local policy on raising concerns and whistleblowing.
The following web-site also has some useful information, sign-posting to further advice and guidance, and a whistleblowing helpline:
www.nhsemployers.org/your-workforce/retain-and-improve/raising-concerns-at-work

Click on 'Guidance for staff'
In order to effect change, ***'courage must be accompanied by passion, innovation, and the vigilance to see what needs to be challenged'*** (Lindh et al, 2010, p563).

ASSESSMENT COMPONENT

Formative assessment:
Reflective account – incident from practice – identifying what has been learned and learning needs.
Summative assessment:
Critical analysis of a case study
Structured essay

EVALUATION COMPONENT

1. Self-evaluation: the learner should evaluate how the tool has assisted learning and what has been learned. This stage of evaluation should focus on use of the reflective diary and the development and awareness of courage.
2. Peer evaluation: peer learning groups should discuss their use of the tool: how it has assisted learning and what has been learned. This stage of evaluation should focus on knowledge gained regarding courage.
3. Teacher evaluation: teachers should evaluate the tool through observing classroom activities that demonstrate students' developing skills in relation to displaying confidence and courage, focusing on how they make decisions in relation to the need to convey concerns about unsatisfactory care.
4. User group evaluation: it is important to involve patients (or former patients) in the evaluation of this tool. User groups could be approached to invite them to comment on the tool. In areas where users are involved in classroom teaching activities, user group members can be invited to evaluate the tool's effectiveness in helping students to develop their confidence and courage to identify unjust care and to raise their concerns appropriately.

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The Middlesex University Courage Tool Evaluation

CRITERIA	FULLY MET	PARTLY MET	NOT MET
a) Contained customised steps to help students progress through their learning goals	86%	14%	
b) Provided observable evidence of learning	71%	29%	
c) Clarified what students knew and did not know	86%	14%	
d) Allowed the teacher to see/hear (and intervene) when students did not understand	95%	5%	
e) Led to and connected with other tools in the process of meeting larger /higher level learning goals	90%	10%	
f) Helped students synthesize knowledge and meaning	90%	10%	
g) Provided building blocks that enable students to step into and through difficult concepts or processes to reach predetermined learning goals	90%	10%	
h) Provided pathways that led to depth and clarity in learning	95%	5%	
i)Adds to the meaning-making in the classroom	95%	5%	

NB: When the percentages do not add up to 100%, this indicates that some participants did not rate the specific item/s.

16. I am a student / qualified healthcare participant [21]

17. I am a teacher/trainer [ ]

18. I am a patient [ ]

Students' Comments:

We need more time to discuss.
Should implement the tool in year one before placements.

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The Edunet Courage Tool & Evaluation

by
Victor Dudau and Mihai Pistol
Romania

MORAL COURAGE IN HEALTHCARE:
ACTING ETHICALLY IN THE PRESENCE OF DISCRIMINATION

THEORETICAL COMPONENT

Healthcare professionals often face complex ethical dilemmas in the workplace regarding the discrimination. Cultural stereotypes and discrimination continue to be a part of the society and have adversely affected minority populations, the health care system in general and the profession of nursing. Individuals and groups can be discriminated against based on race, ethnicity, language, religion, culture and other characteristics. Discrimination may reduce an individual's choices in healthcare and family/social life and limit access to measures that can be taken to maintain health and quality of life. Stigma and discrimination can lead to social isolation.

This tool is both for students to learn on their own or with others about the topic of the courage and is developed in the framework of the project Tools for Intercultural Education of Nurses in Europe (IENE 3) by a team of psychologists, trainers from EDUNET Organization and nurses teachers at "EDUNET" Nurses School, integrating practices with contemporary psychology and scientific research on moral courage .

Principles and Values

Ethical values that underpin this tool: honesty, integrity, fairness, respect, responsibility, empathy, compassion and courage
The tool helps students to understand and to be able to apply values such as:

- Right to equal access to care and treatment
- Right to information
- Right to explanation appropriate to the patients capacity of understanding
- Right to informed consent
- Right to free choice
- Right to privacy and confidentiality
- Right to dignity
- Right to observance of quality standards

The principles which inform the methodology derive from the previous work on the Papadopoulos, Tilki and Taylor model of transcultural nursing and cultural competence (1998, 2006) and the Model Intercultural Education of Nurses in Europe (IENE1 & IENE2 projects www.ieneproject.eu), as well as other principles of intercultural education which can be found in the literature. These are:

- Respecting the cultural background and identity of the learner by relating learning to their previous knowledge and experiences
- Providing equal access to learning by eliminating discrimination in the education system and by promoting an inclusive learning environment

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- Promoting learning which encourages the understanding of personal values and the development of self- awareness, both of which form the basis for reflective communication and co-operation across cultures and social boundaries
- Promoting a critical approach regarding the power linked to the production and use of knowledge to either oppress or emancipate people
- Encouraging the establishment of peer learning communities for support and the exchange of knowledge and experiences
- Promoting courage. Thinking outside the box and speaking out against injustice.
- Promoting the understanding and tolerance of others and their cultures, the acceptance of diversity and the inclusion of others

Aims

The tool "**Moral courage in healthcare: acting ethically in the presence of discrimination**" aims to help nurses and other health care professionals to define moral courage, recognize and develop moral courage when faced with ethical challenges.

Learning outcomes

At the end of this training, the participants will be able:

- To define moral courage and concepts related to moral courage;
- To understand the importance of moral courage in healthcare;
- To recognize moral courage in the workplace ;
- To demonstrate courage when faced with discrimination;

Relevant definitions and terms/ What the research says

Moral Courage
Ancient Greek philosophers, such as Plato and Aristotle, frequently used the term in reference to character on the battlefield. Plato and Aristotle discussed courage as a trait set aside for situations where individuals feared death. Aristotle specifically discussed courage in the context of being able to wage war while being mindful of the possibility of injury or death. To Aristotle, bravery was a virtue that enabled Greek soldiers to respond appropriately to the fear of the battle (Day, 2007; Lachman, 2007; Miller, 2005).

Moral courage is displayed by individuals, who, despite adversity and personal risk, decide to act upon their ethical values to help others during difficult ethical dilemmas. These individuals strive to do the right thing, even when others chose a less ethical behavior, which may include taking no action at all (Lachman, 2009; Sekerka & Bagozzi, 2007). Morally courageous professionals persevere to stand up for what is right even when it means they may do so alone. It requires a steadfast commitment to fundamental ethical principles despite potential risks, such as threats to reputation, shame, emotional anxiety, isolation from colleagues, retaliation, and loss of employment. Morally courageous individuals are prepared to face tough decisions and confront the uncertainties associated with their resolve to do the right thing despite the consequences they may face (Clancy, 2003; Kidder, 2005; Lachman, 2007; Miller, 2005; Peake, 2006).

Associated concepts:

Moral character - possession of the virtues of temperance, justice, wisdom, and courage (Stanford Encyclopedia of Philosophy, 2007).
Moral courage – individual's capacity to overcome fear and stand up for his/her core values (Lachman, 2007a)
Moral virtue - performance of repeated acts of virtue (e.g. courage); a habit of practicing virtue (Aristotle, 350 BCE/1998)

Moral integrity - to feel good about oneself in a fundamental way, to perceive oneself as both a professional who does good work and as a person of character who strives to live a moral life (Laabs, 2007)
Ethical competence - ability of a person to analyze and respond to a moral problem.

Stereotypes, stigma and discrimination
Stereotypes are ideas held by some individuals about members of particular groups, based solely on membership in that group.
A stereotype is a set of beliefs about the characteristics or attributes of a group of people, which can lead to stigma and discrimination. The characteristic or attribute that the stereotype is centred around is considered as either more or less prevalent in one group, relative to other groups, and therefore distinguishes one group from another (Judd & Park, 1993).
Stereotypes are often used in a negative or prejudicial sense and are frequently used to justify certain discriminatory behaviors. This means that the stereotyping of individuals can often lead to stigmatisation, which in turn leads to discriminatory behaviour.

Stigma is mark of disgrace associated with a particular circumstance, quality, or person (http://www.oxforddictionaries.com/). The concept of stigma is the process of perceiving a characteristic of another, as deviant from the social expectations that are held by the majority. Stigma becomes discrimination when thoughts, beliefs or attitudes evolve into direct action.

Discrimination is defined as any unfavourable treatment of an individual based solely on their membership of a certain group (Giddens, Duneier, Appelbaum & Carr, 2009).
Discrimination involves exhibiting a negative behaviour towards members of a social group, other than one's own, and can result in limiting members of one group from opportunities that are available to others.
Discrimination is an unfair treatment of a person or group on the basis of prejudice. Particular characteristics include; race, sexual orientation, or particular physical attributes, and lead ultimately to some form of rejection or exclusion (Giddens et al., 2009).

Stereotyping, stigma, and discrimination are three different aspects of the same response (Fiske, 1998; Rüsch, Angermeyer & Corrigan, 2005). The term stigma refers to problems of knowledge (ignorance), attitudes (prejudice) and behaviour (discrimination)
For more definitions , see the IENE glossary http://ieneproject.eu/glossary.php.

What the research says

Transcultural Health and Social Care: Development of Culturally Competent Practitioners, Irena Papadopoulos (2007), p*rovides research-based information on culturally competent care of vital importance to all health and social workers in multi-cultural communities.*

Intercultural Education of Nurses in Europe, www.ieneproject.eu, is a *multilingual website which develop a new model for intercultural education of nurses (PPT/IENE Model), addressing nurses and healthcare professionals working in contact with patients with different cultures and languages .*

Tools for Intecultural Education of nurses in Europe project, http://ienetools.wordpress.com/ provides learning tools aiming to increase the skills of nurses and health care professionals for providing culturally competent and compassionate care to patients. Colonel John S. Murray, in the article Moral Courage in Healthcare: Acting Ethically Even in the Presence of Risk, defines the moral courage, describes ongoing discussions related to moral courage,

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explains how to recognize moral courage, and offers strategies for developing and demonstrating moral courage when faced with ethical challenges.

In the article Moral Distress and Moral Courage in Everyday Nursing Practice, Gallagher, A., (March 21, 2010) examines the concepts of moral distress and moral courage within the context of nursing practice. Stigma and Discrimination around HIV and HCV in Healthcare Settings: Research Report, 2012 are defined the term of discrimination and in relation with stereotypes and stigma.

What the legislation/treaties/conventions says on the topic

The European non-discrimination directives prohibit differential treatment that is based on certain 'protected grounds', containing a fixed and limited list of protected grounds, covering sex (Gender Goods and Services Directive, Gender Equality Directive (Recast)), sexual orientation, disability, age or religion or belief (Employment Equality Directive), racial or ethnic origin (Racial Equality Directive), Handbook on European non-discrimination law (http://fra.europa.eu/)

Romanian Law no. 48/2012, prevents and punishes all forms of discrimination.

What local policies say

General nurses and midwives are required to show a faultless conduct towards ill, always respecting its dignity. (Article 5 of The Ethic Code of the practitioner midwife and nurse in Romania). Upon receipt of the Order of Nurses, Midwives and Nurses in Romania, registered practitioner nurse and midwife take the oath to exercise profession with dignity, to respect human being and his rights, to not discriminate patients by nationality, race, religion, political affiliation or social status.

PRACTICAL COMPONENT

Practical activities

1. Recognition of a moral courage situation

Activity 1.1 What is moral courage for you?

Moral courage is seen in individuals who, when they uncover an ethical dilemma, explore a course of action based on their ethical values, and follow through with a decision as to the right course of action regardless of the possible consequences this course of action might present. Moral courage generally occurs when individuals with high ethical standards face acute or recurring pressures to act in a way that conflicts with their values (Clancy, 2003; Miller, 2005). Moral courage can be seen in a staff nurse who, under pressure from administration, refuses to document patient care that wasn't provided; in a researcher who declines to engage in scientific misconduct for the purpose of receiving funding to help the organization enjoy better standing in the research community; or in an academician who rejects unrelenting demands to pass failing students despite threats to tenure (Murray, 2007a).

Ask to these questions:

a) *What is moral courage for you?*

b) *Exemplify the moral courage in professional practice when confronted with ethical misconduct or discrimination in a clinical setting or the classroom.*

Activity 1.2 What is a courageous behaviour?

The following example demonstrates moral courage in clinical practice:

"Emily was a novice nurse employed at an academic medical centre. Her peers respected her and described her as an attentive and meticulous nurse with strong work values. Over time Emily noted a behaviour in the work setting that concerned her and conflicted with her ethical principles. She had observed her supervisor falsifying training records of nurses still on orientation so that these new nurses could begin earlier to work independently, thus improving staffing levels. When Emily brought this behaviour to the attention of the more senior nurses on the unit, they explained that they experienced retaliation if they even mentioned this misconduct. After much deliberation, Emily felt that she had an ethical responsibility to take action and bring this matter to the attention of the hospital administration. As soon as she did this, her supervisor began to berate her in staff meetings, change her work schedule unfairly and without notice, withhold needed information, set unreasonable deadlines, and prevent her opportunities for professional advancement. Recognizing that nurses have an obligation to always demonstrate the highest professional and ethical standards, Emily sought guidance from the medical centre's nurse ethicist. This guidance and support helped her to stand firm and stay resolute in her determination to do what was right".
(Murray, J.S., (2010) "Moral Courage in Healthcare: Acting Ethically Even in the Presence of Risk)

Discuss this case in the groups of colleagues and explain:

a) Which ethical misconduct or discrimination the Emily observed?
b) What Emily did?
c) What risks and consequences Emily accepted taking these actions?
d) Why do you consider that Emily was courageous?

2. Discrimination in healthcare

Activity 2.1: What is discrimination?

There can be different types of discrimination by a healthcare or care provider:

- direct discrimination
- indirect discrimination
- discrimination arising from a disability
- harassment
- victimisation

Read more about Discrimination categories and defences in Handbook on European non-discrimination law (http://fra.europa.eu/), page 21-36 , and establish what type of discrimination is each situation?

a) Treating someone differently and worse than others because of who he is, because of who they think he is or because of someone you are connected to;
b) Applying a policy, rule or way of doing things that puts some people at a disadvantage compared with others;
c) Treating someone badly because of something connected to his disability or fails to make a reasonable adjustment if someone is disabled;

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d) Treating someone in a way that is offensive, frightening, degrading, humiliating or distressing;

e) Treating someone badly because s/he complained about discrimination or because they think s/he complained about discrimination.

Activity 2.2 What is the right thing to do?

Discrimination is when a healthcare or care provider treats a person differently and worse than someone else for certain reasons: sex, sexual orientation, disability, age, race, ethnicity, colour and membership of a national minority, nationality or national origin, religion or belief, language, social origin, birth and property, political or other opinion, named the low protected grounds.

Analyze the following examples of unfair treatment in health or care services and establish what behaviours can be considered unlawful discrimination under the and why these unfair treatments by a healthcare or care provider is considered unlawful discrimination.

Refuse someone the cancer treatment because of the age	Unfair treatment /Unlawful discrimination	Which protected grounds
Someone can't register with because is Gypsy		
A local authority social services department mustn't take longer to assess someone needs because he is a Romanian Traveller.		
Someone finds it difficult to communicate with hospital staff because the hospital doesn't provide interpreters;		
A private care home refuses to accept someone because is gay;		
A social worker is verbally abusive towards someone because the person is a transsexual.		
Someone complains about the treatment of his disabled mother to the manager of her care home. As a result, they increase her fees which they know he is paying for.		

(http://www.adviceguide.org.uk/wales.htm)

3. Moral chooses according to the ethical values

Activity 3.1: What are ethical values?

Read the Code of Ethics for Nurses about the nurses' ethical responsibility when the nurse is aware of inappropriate or questionable practice in the provision or denial of health care and make a list of the ethical values.

Activity 3.2: What are the best ways to demonstrate moral courage?

Study case
"A Hospital surgery unit requires patients to provide proof of address when registering. This applies to all new patients regardless of their protected characteristic. But Gypsies and Travellers are less likely to be able to provide a proof of address and therefore they'll find it more difficult to register."

Using the table of critical checkpoints below, analyze, in group, the situation presented above and explain the actions for each step and what is the best ways to demonstrate moral courage?

Steps	Checkpoint	Explanation
1	Evaluate the circumstances to establish whether moral courage is needed in the situation	
2	Determine what moral values and ethical principles are at risk or in question of being compromised	
3	Ascertain what principles need to be expressed and defended in the situation – focus on one or two of the more critical values	
4	Consider the possible adverse consequences/risks associated with taking action	
5	Assess whether or not the adversity can be endured – determine what support/resources are available	
6	Avoid stumbling blocks that might restrain moral courage, such as apprehension or over reflection leading to reasoning oneself out of being morally courageous in the situation	
7	Identify the ways to develop moral courage in practice	

(Adapted from Kidder, 2005, p.17 *Critical Checkpoints in using Moral Courage for Ethical Decision Making*)

Which action did you choose in this case?

a) To try to solve the problem?
b) To discuss with the person carrying out questionable practice?
c) To report the ethical violations to an administrator within the organization?
d) To report to a higher authority outside the organization?

4. Expression and action

Activity 4.1: What action do I need to take against discrimination?

You have made decision to resolve the issues presented in Study case below by discussing them with the doctor, nurses or the unit manager.

Make an **complaint**, by talking with unit manager, about this discrimination against Gypsies and Travellers in their healthcare, including the following things in your conversation:

a) a description of the services provided;
b) the names and job titles of the people involved;
c) a short description of what happened;
d) the date and time of the incident;
e) a description of how the incident affected Gypsies and Travellers;
f) what you want the organisation to do now - for example review a decision already taken
g) when you expect a reply.

Activity 4.2: Developing Risk Tolerance*.*

Numerous healthcare situations call for courage. What is common to all of these situations is the fear that may be experienced as the practitioner considers the cost of the action and the consequences of a particular intervention or of getting it wrong. There may be fear of an extreme emotional reaction, of violence, of contamination, of negative reactions from colleagues, or of losing one's job. Such fears may inhibit nurses and other practitioners from acting ethically. Lachman (2009) cited Albert Einstein as saying, "the world is a dangerous place, not because of those who do evil, but because of those who look on and do nothing" (p. 3). As discussed above, organisational constraints may cause nurses to feel as though they lack the courage to do the right thing or raise concerns about poor standards of care. One danger or hindrance to moral courage is that of ethical incompetence. Ethical competence requires cognitive strategies, including the ability to analyze and thoughtfully respond to a moral problem unrestrained by automatic responses and belief/emotional fixations (Sporrong, Arnetz, Hansson, Westerholm, & Hoglund, 2007). In other words, ethical competence demands emotional control which enhances insight into both the situation and one's reaction to the situation. Another danger to moral courage is that of risk aversion. Moral courage requires the willingness to take risks that leave one vulnerable to harm or loss.

By taking actions in the situation below, you accepted some risks and consequences. Identify and discuss about:

a) What risks and consequences could be for you taking these actions?
b) What could the consequences if you "look on and do nothing"?
c) What are your fears which may inhibit you from acting ethically?
d) What do you need to handle with your fear?

Activity 4.3: How to act in response to the fear

Discuss with other colleagues about the "worst case scenario" of a risk you are ready to take when during the actions of and realize a plan to deal with the worst possible outcome, going through these steps:

e) Identify the risk you want to take
f) Identify the situational fear you experience
g) Determine the outcome you want and what you have to do to achieve this outcome
h) Identify resources accessible to you
i) Take action

(*Adapted from Vicki D. Lachman,(2010) - Steps to overcome your fear.)*

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ADDESSMENT COMPONENT

3.1 Practical assessment
Final assessment: Presentation of courageous action in different situations of unfair treatment or unlawful discrimination.
Will be assessed: practical skills and capacity of building an action plan against discrimination and the values promoted : respect, tolerance, dignity and rights of patients.
Each trainee is to be assessed against the provided assessment sheet, which is to be completed by the trainer / assessor.
When the assessment has completed, the trainer give feedback to the trainees on their performance
Resources: *Assessment Sheet*

EVALUATION COMPONENT

The participants in piloting the tool (student nurses and registered nurses) will take part in the evaluation.
The evaluation criteria are :

- Does tool helps students progress through their learning goals?
- Is it practical and easy to use by both teachers/trainers and students?
- Is it relevant, innovative and important to students learning pathway?

Evaluation will be made trough an evaluation questionnaire containing a set of questions following with what extend the learning tool meet the criteria above.
The report on the evaluation will be shared to the trainers' team and will conduct a meta-analysis of results, to identify the main themes which will guide the revision of the tool.
Resources: *Evaluation Questionnaire*

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Peake, F.A. (2006). *Moral courage.* Montana: Kessinger Publishing.

TAYLOR G., PAPADOPOULOS I., DUDAU V., MAERTEN M., PELTEGOVA A. & ZIEGLER M. (2011) Intercultural education of nurses and health professionals in Europe (IENE). *International Nursing Review***58**, 188–195

The Edunet Courage Tool Evaluation

CRITERIA	FULLY MET	PARTLY MET	NOT MET
a) Contained customised steps to help students progress through their learning goals	96%	4%	0
b) Provided observable evidence of learning	83%	17%	0
c) Clarified what students knew and did not know	84%	16%	0
d) Allowed the teacher to see/hear (and intervene) when students did not understand	94%	6%	0
e) Led to and connected with other tools in the process of meeting larger /higher level learning goals	74%	26%	0
f) Helped students synthesize knowledge and meaning	84%	16%	0
g) Provided building blocks that enable students to step into and through difficult concepts or processes to reach predetermined learning goals	93%	7%	0
h) Provided pathways that led to depth and clarity in learning	89%	11%	0
i)Adds to the meaning-making in the classroom	78%	22%	0

NB: When the percentages do not add up to 100%, this indicates that some participants did not rate the specific item/s.

19. I am a student / qualified healthcare participant — 87

20. I am a teacher/trainer

21. I am a patient

Students' Comments:

It is relevant to nurse's profession.
Very relevant to nursing training programmes.

Lifelong Learning Programme

This project has been funded with support from the European Commission

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The Azienda Ospedaliera Universitaria Senese Courage Tool & Evaluation

by
Maurilio Pallassini, Maria Luisa Verzuri, Norvegia Belardinelli, Monica Bianchi, Lore Lorenzi and Claudia Rustici
Italy

BEYOND THE FEAR

THEORETICAL COMPONENT

Principles and Values

Courage is a virtue that is necessary to the dutiful practice of all healthcare providers; particularly courage supports the nurses in the daily practice of their profession. Characteristics that promote moral courage in nursing are: self-awareness and interpersonal awareness, emotional self-control, danger management, moral integrity, compassion, respect.

Aims

To strengthen the self-awareness, self-control and fear and anger management
To enforce ethical-deontological competence and relational competence
To enhance ethical attitude-behaviour based on courage

Learning outcomes

Participants will able to:

- identify and describe professional dangerous situation and contingency;
- describe own experience in dangerous situation;
- report about self and other people's awareness;
- identify and describe ethical obligation appropriated to the dangerous situation;
- identify, describe and simulate technical skill of cognitive reframing and self-soothing;
- identify, describe and simulate technical skill of improvement of the risk tolerance;
- report about conflict between daily professional life and ethical obligation;
- identify, describe and simulate technical skill of assertiveness communication and negotiation;

Relevant definitions and terms/ What the research says

Moral courage: individual's capacity to overcome fear and stand up for his/her core values (Lachman VD. (2007). Moral courage: A virtue in need of development? MedSurg Nursing Journal, 16(2), 131-133)

Moral integrity: to feel good about oneself in a fundamental way, to perceive oneself as both a professional who does good work and as a person of character who strives to live a moral life (Laabs CA. (2007). Primary care nurse practitioners' integrity when faced with a moral conflict. Nursing Ethics, 14(6), 795-809)

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Davidson PM. Daly J. Hill MN. (Oct 2013) Editorial: Looking to the future with courage, commitment, competence and compassion. J Clin Nurs; 22(19-20):2665-7
Abstract: healthcare systems are in a state of flux and change. Globally, there are pressures to meet the increasing and diversifying healthcare needs of individuals and populations. Contemporary healthcare delivery must be responsive to epidemiological transitions, increasing globalisation and the intensifying politicisation and scrutiny of health care. Nurses have a choice – to either be passive recipients of reconfigured healthcare systems or be change agents applying their skills to assure that healthcare models are person-centred, interdisciplinary, evidenced based and outcome focused.

Lindh IB. Barbosa da Silva A. Berg A. Severinsson E. (Sept 2010) Courage and nursing practice: a theoretical analysis. Nurs Ethics;17(5):551-65

Abstract: this article aims to deepen the understanding of courage through a theoretical analysis of classical philosophers' work and a review of published and unpublished empirical research on courage in nursing. The authors sought answers to questions regarding how courage is understood from a philosophical viewpoint and how it is expressed in nursing actions. Four aspects were identified as relevant to a deeper understanding of courage in nursing practice: courage as an ontological concept, a moral virtue, a property of an ethical act, and a creative capacity. The literature review shed light on the complexity of the concept of courage and revealed some lack of clarity in its use. Consequently, if courage is to be used consciously to influence nurses' ethical actions it seems important to recognize its specific features. The results suggest it is imperative to foster courage among nurses and student nurses to prepare them for ethical, creative action and further the development of professional nursing practices.
.
Lachman VD. (Sept 30, 2010) Strategies Necessary for Moral Courage. OJIN: The Online Journal of Issues in Nursing; Vol.15, No.3, Manuscript 3. In: http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/JournalTopics

Abstract: moral courage involves the willingness to speak out and do that which is right in the face of forces that would lead a person to act in some other way. In this article the author discusses the *CODE* acronym she has created to help nurses remember key components for actualizing moral courage. After introducing the virtue of moral courage, the author presents strategies to operationalize moral courage, organizing the discussion around the *CODE* acronym. “C ” represents the courage (moral courage), the willingness to overcome fear and stand up for core values. The “O” reminds nurses of their obligation to adhere to the American Nurses Association *Code of Ethics for Nurses*, which delineates nurses’ ethical responsibilities in a variety of circumstances. The “D” is for danger management, with a focus on developing cognitive strategies and overcoming risk aversion. Because moral courage is essentially an act, the “E” reflects the expression and action component. Assertiveness and negotiation strategies are presented along with clinical examples.

Murray JS. (Sept 30, 2010) Moral Courage in Healthcare: Acting Ethically Even in the Presence of Risk. OJIN: The Online Journal of Issues in Nursing; Vol. 15, No. 3, Manuscript 2. In: http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/JournalTopics

Abstract: examples of unethical behaviours are seen today in academia, politics, sports, entertainment, banking, and the legal system. Healthcare professionals working in clinical practice, education, research, and administration are not immune to these unethical

behaviours. They face ethical dilemmas on a regular basis. Shortages in the numbers of clinicians to deliver patient care, inadequate staffing levels, cost containment measures, consolidation of healthcare organizations, and ineffective leadership have resulted in the escalation of ethical dilemmas nurses face today in healthcare environments. How individuals respond to these ethical dilemmas depends on their previous experiences with unethical behaviour, their individual personality traits, and their ethical values, as well as their knowledge of ethical principles.

Edmondson C. (Sept 30, 2010) Moral Courage and the Nurse Leader OJIN: The Online Journal of Issues in Nursing; Vol. 15, No. 3, Manuscript 5. In: http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/JournalTopics

Abstract: today's nurse leaders practice in very complex environments. This complexity leads to value conflicts and creates the potential for moral distress. Jameton's sentinel work framed the concept of moral distress as arising when one knows the morally right thing to do, but cannot do so because of organizational constraints. In this article the author reviews sources of moral distress among nurse leaders, discusses the nurse leader's responsibility for demonstrating and supporting moral courage, identifies threats to moral courage among nurse leaders, offers strategies to promote moral courage, and makes recommendations for the continuing development of moral courage.
Gallagher A. (March 21, 2010) Moral Distress and Moral Courage in Everyday Nursing Practice. OJIN: The Online Journal of Issues in Nursing; Vol. 16 No. 2. In: http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/JournalTopics

Abstract: In this article the author examines the concepts of moral distress and moral courage within the context of nursing practice. Examples of challenging healthcare situations from the United Kingdom and Ireland are discussed in the light of the examination of these two concepts. The examples illuminate features of healthcare situations that need to be considered in relation to different organisational and cultural contexts. This requires an understanding of the complexity of clinical contexts and an appreciation of the fallibility and vulnerability of nurses and other practitioners. The goal of this article is to encourage healthcare organisations to create supportive structures and sensitive leadership that will enhance moral courage in the work setting.

What the legislation/treaties/conventions says on the topic

Decreto Ministeriale 14 settembre 1994, n°739
Regolamento concernente l'individuazione della figura e del relativo profilo professionale dell'Infermiere. Gazzetta Ufficiale del 9 gennaio 1995, n°6.
In: http://www.ipasvi.it/archivio_news/leggi/179/DM140994n739.pdf

Codice Deontologico dell'Infermiere.
Approved by Comitato Centrale della Federazione IPASVI by resolution n.1/09, January 10, 2009 and from Consiglio Nazionale dei Collegi IPASVI in the meeting of January 17, 2009.
In: http://www.ipasvi.it/norme-e-codici/deontologia/il-codice-deontologico.htm

Commentario al codice deontologico dell'Infermiere.
Edited by Federazione Nazionale dei Collegi degli Infermieri IPASVI.
In: http://www.ipasvi.it/norme-e-codici/deontologia/commentario.htm

The international code of ethics for nursing by the International Council of Nurses (ICN)

The international code of ethics for nursing adopted by the International Council of Nurses in 1953. Revised in 2012.
In: http://www.cnai.info/index.php/estero/icn/codice-deontologico

Code of Ethics for Nurses – American Nurses Association (ANA)
The Code of Ethics for Nurses was developed as a guide for carrying out nursing responsibilities in a manner consistent with quality in nursing care and the ethical obligations of the profession. In: http://www.nursingworld.org/codeofethics

ANA Position Statements on Ethics and Human Rights
The position statements from ANA regarding Ethics and Human Rights. In: http://www.nursingworld.org/MainMenuCategories/
Ethics Standards/Ethics-Position-Statements. Of particular interest: Cultural Diversity in Nursing Practice. This statement describes the features of an operational definition of cultural diversity as it is expressed in nursing practice, education, administration and research.
In: http://www.nursingworld.org/MainMenuCategories/EthicsStandards/Ethics-Position-Statements/prtetcldv14444.html

International Council of Nursing Fact Sheet: ICN on Health and Human Rights
ICN Nursing Matters fact sheets provide quick reference information and international perspectives from the nursing profession on current health and social issues. In http://www.icn.ch/images/stories/documents/publications/fact_sheets/10b_FS-Health_Human_Rights.pdf

What do local policies say?

Delibera n° 697 del 14 luglio 2003 della Giunta Regionale della Regione Toscana. Il Patto con il cittadino: repertorio di impegni per la Carta dei servizi sanitari con relativi indicatori e standard.
In: http://www.usl7.toscana.it/index.php/amministrazione-trasparente/servizi-erogati/standard-di-qualita

Carta dei Servizi - Azienda Ospedaliera Universitaria Senese: carta dei diritti e dei doveri degli utenti
In: http://www.ao-siena.toscana.it/carta_diritti_utenti.htm

PRACTICAL COMPONENT

Theoretical approach, individual definitions of courage, group discussion on different point of view, framework of cognitive aspects. Recall of professional deontology.

Strengthening of emotional self-awareness of fear and helplessness.
Moral courage: analysis and identification of practical aspects.

Practical activities

Analysis of risk situations and identification of practical solutions based on brave behaviours. Discussion on different approaches.

Management strategies of the danger: cognitive reframing, self-soothing techniques, risk tolerance.

Relational techniques: assertiveness and dialogue.

Analysis of the different behaviours in in critical situation through a problem based learning approach.

Watching short videos on several critical topics: look after non-EU aggressive patients, communication of unexpected and 'negative' events, managing conflicts among nurses-patients and nurses-nurses.

ASSESSMENT COMPONENT

Teachers: anthropologist, clinical educationalist, tutors (nurses, obstetricians and representation of foreign associations) will create a questionnaire (open-ended questions) to identify what has been learned. Participants, 20 nurses working in different wards, will answer individually and later they will discuss together on the various responses.

Participants will be divided into two groups and elaborate two projects on how nurses can show courage and deliver compassionate care to patients.
The components of the groups will be trainers for the next courses on the basis of the developed projects.

20 groups of 15 health-care workers from wards that are more impacted by foreigners (emergency, urgent medicine, gynaecology, orthopaedics, paediatrics, and later all other wards) and 5 students from the three-year degree programme in nursing will participate in the following editions of the course.

Evaluation through systematic observation (low degree of structure) carried out directly by the teachers for the full duration of the toolkit. The survey for the exploration of learning outcomes produces a true and complete description of the conditions in which it occurs.

EVALUATION COMPONENT

The evaluation of the toolkit is carried out by the learners, teachers and patients (in the following courses). The evaluation is oriented to the recognition of the originality of the techniques and new contents learned in relation to estimates the effects in the employment context.

Effective achievement of learning goals (theoretical and practical)
Quality of the theoretical content
Quality of teaching activities and facilitation
Relevance and quality of materials used.
Time Management

A questionnaire will be carry out in order to understand if the tool allow students to do a self-evaluation on what they have learned and to show how to be courageous.

During group works participants will discuss on their knowledge about courage and how show their courage in different situations. Teachers will observe the behaviours of nurses during the demonstrations.

Satisfaction questionnaire administered at the end of the toolkit will be fill in by patients. At a distance of two months will be conducted a re-valuation of effective achievement of learning goals. (Theoretical and practical)

A report on the evaluation will be created by teachers and the results will be useful to make changes to the tools, if needed.

The Azienda Ospedaliera Universitaria Senese Courage Tool Evaluation

CRITERIA	FULLY MET	PARTLY MET	NOT MET
a) Contained customised steps to help students progress through their learning goals	91%	9%	
b) Provided observable evidence of learning	92%	8%	
c) Clarified what students knew and did not know	83%	17%	
d) Allowed the teacher to see/hear (and intervene) when students did not understand	90%	10%	
e) Led to and connected with other tools in the process of meeting larger /higher level learning goals	84%	16%	
f) Helped students synthesize knowledge and meaning	88%	12%	
g) Provided building blocks that enable students to step into and through difficult concepts or processes to reach predetermined learning goals	85%	15%	
h) Provided pathways that led to depth and clarity in learning	90%	10%	
i)Adds to the meaning-making in the classroom	92%	8%	

NB: When the percentages do not add up to 100%, this indicates that some participants did not rate the specific item/s.

22. I am a student / qualified healthcare participant — 15

23. I am a teacher/trainer — 5

24. I am a patient —

Students' Comments:

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The Volkssolidaritat Courage Tool & Evaluation

by
René Hildebrandt, Karin Senf and Friederike Jung
Germany

1ST AID COURAGE COMPASS IN CASES OF DEATH

THEORETICAL COMPONENT

Principles and Values

• nurses are confronted with high emotional situations, e.g. cases of death
• courageous acting
• overcoming of fear
• comprehension
• assistance
• heartiness
• empathy

Values
• humanity
• tolerance and acceptance
• dignity
• equality

Aims

Nurses should feel safe and supported by us in every situation of their daily work. So they could fully focus on the care.
Sometimes courage is needed. Especially high emotional situations, such as finding a dead patient, require often courageous acting/overcoming fears in order to don‘t become incapable of action. We like to support and to promote courageous acting.

Learning outcomes

When you have worked through this tool, you will be able to:
1. I‘m not alone in emotional incriminating situational.
2. There are many ways of assistance with it I don‘t have to handle alone the death of a patient.
3. I‘m exactly aware of what I have to do in a case of death.
4. Through the safe acting with the deceased I can approach courageous these situations.
5. I won‘t have disadvantages if I can not or will approach these situations alone. Asking for help is not a sign of weakness or unprofessionally.

Relevant definitions and terms/ What the research says

Courage is not an explicit content in the German care literature and education. Even if courageous acting is often required in their daily work because working with human beings is

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always afflicted with uncertainty and unpredictable situations. How will I react to the patient today? Will s/he react aggressive or is s/he may be deceased in the meantime? Confronting these uncertainties requires courage.

Generally courage is defined in the German language use as follows:

Courage:
Courage, also daring or spiritedness, means that you are able and willing to dare something. That means that you betake to a situation which is connected to danger, uncertainty. (de.wikipedia.org)
Courage is the ability, to overcome your fear in dangerous and risky situations. Fearlessness in a situation in which you could have fear. (duden.de)
Kreisverband Gera e.V.
(General) Willingness to do the right thing in contrast to prospective disadvantages. (duden.de)

Basic forms of courage after the Swiss psychotherapist Andreas Dick:

- physical courage (danger of a possible damage to life or physical condition
- ethical or social courage (danger of a possible social exclusion)
- psychological or existential courage (danger of a possible destabilisation of the personality)

Research findings regarding the issue

Could not find any.

What do national legislation and international/European treaties and conventions say on the topic?

Penal Code Non-Assistance Help §323c
Reasonability of help
You can only be punished for non-assistance of a person in danger, when the help is even reasonable for the helper. Every person is committed to help on her best possible way. Which type of help is reasonable depends among others on:

- personality of the helper
- their psychological and mental strengths in the critical moment
- their experience of life and education (a doctor could help more than a non-medical layman).

Reasonable in the event of a case is:

- acceptance of a business disadvantage
- relatively small chance of injury

To neglect help
The necessary and reasonable help has to be supplied, not just any help. Otherwise it does not depend on, if the imminent danger is really fulfilled. Who neglect help, remains even punishable after paragraph 323c StGB when accidentally another person frees the victim of the emergency.

What do local policies say?

Care guidelines of the Volkssolidarität contains following relevant contents
• We as a team of nurses, care helpers and federal volunteers face up the charge of care for ill,old and disabled people, where themself or private helpers can‘t do this or to support private helpers and relatives.

• For us is especially important: motivation, creative contribution and shaping, to take self dependent initiative but also to know about your own limits and care about your health.

PRACTICAL COMPONENT

Practical activities

Every student or nurse get the 1st Aid Courage Compass. The trainer/mentor-nurse supplies and explains it use and meaning starting with the overall aim:
Nurses should feel safe and supported by us in every situation of their daily work. So they could fully focus on the care.
Sometimes courage is needed. Especially high emotional situations, such as finding a dead patient, require often courageous acting/overcoming fears in order to don‘t become incapable of action. We like to support and to promote courageous acting.

Mentioning of the learning aims:
1. I‘m not alone in emotional incriminating situational.
2. There are many ways of assistance with it I don‘t have to handle alone the death of a patient.
3. I‘m exactly aware of what I have to do in a case of death.
4. Through the safe acting with the deceased I can approach courageous these situations.
5. I won‘t have disadvantages if I will approach these situations alone. Asking for help is not a sign of weakness or unprofessionally.
Every nurse should carry now a 1st Aid Courage Compass; thereby s/he has it available in every situation to conflict with general standards.

ASSESSMENT COMPONENT

• Theoretical Assessment
• Practical Assessment
Both are possible for the piloting. Now we do only theoretical assessment. The content/ standards will be proofed every two years in a working group. The care head manager will conduct a minimum of one conversation with a concerned nurse after finding a deceased.

EVALUATION COMPONENT

• Whole nurse staff of the Volkssolidarität Gera and maybe also the staff of the Volkssolidarität Jena.
• What should be evaluated?
Quality of the 1st Aid Courage Compass
Will learning aims be achieved?
Usability
• Evalutation with the standardised data sheet
• Results should be used for improving the 1st Aid Courage Compass or its use. Compass can be shared with other divisions of the Volkssolidarität.

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The Volkssolidaritat Courage Tool Evaluation

CRITERIA	FULLY MET	PARTLY MET	NOT MET
a) Contained customised steps to help students progress through their learning goals	44%	46%	6%
b) Provided observable evidence of learning	30%	44%	16%
c) Clarified what students knew and did not know	22%	50%	4%
d) Allowed the teacher to see/hear (and intervene) when students did not understand	40%	28%	
e) Led to and connected with other tools in the process of meeting larger /higher level learning goals	50%	50%	
f) Helped students synthesize knowledge and meaning	54%	68%	
g) Provided building blocks that enable students to step into and through difficult concepts or processes to reach predetermined learning goals	68%	24%	
h) Provided pathways that led to depth and clarity in learning	60%	32%	
i)Adds to the meaning-making in the classroom	48%	30%	

NB: When the percentages do not add up to 100%, this indicates that some participants did not rate the specific item/s.

25. I am a student / qualified healthcare participant — 10

26. I am a teacher/trainer — 30

27. I am a patient — 10

Students' Comments:

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The Albeda College Courage Tool & Evaluation

by
Marga Hop
The Netherlands

THEORETICAL COMPONENT

Principles and Values

In our multicultural society, nurses and caregivers are expected to deliver a qualitatively high standard of care regardless of the culture of patients, and to uphold the interests of patients. Healthcare professionals are exposed to standards, values and customs with which they are unfamiliar. Sometimes these are in conflict with their own standards and values. Thus, how do you uphold the interests of those individuals? How do you protect some one against unfair treatment? How do you identify what really matters to those individuals and what do you do in situations that are in conflict with your own values or the values of the organisation for which you work?

It requires professional courage to demonstrate ethical behaviour in such situations and to uphold the interests of others.
In the Netherlands, we have the Nationale Beroepscode van Verpleegkundigen en Verzorgenden[1]. This code of conduct is an aid for healthcare professionals in terms of how to manage moral dilemmas. Healthcare professionals will repeatedly have to weigh up what might be the right approach in presenting situations.

For the purposes of this exercise, professional courage is defined as: the courage to address issues based on one's own morals.
Having courage means standing up for your beliefs and the desire to do the right thing. You take responsibility for demonstrating your professional values, even at the risk of suffering consequences personally.

Educational principles:

- Exploration of experiences
- Exploration of the concept
- Self-reflection
- Collaborative learning
- Stimulation of curiosity
- Practising with methodology

The tool is also informed by the following values:
- Caring
- Compassion
- Justice
- Integrity
- Accountability
- Equality

[1] V&VN /NU 91 January 2007, Nationale Beroepscode van Verpleegkundigen en Verzorgenden

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Aims

Using a step-by-step plan, students learn how to respond courageously to an issue and/or address a particular situation.
The objective of the workshop centres on the first segment, namely **Cultural Awareness** as per the Papadopoulos, Tilki Taylor Model for developing intercultural competence in the care sector.

Learning outcomes

- Students recognise their own preconceptions and stereotyping behaviour
- Students recognise (moral) dilemmas.
- Students are familiar with and understand the concept of 'moral and professional courage' and can reflect upon this
- Students are familiar with the code of conduct as per the Nationale Beroepscode van Verpleegkundigen en Verzorgenden
- Students use the guidelines to devise actions regarding (moral) dilemmas.
- Students can explain the difference between being courageous, being arrogant and wanting to be proven right

Relevant definitions and terms/ What the research says

1. *S. Murray, J., PhD, Online journal of issues in nursing, vol. 15, no.3 September 2010, Moral Courage in Healthcare: Acting Ethically Even in the Presence of Risk*

In this article, moral courage is defined. Furthermore, the author describes ongoing discussions related to moral courage, moral arrogance and moral certitude, explains how to recognise moral courage and offers some strategies for developing and demonstrating moral courage when facing ethical challenges. In describing the discussion, the author refers to the Code of Ethics for Nurses from the American Nurses Association (ANA)
Moral courage is defined as the pinnacle of ethical behaviour; it requires a steadfast commitment to fundamental ethical principles despite potential risks, such as threats to reputation, shame, emotional anxiety, isolation from colleagues and loss of employment. The awareness of factors that support/inhibit moral courage can be of help in facing ethical challenges and upholding ethical environments. Some useful instruments are provided, such as a list of critical checkpoints in using moral courage for ethical decision and a table offering examples of inhibitions on moral courage. In this lesson, this list used as an instrument to reflect on moral decision-making.
http://www.nursingworld.org/MainMenuCategories/EthicsStandards/Courage-and-Distress/Moral-Courage-and-Risk.html#Defined

2. *Marlies Van Der Zande, Andries Baart, Frans Vosman, Journal of Advanced Nursing, Volume 70, Issue 1, pages 68–76, January 2014, Ethical sensitivity in practice: finding tacit moral knowing*

This article adds a broadened perspective on ethical sensitivity, focusing primarily not on decision-making, but on daily care practices in their institutional context. Empirical research on care practices – more than just on decision-making – enhances the awareness of both explicit moral knowledge and tacit moral knowing of the professional caregiver. Investigating tacit moral knowledge is far from easy and has methodological consequences for, and influence on the research design.
http://onlinelibrary.wiley.com/doi/10.1111/jan.12154/full

Increasing self-management and self-reliance

3. *Program Visible Link, a research report by Petra Kanters/ Sanneke Wichgers/ Elly Verblaauw. HRO/Rotterdam University of Applied Sciences. December 2012*

The "visible link" ZonMw's[2] program is funding 96 projects throughout the Netherlands for the deployment of extra community nurses so that they are able to perform duties additional to their officially indicated tasks. The community nurses in the 'Visible Link' projects provide care in the broadest possible sense of the word. They are a visible presence in the community and easily accessible to all. They know the people in the neighbourhood and local community services, and they are aware of the local environment. This enables them to help quickly and bring in the right organisations and support when needed. The "Visible links" often work in complex situations. Dealing with this complexity demands professional action and courage on different levels at the same time.

4. *Legislation and regulations in respect of the* ***Beroepscode Verpleegkundige en Verzorgende Beroepen (code of conduct)***
   In addition to the principles of the profession, the Beroepscode van Verpleegkundigen en Verzorgenden describes the relationship between the nurse and the patient, other caregivers and the community.

In article 2, relationship with the patient; it states that every patient has the right to care, and specifically states that ethnic origin, nationality, culture, age, gender, sexual orientation, race, religion, ideology, political conviction, socio-economic status, physical or mental disability, nature of health issues or lifestyle may not influence whether and what care someone receives.[article 2.1]

The caregiver is central and the nurse upholds the interests of the patient.[article 2.2]

Provision of care is tailored as far as possible to the needs, standards and values, cultural and ideological views of the patient [article 2.3]

In article 3, the relationship with other patients is described, with specific reference to the nurse protecting the patient against unethical, incompetent, unsafe or otherwise lacking provision of care from other caregivers.[article 3.6]

Nationale Beroepscode van Verpleegkundigen en Verzorgenden [The Code; Standards of conduct, performance and ethics for Nurses]
http://www.venvn.nl/Portals/20/publicaties/20070112beroepscodeposterdef.pdf

5. *Quality of Health Facilities Act*
The Quality of Health Facilities Act (KWZ) describes the individual responsibilities of care institutions to provide a qualitatively high standard of care within the global context.

Four criteria are described; 1. responsible care 2. quality-focused policy

[2] ZonMw is the Netherlands organisation for health research and development

3. quality systems and 4. annual report.

Institutions are obliged to develop policy in relation to these 4 aspects. The Inspectorate supervises implementation.

In real terms, this means institutions are accountable for the care offered and that they are responsible for the quality and training of staff members.
http://www.igz.nl/onderwerpen/handhaving_en_toezicht/wetten/kwaliteitswet_zorginstellingen

5. Individual Healthcare Professions Act (BIG Act)

Professionals practising independently are subject to the Individual Healthcare Professions Act [BIG Act]

This legislation defines the framework for the training requirements with which a Nurse must comply, as well as a nurse's individual responsibilities in terms of activities carried out. A nurse may only conduct activities in which he/she is competent and qualified. It demonstrates professional courage when a nurse indicates not to want to conduct an activity because he/she feels unqualified, or asks questions in response to an order from a doctor because this is unclear or inappropriate.

http://www.igz.nl/onderwerpen/handhaving_en_toezicht/wetten/wet_big/

PRACTICAL COMPONENT

The lesson requires no preparation. During the lesson, you work on the subject with your fellow students and the tutor. The lesson comprises 2 sessions of 50 minutes.
During the classroom discussions the teacher uses the Powerpoint presentation "Professional and Moral Courage".

The objective of the lesson is *to create awareness* of the meaning of professional courage in the care sector (PTT Model of Cultural Awareness) in general and in relation to diversity and multiculturalism.

Cultural Awareness and Courage

Activity 1:
Explore the concept of 'moral and professional courage' using the multicultural casuistry introduced by the tutor.

In order to act with courage, it is necessary to examine what is understood by professional courage. Using the casuistry introduced by the tutor, the concepts of moral and professional courage are explored, at the same time observations are underpinned with theoretical explanations. The casuistry is general to start with and is continually extended.

Case study 1

You see someone stealing something from a patient.

(This case study is continually extended. E.g. does it matter who the thief is? Does it matter if you know the thief is experiencing financial difficulties?)

This case study is used as the basis for a classroom discussion.

What is an intercultural dilemma?

What are standards and values? (What people find important. Behaviour)

What does having 'moral courage' mean? (Morals are closely associated with outlook on life, are often culture-bound).

Outcome

Highlights that diversity in thoughts and actions is possible. There is no single solution. The abovementioned determines how the person experiencing the situation reacts.

Case study 2

You see your supervisor/colleague seating someone in a chair somewhat heavy handedly. The patient is crying and has a bruise.

Answer the following questions in relation to this case study.

What is the code of conduct for caregivers?

How could you use this?

What does having professional courage mean? (courage that is based on the code of conduct, that transcends culture)

Explanation of the step-by-step model:

1 Evaluate the circumstances to establish whether moral/professional courage is needed in the situation.

2 Determine what moral/professional values and ethical principles are at risk or in question of being compromised.

3 Ascertain what principles need to be expressed and defended in the situation.

4 Consider the possible adverse consequences/risks associated with taking action.

5 Assess whether or not the adversity can be endured – determine what support/ resources are available.

6 Avoid stumbling blocks that might restrain moral courage, such as apprehension or over-reflection leading to reasoning oneself out of being morally courageous in the situation.

7 Continue to develop moral courage through education, training and practice.

The step-by-step model is taken from "Critical Checkpoints in using Moral Courage for Ethical Decision Making" by Day, L (2009)

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Outcome:

Students are familiar with and understand the step-by-step model.

Case study 3

A patient wants to give you a painting. This lady is of Afghan origin. You know that refusing a gift is considered a great insult in that culture.

Answer the following questions in relation to this case study.

What course of action would you follow?

Why would you follow this course of action?

What do you need in order to know what you should/can do in this situation?

What thoughts go through your head as you consider whether to do something or not?

What factors determine whether you do something or not?

What is the difference between being courageous, being arrogant and wanting to be proven right?

Outcome:

Students are able to apply the step-by-step plan in a given situation.

Activity 2

Two videos are viewed in a classroom setting with the aim of identifying one's own/ others' preconceptions and stereotyping behaviour.

Outcome:

No one is free of preconceptions and use of stereotyping. Students recognise their own preconceptions and stereotyping behaviour that plays a role in their behaviours (Iceberg theory)

Activity 3

Students draw on casuistry from their own practice and use the step-by-step plan as an aid to explore how the situation can be addressed in a way that upholds the interests, values and standards of the patient.

Students are aware of and can describe various possible outcomes. After all, being courageous is also determined by one's own moral compass.

After exploration in small groups, the situations examined are discussed by the class as a whole.

Appreciation and respect for the views of others forms an important point of departure. Probing and exploratory questions ensure deepening of the learning gained.

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Outcome:

Students can apply the theoretical step-by-step plan to their own situations in practice.

ASSESSMENT COMPONENT

Formative assessment:

1. Reflection with the aid of a questionnaire.
2. Using the casuistry as a basis, have students describe a situation via the step-by-step plan.

EVALUATION COMPONENT

1. A feedback questionnaire that allows students/tutors to evaluate the lesson.

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The Albeda College Courage Tool Evaluation

CRITERIA	FULLY MET	PARTLY MET	NOT MET
a) Contained customised steps to help students progress through their learning goals	84%	16%	
b) Provided observable evidence of learning	73%	23%	4%
c) Clarified what students knew and did not know	91%	9%	
d) Allowed the teacher to see/hear (and intervene) when students did not understand	91%	9%	
e) Led to and connected with other tools in the process of meeting larger /higher level learning goals	89%	11%	
f) Helped students synthesize knowledge and meaning	95%	5%	
g) Provided building blocks that enable students to step into and through difficult concepts or processes to reach predetermined learning goals	91%	9%	
h) Provided pathways that led to depth and clarity in learning	84	14%	2%
i)Adds to the meaning-making in the classroom	91%	9%	

NB: When the percentages do not add up to 100%, this indicates that some participants did not rate the specific item/s.

28. I am a student / qualified healthcare participant — 41

29. I am a teacher/trainer — 3

30. I am a patient —

Students' Comments:
It was a good lesson. I didn't know that discrimination is so common in society and that it is embedded in our language.

It was a nice lesson, i learned a lot. Discrimination and diversity are interesting subjects

Good lesson, problems are recognizable, good solutions and a very current theme

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The Marmara University Hospital Courage Tool & Evaluation

by
Serpil Tural
Turkey

THEORETICAL COMPONENT

Principles and Values

The identification of nursing concepts has facilitated theory development and the growth of nursing knowledge, which has led to many nursing advancement. Many concepts have being identified and inquired in nursing, yet there are some that still remain unexplored; one of these concepts is courage.

Courage still remains undefined in nursing. Spencer and Smyth (2007) stated that courage is a concept that remains invisible in nursing, Yet it is essential to the advancement of nursing practice (Spencer, and Smythe 2007). While, Day (2010) stated that "Courage is a virtue that is necessary to the conscientious practice of all health care providers" (Day, 2010). It is the virtue that leads nurses to develop other virtues and skills like leadership, advocacy, commitment, caring, and conflict resolution amongst others. Without courage, nursing would be a robotic job that implies following orders without any regards for the patients health care outcomes. According to Thomas (2007), courage is a requirement to be a leader. "Leaders must consistently find the courage to hold true to their beliefs and convictions" (Thomas, 2003). Today's nursing leaders need to be courageous to face the politics of the health care systems and improve nursing for the future. Without courage nurses would have no voice in society and as a profession.

The principles:

- Learning from each other
- Valuing experience
- To be innovative
- Team working
- Equality
- Tolerance
- Personal development
- Fostering curiosity

The tool is also informed by the following values:

- Caring
- Dignity
- Justice
- Respect
- Knowledge

Aims

1. To understand the need for courage in nursing practice,
2. To recognize the courage,

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3. Evaluate your courageous behaviour from your own experience,
4. To understand what time would necessary to show courage,
5. To understand which abilities require to have courage,
6. To understand the relationship between the confidence and courage.

Relevant definitions and terms/ What the research says

Courage is considered one of the four cardinal virtues, and it has been valued throughout the history of human kind as an important moral virtue. Spence and Smythe stated that the word courage derives from the old French word “corage” which means “heart” and “spirit”. Corage latin origin is “Cor” meaning “more at heart”. The word courage is still associated with inner strength (Spence and Smythe 2007) and inner power. According to this etymology, courage seems to derive from feelings that arise from within the heart and can provoke a fighting spirit. The APA Dictionary of Psychology (2007) defined courage as “The ability to meet a difficult challenge despite the physical, psychological, and moral risks involved in doing so” (The APA Dictionary of Psychology, 2007, p.239).

Courage is a virtue vital for good nursing, and has brought many benefits and advancements to the nursing profession, yet it has received little credit as a nursing skill. Making courage visible to nursing, can help incorporate it as part of the skills training for nurse leaders in nursing schools. This can bring further advancement to the nursing profession. Also, Having a courageous character can benefit patients since it provokes them to be more willing to take treatments and fight illnesses. The literature review identified physical courage, moral courage, psychological courage, and civil courage as different extensions of courage, and it reinforced that moral courage is the one necessary for nursing. It also identified caring, knowledge, and the ability to overcome fears as some of the defining attributes of courage. The willingness to have a courageous character can be provoke by confidence and a sense of duty, and it can lead to self esteem boosts and good learning experiences. Currently, only a few qualitative methods have been identified to study the phenomena of courage in nursing. It is harder to measure courage with quantitative methods because it is subjective in nature, and people experience it differently, depending on their values, believes, and cultures. More studies need to be done to incorporate courage as a nursing concept, and to identify tools and therapies that can entice courage in patients. Courage needs to be recognized as a necessary skill in the health care systems, and it needs to be incorporated as part of the skill training in nursing schools; specifically at the masters and doctoral level.

According to Thomas (2003), courage is a skill that can be learned, with the proper training one can learn to control fears and make the right choices (Thomas, 2003). Training nurses to be courageous and stand up for their values is what leads nurses to become great caregivers, great leaders, and great advocates.

Defining attribute

A defining attribute of courage is caring. Peterson,S and Bredow,T (2009) defined caring as a “nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility” (Peteson, S. Bredow, T, 2009. p.193). The feeling of caring and feeling connected to someone or something leads to willingness to make sacrifices to protect what is loved and cared for. Caring is a crucial component of courage. Without caring, there is no need for courage, and without courage, caring does not last; the sense of duty and responsibility is lost because the person lacks the courage to do what it takes to provide the caring. Caring is a concept widely recognized in nursing, yet the concept of courage is often overlooked. Caring about the patients and the profession can bring positive changes, but only when there is the courage to provoke the changes. The sense of responsibility that

nurses have towards their patients and the profession is what has driven generations of nursing leaders to be courageous and work on research, theories, and hospital policies to re-shape the nursing profession.

Another defining attribute of courage is knowledge. Having knowledge builds confidence, and confidence provokes acts of courage in the face of injustice. “Knowing” how to react when necessary exemplifies courage. Aristotle believed that knowledge and experience is what differentiates courage from recklessness. He stated that acts base on knowledge are courageous, whereas acts without knowledge are a compulsion and not brave. He exemplified it with courageous soldiers that prepared for battle by learning the art of war and fighting techniques, and also by preparing themselves physically and mentally (Aristotle revised trans 2009, III.8). Though the art of nursing is different from the art of war, nurses also need to be knowledgeable to be prepared to confront the everyday challenges that the nursing profession brings. Acts of moral courage are based on knowledge. The nurse needs an understanding of morals and values to differentiate between right and wrong and to assess the need to intervene and protect what is valued. Without the proper knowledge, the nurse may be reckless and not know how to act to reach the valued objective. Also, having partial knowledge can lead to embarrassments and self-ridicule; a nurse boycotting against abortions in front of a hospital that does not perform elective abortions can be discrediting and will not bring any benefits to the abortion cause.

Overcoming fears is also a defining attribute of courage. Per the literature review, to commit a courageous act, one must first overcome fears. Fears are a physiological response to threats causing a chemical reaction in the body that leads to the fight or flight response. This chemical reaction gets the body ready to act, however, the action that follows depends on the person’s core values and ability to cope. If the fears are not overcome, then the action may be labelled as cowardice instead of courage. According to the Encyclopaedia of Ethics (2001), Cowardice is the opposite of courage and is consider a vice in most cultures. Cowardice is failing to act properly because of fears, whereas, courage requires to control the emotion of fear and act appropriately in an given situation; and it rejects the idea that courage is the absence of fears (Encyclopaedia of Ethics, 2001, p. 353-354). Aristotle mentioned that acts done without fear are not courageous acts, and the person that has no fears is not courageous, but does not care and has lost love for life itself (Aristotle revised trans 2009. III.7).

In earlier research focused on illuminating the qualities essential for advancing nursing practice, Spence (2004a) identified several key "C" words including: **C**onfidence, **C**ognitive **c**apacity and Clinical **c**redibility. Yet there seemed to be something missing. Something else was required to overcome the myriad of factors that constrained the advancement of practice. Further thinking, dialogue and reading suggested that another, perhaps more significant quality, that of **courage** (Spence, 2004b) was critically important.

Considerable courage exists in the everyday world of nursing practice on multiple levels. Delmar (2004) has argued convincingly that courage and readiness are essential to the development of moral competence in nursing. Walston (2003) suggests that the courage of nurses in hospital environments is tested daily as they attempt to balance the requirements of bureaucracy with the nurturing and humanitarian philosophies underpinning their profession, and Williams (2000), speaking collectively of New Zealand's nurse leaders, identified a pattern of attitudes, beliefs and responses that has ensured the continued primacy of the nurse in driving nursing forward. Seeing courage 'as' a particular way of responding as a nurse helps to illuminate its less tangible dimensions.

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PRACTICAL COMPONENT

Methodology: We started with head nurses from different clinics in hospital. After sharing the tool about courage by presentation, the training was continued with group study and workshop. At the end of study with head nurses, we selected the volunteers who will be mentors or role models to other nurses to disseminate the courage tool and share his or her experiences with young nurses about courage behaviour. Both methods facilitate the exploration of courage as a nursing skill through real nursing stories and experiences.

Group study- Discussion:

Activities:

1- **Self-awareness:**
What is the meaning of courage for you?
Courage as a Response to Threat or Challenge
Give an example for a courageous person in your mind,

What is your courage level?
We asked the participants to write a story of a time when they had to act courageous, then gave them a questionnaire about feelings and thoughts that they experienced before and during the act. This method seems more effective in measuring antecedents that lead to courageous acts.

Relationship between confidence and courage?
Courage as Requiring Confident Knowing
Discussion: why people know but they don't do anything?

2- **Relationship between sensitivity and courage**? What is your preference: to say nothing, to say something but do nothing, or to speak up and move…
If your answer is third option, it requires having knowledge and good communication skills.

3- **Decision making process**:
a) Define the problem,
b) Assess the ethical situation,
c) Evaluate the options,
d) Search the possible results,
e) Decide to action,
f) Evaluate the results.

4- **Be mentor (Rol Model)** Nurses can develop a courageous character with some training. According to Aultman (2007), health care providers can learn to have moral courage through modelling and mentoring by having ethics committees, continuing of ethics education, and policy development updates (Aultman, 2007).

Courage, a capacity for sustained commitment, the acceptance of continual challenge and the ability to champion one's cause are essential to advancing nursing practice. Nurses can and do act courageously. They must 'en-courage' each other and be 'encourage-d' by others to do so.

Courage can be learned and built into the character through training and practice

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Learning together (experiential learning)
Share your stories about courage with young nurses who are little experienced.

Case analysis about courage in nursing: Model case
A 59 year old Male is admitted to the telemetry unit on a Thursday night with complaints of chest pain, elevated cardiac enzymes, EKG changes, critical BUN and creative levels, and electrolyte imbalances. The Cardiologist wants to do a cardiac angiogram, but the procedure is placed on hold due to the kidney function because the dye will further damage his kidneys. The nephrologist on consult sees the patient on Friday afternoon, diagnoses him with acute renal failure, and orders Intervention Radiology to place a Quinten catheter to start patient on haemodialysis as soon as possible. Intervention Radiology only take cases until five PM from Monday to Friday and close on the weekends. Because the order was placed on such late notice, the procedure will not be done until Monday. The nurse calls the Interventional Radiology manager to see if there is anyway that it can be done on Friday, but the manager is not able to help. The attending physician is informed, he orders Cardiovascular surgery to be on consult for placement of the Quinten catheter. The cardiovascular surgeon states that the consult will be done in the late evening because the operating room cases take priority. The cardiologist then schedules the angiogram for Monday.

At three pm the patient gets diaphoretic and starts complaining of severe chest pain. Upon assessment, there are changes in the vital signs. The nurse orders a stat EKG and gives the patient morphine and nitro-glycerine 0.5mg sublingual time three doses. The patient confirms alleviation of symptoms with the interventions. The cardiologist is informed, but states that the angiogram cannot be done until the dialysis catheter gets placed. At five PM the patient has another episode of chest pain in which the above interventions are repeated and the patient's pain level improves again. The cardiologist is informed again, but now he is infuriated over the phone call, and the answer remains the same. At six thirty PM the patient has a third episode of chest pain, but this time, the nurse senses panic in the patient's eyes as the patient holds her hand and says, "Help me". The nurse then calls a rapid response to get the arrhythmia nurse and the MICCU nurse in the room. Then she goes over the cardiologist head and pages the cardiac fellow to come and evaluate the patient. Upon assessment, the cardiac fellow states, "If we do not do an angiogram now there will be no need for the kidneys". The patient is rushed to the angiogram and then transferred to the intensive care unit. While the patient is getting an angiogram, the nurse goes over the cardiovascular surgeon's head and calls the head of surgery. The head surgeon sends the cardiovascular surgeon on call to place the dialysis catheter at the same time as the angiogram is being done. The nurse then proceeds to inform the nephrologist so that dialysis can be scheduled after the procedure. Two of the doctors were furious with the nurse, but the patient's life was saved.

This case represent the moral courage that nurses express on a daily basis to protect their patients, and their licenses. It also includes the defining attributes of courage. The nurse displays caring through her sense of responsibility and commitment to meet the patient's health care needs. She does everything in her power to prevent the delay of care, from calling the Intervention Radiology manager in an attempt to accelerate the process, to going over two of the consulting physicians heads to increase the patient's survival chance. The nurse caring attributes drive her to display courage and stand up for the patient's right to live; even at the expense of potential failure. Knowledge is also displayed in the above case. The nurse uses her knowledge to examine the situation, then, based on this knowledge she decides to act. Her intuition and experience is telling her that the patient is having a myocardial infarct, and that something needs to be done promptly. The doctors on consult are not listening to her so she calls a rapid response to get nurses with more experience and

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knowledge in the room to assist. Then, based on her knowledge of the chain of command, she decides to call the cardiac fellow and the head surgeon to get help for the patient. Her knowledge of the situation reinforced her ability to overcome her fears. Overcoming fears is another defining attribute that is displayed in the case. The nurse has the knowledge to act, but still has to overcome the fears of angry co-workers and retaliation. She knows that bypassing the doctors will infuriate them and can have potential consequences for her career, but base on her professional knowledge, if she does not act, the patient will not make it through the night. The nurse then chooses her sense of duty to protect her patient over fear of angry co-workers.

Contrary Case

Continuing with the above case, when the patient holds the nurse's hand and says "help me", the nurse picks up on the patients panic, but does not know what to do. She already called the cardiologist twice and got yelled at for doing so. The nurse proceeds to tell the patient that she is doing everything in her power to help him, and that he has to wait for the cardiovascular surgeon to place the catheter. She then proceeds to give the patient more morphine and nitro-glycerine. two hours later, the nurse received a phone call from central telemetry informing her that the patient is sustaining ventricular tachycardia. The nurse rushes to the room and finds the patient unconscious; she calls the code blue and starts resuscitation attempts. By the time the code blue team gets to the room the patient is in ventricular fibrillation. Further attempts to resuscitate the patient continues for twenty minutes, and then the patient gets pronounced death. The nurse may have the defining attribute of caring, but lacks the courage to do extraordinary measurement to save the patient's life. The cardiologist had yelled at her for the continuous calling, and so, she is afraid to call again. Also the defining attribute of knowledge is lacking in this case. The nurse might know-based on her experiences-that the patient is in trouble, but she does not know how to help him. She might not know that there is a cardiac fellow on call or an arrhythmia nurse available to help, and so she does not intervene due to the lack of knowledge. The nurse is also not able to overcome her fears. She is too afraid to advocate for the patient, and call others for help. Even if she does not know about available resources, she can always resort to her manager or team leader for further assistance, but she does not do so for fear of demoralization and being labelled incompetent.

EVALUATION COMPONENT

Learner evaluation, the learner should evaluate the tool in how it has assisted learning and what has been learned. This stage of evaluation should focus on awareness of courage.

Trainer evaluation: trainers should evaluate the tool through observing learning activities that demonstrate learners' developing skills in relation to displaying confidence and courage, focusing on how they make decisions in relation to the need to convey concerns about unsatisfactory care.

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The Marmara University Hospital Courage Tool Evaluation

CRITERIA	FULLY MET	PARTLY MET	NOT MET
a) Contained customised steps to help students progress through their learning goals	22	13	1
b) Provided observable evidence of learning	22	14	
c) Clarified what students knew and did not know	19	17	
d) Allowed the teacher to see/hear (and intervene) when students did not understand	31	5	
e) Led to and connected with other tools in the process of meeting larger /higher level learning goals	19	16	1
f) Helped students synthesize knowledge and meaning	21	15	
g) Provided building blocks that enable students to step into and through difficult concepts or processes to reach predetermined learning goals	19	17	
h) Provided pathways that led to depth and clarity in learning	22	14	
i)Adds to the meaning-making in the classroom	27	9	

NB: When the percentages do not add up to 100%, this indicates that some participants did not rate the specific item/s.

31. I am a student / qualified healthcare participant — 32

32. I am a teacher/trainer — 4

33. I am a patient —

Students' Comments:

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Toolkit Three

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The Middlesex University Intercultural Communication Skills Tool & Evaluation

by
Alfonso Pezzella, Laura Foley, Sandra Connell, Irena Papadopoulos
United Kingdom

INTERCULTURAL COMMUNICATION TOOL

THEORETICAL COMPONENT

Principles and Values

Intercultural communication can be referred to as how people from different cultures languages, social and economic backgrounds, beliefs and regions come together to communicate (Ivliyeva, 2013).

The principles and values that guide this tool include:

- Genuine Curiosity
- Flexibility
- Open mindedness
- Tolerance
- Valuing experience
- Courage
- Acceptance
- Respect
- Patience

Aims

The aim of this tool is to develop your understanding of culture, and the need for awareness in intercultural communication. You will be engaged in learning through reflection, knowledge acquisition and practical activities.

Learning outcomes

When you have worked through this tool, you will be able to:

- Articulate the need for the focus on intercultural communication in current nursing practice;
- Discuss the theoretical underpinnings of intercultural communication, and the meaning of intercultural communication from different viewpoints;
- Reflect on your own practice in relation to the ability to display intercultural communication;
- Reflect on when it might be desirable to communicate competently at an intercultural level;
- Identify strategies to nurture confidence in your own practice when communicating with people from different cultures.

Relevant definitions and terms/ What the research says

What do we mean by culture?

In considering intercultural communication, it is important to first define what we mean by culture. There are multiple definitions, however Leininger (1997 cited in Bach and Grant, 2009 P126) provide a useful definition as “A common collectivity of beliefs, values, shared

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understanding and patterns of behaviour of a designated group of people. Building on from this, Bach and Grant (2011: P127) view culture as "a learned social experience that is often handed down through generations, thus providing a continuing connectedness with others in a community… there may be differential status roles and yet individuals connected within the culture are regarded as like-minded persons, whereas someone who is not part of the culture can be treated with mistrust and suspicion. A wide consideration of culture can include individuals, groups, organisations and professionals. Being open to the variety of values and beliefs that each culture may have can also enhance cooperative relationship (Sully and Dallas, 2010). This gives us a wider understanding of culture in the context of historical and societal perspectives. While understanding the cohesive elements of a culture, it is important to also be mindful of the individuality of people that we work and communicate with. Failure to recognise uniqueness and failure to understand that all individuals from a culture will not necessarily have the same values and beliefs can result in stereotyping (Elder et al, 2009).

Why do we need an understanding of culture?

The frequency of migration raises the importance of understanding multiculturism, which refers to the coexistence of many diverse cultural groups with one heterogeneous society (Bach and Grant, 2009). Cultural diversity related to matters such as ethnic origin, race, gender, geographic location, economic status, nationality, language, politics and religion (Bach and Grant, 2009). Healthcare professionals in the UK work with people from many different cultures and backgrounds, which highlight the need for healthcare professionals to not only have an understanding of different cultures, but also be aware of how to communicate competently with people from different cultures. Indeed, staff themselves will be culturally diverse, who will have their own cultural values that may influence decisions and allocation of tasks (Bach and Grant 2009). This requires culturally sensitivity, which Thompson (2001, cited in Bach and Grant 2009) highlights as preventing alienation and invalidation of people, while also preventing key issues being missed.

Intercultural Communication

Intercultural communication is communication across cultures and social groups. It involves the understanding of different cultures, languages and customs of people from different cultures (Wikipedia). It can be referred to as how people from different cultures languages, social and economic backgrounds, beliefs and regions come together to communicate (Ivliyeva, 2013).

According to Ivliyeva (2013) the skills of communication in general are what we use in intercultural communication. In addition, intercultural communication includes non-judgemental and active listening, clarification and summarising as well as respecting others.

The issue of culture is a complex matter, which has an impact on the delivery of care, and also how healthcare teams work together. Nurses need to be able to communicate with knowledge of culturally appropriate language; an awareness of the impact of culture on values and behaviours is needed (Bach and Grant, 2011).

Leininger (1978) identified three potential supports for communication with diverse cultural groups, these include:

- *Cultural preservation*: This refers to recognition of health practices specific to a culture, which may be helpful or harmful. This requires attention to artefacts that should be respected and considered when addressing the individual's health.
- *Cultural Negotiation*: Negotiation between both sides i.e. healthcare professionals and the individual, their family etc. to establish differences in goals, to establish shared understanding and a way forward. This may for example include considering issues such as

making eye contact with a person, which may signify avoidance for one individual, but is a display of respect for another.

- *Cultural patterning*: this relates to intervening to change patterns of behaviour which are having a negative impact on the person's health. This may include consideration of any legal aspects as well as the individual's wishes.

The way in which practitioners communicate with individuals from different cultures takes skill. According to Sully and Dallas (2010), practitioners need to have awareness of the differences in communication styles of the people the work with, who may be from a diverse range of cultures. However, stereotyping needs to be avoided, practitioners should not just consider that a person from a specific culture will require specific considerations, and must look at the individuals themself.

Sully and Dallas (2010) also recommend the use of reflection and self-awareness skills by the practitioner, in order to challenge any generalisations and stereotypes they might hold.

Language, tone of voice, speed and pronunciation are all key elements of effective communication, which also should be considered when working across cultures (Sully and Dallas, 2010). The use of touch, personal space, hand gestures or eye contact can vary greatly between cultures, something which practitioners need to be aware of as well.

Sully and Dallas (2010) also identified some key areas:

- *Self-disclosure:* this may vary between different groups, and the relevance they place on it. The practitioner must emphasis the important of sharing specific information to ensure vital information is gained.
- *Demonstrating respect:* in a number of cultures, making eye contact with a person in authority for example can be seen as disrespectful; Professionals need to have an awareness of matters such as this, to avoid conflict through misunderstanding.
- *Values and beliefs:* how we relate to others is deeply influenced by our cultural heritage, values and beliefs.

Finally, Ivliyeva (2013) discussed three phases to becoming a skilled intercultural communicator:

- *(Intercultural) Knowledge*: Knowledge of cultural values, beliefs, characteristics and behaviours
- *(Intercultural) Awareness*: This comes from having intercultural knowledge, which promotes flexibility and openness, influencing attitude and behaviour
- *(Intercultural) Understanding*: This enables the individual to recognise and respond to people in ways that otherwise may result in miscommunication due to cultural differences.

What does national legislation and international/European treaties and conventions say on the topic?

In the UK, the Nursing and Midwifery Council (NMC) have recently published a revised Code on professional standards of practice and behaviour for nurses and midwives. The Code (2015) contains standards that must be upheld by all UK nurses and Midwives. Four key areas are identified: Prioritise People, Practice Effectively, Preserve Safety and Promote Professionalism and Trust, each of which is elaborated in further detail to guide practice. The requirement of cultural sensitivity is noted under the section 'Practice Effectively'- '7- Communicate Clearly':

7.2: Take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own and other people's needs.
7.3: Use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to peoples personal and health needs.
7.5 Be able to communicate clearly and effectively in English.

The NHS Constitution (2013) states that in providing care:

…we respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relive suffering. We find time for those we serve and work alongside. We do not wait to be asked, because we care… . (page 5)

What do local policies say?

At Middlesex University we value people. We aim to create a positive change by making a lasting impression on society, business and the wider world around us. Our focus is academic excellence through excellent teaching, learning and research. We embrace innovation, creative and practical thinking, investing in our students, staff and the facilities they need to make a dramatic impact on teaching and research. Our mission is to produce a growing community of staff, students and partners who make valuable contribution to economic, cultural and social wellbeing of the societies in which they live and work.

In terms of Equality and Diversity, Middlesex University is committed to becoming an equality and diversity employer. It is important that people from all groups in society are represented at all levels of employment. This is important both for the success and development of the institution and for the provision of role models.

Employment policy at Middlesex will strive to:

- eliminate unfair discrimination at each stage of the recruitment process and throughout an individual's period of employment;
- act positively, to redress discriminatory practices;
- develop patterns of work, which encourage and enable the redress of institutional employment imbalances;
- ensure that all employees and all those acting on behalf of Middlesex University are aware of, trained in, and abide by the Equality and Diversity Policy.

PRACTICAL COMPONENT

Practical activities

The importance of ensuring clarity of communication cannot be underestimated for the multidisciplinary team. You must be able to ensure that messages are delivered and understood as intended, while understanding the possibility that meaning might be misconstrued due to cultural reasons.

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Cultural awareness

Activity 1: *Chinese Whispers*

One student will be given the phrase "*"Nurses dispense comfort, compassion, and caring without even a prescription" as said by Val Saitsbury.* They will then whisper it to another student, and so on until the message has been relayed to everyone in the group. The last person to receive the message will be asked to say it aloud, to see whether the message has remained the same, or if it has been altered. By the end of the activity, the students may realise that the original message has been changed along the way. This will highlight the potential for messages being misconstrued if not clearly communicated.

Consider the following questions after completing the activity:

- Discuss why this might happen in an intercultural team.
- Consider if you have ever experienced this within your team as a result of intercultural misunderstanding?
- What steps can be taken to reduce the probability of misunderstanding?

Cultural Knowledge and Understanding

Activity 2: *Navigating intercultural communication*

Watch the following video:
https://www.youtube.com/watch?v=PSt_op3fQck
Then consider the following questions:

- Discuss your understanding of intercultural communication.
- What, if any, intercultural experiences (interacting with people of different cultures) have you had?
- How anxious are you when you have to talk to someone from a different cultural background from you? Why?
- How confident do you feel when you have to talk to someone from a different culture? What is it that gives you this confidence?
- What are the main points you have learned from watching this short video and use in your own practice?

Cultural sensitivity

Activity 3: *Working together*

Consider the following scenario and discuss the issues that arise. An English student nurse reported that she felt isolated and 'left out' whilst on placement. This was because the majority of staff and students were of African descent. She said that they often spoke in their own language, and when she approached the office where they were, she felt that she was not welcomed as they either continued talking or laughed and ignored her. As she could not understand she assumed this was about her. They would also often share their food and not include her. She felt sad and hurt by this, and wanted to be a part of the team, but did not know how.

Discuss in your group the following questions:

- What are the main factors causing the student to feel isolated?
- If you were this student, how might you address this problem with the team?

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- What actions can the team make to ensure they include all members of the team regardless of culture?

Cultural Competence

Activity 4: *Tools for practice*.

Thinking about what you have learnt today, in small groups come up with 10 Top Tips for communicating competently at intercultural levels.

Following the group's final decision on 10 Top Tips, spend some time reflecting on the process:

- Did you agree with the final 10 top tips?
- Was there any disagreement within the group about what should be in the final list?
- Why was this?
- How did the group overcome this?

ASSESSMENT COMPONENT

Formative assessment:
Group reflection based on experience from practice, using the content of what has been learned today to guide reflection, identify learning that has occurred, and also future needs.

Summative assessment:
Learning from this tool will be assessed as part of the module within which the tool is embedded.

EVALUATION COMPONENT

1. Self-administered evaluation questionnaire: the learner should evaluate how the tool has assisted learning through an evaluation questionnaire.

2. Peer evaluation: Peer learning groups should discuss their use of the tool, how it has assisted learning and what has been learning. This stage of evaluation should focus on knowledge gained regarding intercultural communication and how they may apply this learning in the work environment.

3. Teacher evaluation: teachers should evaluate the tool through observing classroom activities that demonstrate students developing skills in intercultural communication.

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INTERNET RESOURCES

HTTPS://WWW.YOUTUBE.COM/WATCH?V=PST_OP3FQCK

HTTPS://WWW.YOUTUBE.COM/WATCH?V=LQQTOYSTME4

WHEN YOU LISTEN TO THE FOLLOWING VIDEO REPLACE THE WORDS "BUSINESS" WITH THE WORD "HEALTHCARE"
HTTPS://WWW.YOUTUBE.COM/WATCH?V=NVUU34KZDRG

THERE ARE MANY MORE SHORT VIDEOS ON YOUTUBE

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The Middlesex University Intercultural Communication Skills Tool Evaluation

CRITERIA	FULLY MET	PARTLY MET	NOT MET
a) Contained customised steps to help students progress through their learning goals	100%		
b) Provided observable evidence of learning	98%	2%	
c) Clarified what students knew and did not know	99%	1%	
d) Allowed the teacher to see/hear (and intervene) when students did not understand	100%		
e) Led to and connected with other tools in the process of meeting larger /higher level learning goals	100%		
f) Helped students synthesize knowledge and meaning	100%		
g) Provided building blocks that enable students to step into and through difficult concepts or processes to reach predetermined learning goals	96%	4%	
h) Provided pathways that led to depth and clarity in learning	97%	3%	
i)Adds to the meaning-making in the classroom	96%	4%	

NB: When the percentages do not add up to 100%, this indicates that some participants did not rate the specific item/s.

I am a student / qualified healthcare participant	43
I am a teacher/trainer	6
I am a patient	

Students' Comments:

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The Edunet Intercultural Communication Skills Tool & Evaluation

by
Victor Dudau
Romania

BARRIERS AND CHALLENGES TO INTERCULTURAL COMMUNICATION

All interpersonal communication contains possibilities of ambiguity and misunderstanding, but possibilities of misunderstanding and poor communication become much bigger when we communicate throughout a cultural boundary. Intercultural communication makes easier social interaction and mutual understanding of different culture representatives.

Nowadays new demands are being made on health care professionals to demonstrate appropriate transcultural sensitivity. They should be able to communicate with clients who speak different languages and come from distinct cultural backgrounds. This tool is for students to learn effective intercultural communication on their own or with others. It is developed in the framework of the project Tools for Intercultural Education of Nurses in Europe (IENE 3) by a team of psychologists, trainers.

THEORETICAL COMPONENT

Principles and Values

Ethical values that underpin this tool: honesty, integrity, fairness, respect, responsibility, empathy, compassion.
The tool helps students to understand and to be able to apply values such as:
- Right to equal access to care and treatment;
- Right to information;
- Right to explanation appropriate to the patients capacity of understanding;
- Right to informed consent;
- Right to free choice;
- Right to privacy and confidentiality;
- Right to dignity;
- Right to observance of quality standards.

The principles which inform the methodology derive from the previous work on the Papadopoulos, Tilki and Taylor model of transcultural nursing and cultural competence (1998, 2006) and the Model Intercultural Education of Nurses in Europe (IENE1 & IENE2 projects www.ieneproject.eu), as well as other principles of intercultural education which can be found in the literature.
These are:

- Respecting the cultural background and identity of the learner by relating learning to their previous knowledge and experiences;
- Providing equal access to learning by eliminating discrimination in the education system and by promoting an inclusive learning environment;
- Promoting learning which encourages the understanding of personal values and the development of self awareness, both of which form the basis for reflective communication and co-operation across cultures and social boundaries;
- Promoting a critical approach regarding the power linked to the production and

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use of knowledge to either oppress or emancipate people;
- Encouraging the establishment of peer learning communities for support and the exchange of knowledge and experiences;
- Promoting the understanding and tolerance of others and their cultures, the acceptance of diversity and the inclusion of others.

Aims

The tool —*Barriers and challenges to intercultural communication*- aims to help nurses and other health care professionals to define communication concepts, recognize barriers and challenges to intercultural communication with patients and families and develop intercultural communication competence.

Learning outcomes

At the end of this training, the participants will be able :
1. To define intercultural communication concepts;
2. To identify knowledge, attitudes and skills that indicate intercultural communication competence;
3. To understand the importance of cultural sensitivity and intercultural communication
4. To define own communication style and habits;
5. To identify barriers and challenges to intercultural communication with patients and families;
6. To describe strategies for effective intercultural communication;
7. To demonstrate behaviors that indicate intercultural communication competence in care.

Relevant definitions and terms/ What the research says

Culture

1) Culture: Values, ideas and other symbolic meaningful systems that are transmitted and created by a group of people. (Preschool English Learners);

2) Culture: the total sum of the ways of people' life including norms, learned behavior patterns, attitudes and artifacts; also involves traditions, habits or customs; how people behave, feel and interact; the means by which they order and interpret the world; ways of perceiving, relating and interpreting events based on established social norms; a system of standards for perceiving, believing, evaluating and acting (English Teachers to Speakers of Other Languages, Inc.
(TESOL);

3) Culture: the set of learned beliefs, values, styles and behaviors, generally shared by members of a society or group. (Alabama Archaeology);

4) Culture. The patterns of daily life learned consciously and unconsciously by a group of people. These patterns can be seen in language, governing practices, arts, customs, holiday celebrations, food, religion, dating rituals and clothing. (Equal Opportunity Office, Texas);

5) Culture. The ever-changing values, traditions, social and political relationships, and world view shared by a group of people bound together by a combination of factors that can include a common history/herstory, geographic location, language, social class and religion. (*Sonia Nieto, Affirming Diversity: The Sociopolitical Context of Multicultural Education, Longman, 1992*);

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6) Culture: The system of shared beliefs, values, customs, behaviors, and artifacts that the members of society use to cope with their world and with one another, and that are transmitted from generation to generation through learning (Bates and Plog);

7) Culture: Behaviour peculiar to Homo sapiens.. Includes language, ideas, beliefs, customs, codes, institutions, tools, techniques, works of art, rituals, and ceremonies, among other elements. (Encyclopaedia Britannica);

Communication

1) Communication is the process of conveying information from a sender to a receiver with the use of a medium in which the communicated information is understood the same way by both sender and receiver. It is a process that allows organisms to exchange information by several methods. Communication requires that all parties understand a common language that is exchanged, There are auditory means, such as speaking, singing and sometimes tone of voice, and nonverbal, physical means, such as body language, sign language, paralanguage, touch, eye contact, or the use of writing. Communication is defined as a process by which we assign and convey meaning in an attempt to create shared understanding. (*Baumeister, R. F., & Leary, M. R. (1995). The need to belong: Desire for interpersonal attachments as a fundamental human motivation.Psychological Bulletin 117, 497-529*.

2) There are 3 major parts in any communication which is body language, voice, tonality and words. According to the research, 55% of impact is determined by body language, postures, gestures, and eye contact, 38% by the tone of voice, and 7% by the content or the words used in the communication process. Although the exact % of influence may differ from variables such as the listener and the speaker, communication as a whole strives for the same goal and thus, in some cases, can be universal. (*Mehrabian and Ferris,'Inference of Attitude from Nonverbal Communication in Two Channels' inThe Journal of Counselling Psycology Vol.31, 1967,pp.248-52*);

3) Communication: The successful transmission of information through a common system of symbols, signs, behavior, speech, writing, or signals.(*Massachusetts Department of Elementary and Secondary Education*);

4) Communication is the exchange of ideas, opinions and information through written or spoken words, symbols or actions. (*1995-2002 by Pearson Education*);

5) Communication - The ability to make understood wants and needs using verbal language, sign language, gestures, facial expression, computers, or a combination of methods.(*Riley Child Development Center*);

6) Communication is a movement of matter or energy between two parts of the universe. This matteror energy can be a carrier of information. Verbal communication is based on language and use of expression, the tone in which the sender of the message relays the communication can determine how the message is received and Along with these attributes verbal communication is also accompanied with non-verbal cues. Example of non-verbal cues: facial expressions, hand gestures, use of objects, body movement

Intercultural communication

Intercultural communication is a form of communication that aims to share information across different cultures and social groups. It is used to describe the wide range of

communication processes and problems that naturally appear within an organization or social context made up of individuals from different religious, social, ethnic, and educational backgrounds. Intercultural communication is sometimes used synonymously with cross-cultural communication.

Intercultural communication competence

Intercultural communication is competent when it accomplishes the objectives in a manner that is appropriate to the context and relationship. Intercultural communication thus needs to bridge the dichotomy between appropriateness and effectiveness:
• *Appropriateness.* Valued rules, norms, and expectations of the relationship are not violated significantly. This means that your behaviours are acceptable and proper for the expectations of any given culture
• *Effectiveness*. Valued goals or rewards (relative to costs and alternatives) are accomplished.

The components of intercultural competence

Motivation:
This has to do with emotional associations as they communicate interculturally. Feelings which are your reactions to thoughts and experiences have to do with motivation. Intentions are thoughts that guide your choices, it is a goal or plan that directs your behaviour.

Knowledge:
· This has to do with the vast information you have to have on the person's culture that you are interacting with. This is important so you can interpret meanings and understand culture-general and culture-specific knowledge.
Attitude:
- Display of interest: showing respect and positive regard for the other person;
- Orientation to knowledge: terms used by people to explain themselves and their perception of the world;
- Empathy: Behaving in ways that shows you understand the world as others do. interaction management: A skill in which you regulate conversations;
- Task role behaviour: initiate ideas that encourage problem solving activities;
- Relational role behaviour: interpersonal harmony and mediation;
- Tolerance for ambiguity: The ability to react to new situations with little discomfort;
- Interaction posture: Responding to others in descriptive, non-judgemental ways.

Skills:
- Proficiency in the host culture language: understanding the grammar and vocabulary;
- Understanding language pragmatics: how to use politeness strategies in making requests and how to avoid giving out too much information;
- Being sensitive and aware to nonverbal communication patterns in other cultures;
- Being aware of gestures that may be offensive or mean something different in a host culture rather than your own home culture;
- Understanding a culture's proximity in physical space and paralinguistic sounds to convey their intended meaning.

Traits that make for competent communicators:
- ❖ Flexibility.
- ❖ Tolerating high levels of uncertainty.
- ❖ Reflectiveness.
- ❖ Open-mindedness.

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- Sensitivity.
- Adaptability.
- Engaging in divergent and systems-level thinking.

PRACTICAL COMPONENT

Activity 1: Defining culture

Activities:

1. Reviewing some existing definitions of culture;
2. Write definitions of culture on coloured papers;
3. Participants split into four small groups and start from the word —culture - then participants say two words that they associate with the word —culture. Those two words are taken further and four more associations are added, all the way until the web has eight words. Then the web goes down from four to two and then to one word. At the end a single word closes the web;
4. Participants should discuss how our perception of —culture‖ led us to another meaning of the same thing. This exercise —describes the groups' understanding of Culture;
5. Presenting the group understanding of culture;
6. Trainer presents 7 different definitions (See above 1.4.1) of culture for participants' comments.

Activity 2: Understanding communication?

1. Brainstorming session on definition of communication: each participant choose one word which comes to their mind when they hear —communication‖. Trainer notes the words down on a flipchart paper.
2. Participants split into small groups and create a common definition with using the words or meaning of the words they associated. Afterwards, groups should present their definitions to others.
3. Each group should be provided with a handout containing definitions of communication (see above 1.4.2). They have to decide which definition fits best with their own definition. It should be a common decision.

Activity 3. What are some barriers & challenges to communication?

- Barriers and challenges may arise at any point during interaction: reasons, motivations, goals and plans, contradictory goals when needs conflict, cognitive skills inadequate, goals change if there's a history of failure.
- Barriers arise because perception: low level of accuracy, discrimination, inaccurate stereotypes, errors of attribution—too much, too little, halo effects— perceiving people as consistently good, bad.
- Barriers arise because translation, technical language, idioms, slang, dialect, limited languages, proficiency, no linguistic equivalent
- Barriers arise because culture shock, anxiety that results from losing familiar signs and symbols. Stages of culture shock: honeymoon phase, culture shock, recovery, adjustment.
- Barriers arise because ethnocentrism, notion that one's culture is superior to any other, negative or derogatory evaluations of anything that's different, political, moral, religious.

Give examples of barriers & challenges to communication with patients:

1. Language;
2. Gender roles, family structure;
3. History of the culture, e.g. tribal warfare, ethnic cleansing;

4. Views of causes of illness;
5. Experience with medical systems;
6. Understanding, acceptance of treatment;
7. Ethnocentrism, prejudice, stereotyping;
8. Nonverbal communication patterns.

Activity 4: What do we need to develop intercultural communication competence?

Develop knowledge of other cultures and their understandings of illness, life and death, and their communication styles:
- knowledge of other cultures' views of illness, life, death;
- knowledge of way to explain, treat, and prevent illness, suffering, death, dying, life;
- knowledge of causes of illness;
- knowledge of treatments, naturalistic medicine, alternative medicines;
- know the values that cause conflict majority, minority culture;
- knowledge of interplay of religion, spirituality in healthcare;
- knowledge that culturally determined family roles, dominance patterns, modesty, female purity, pregnancy, childbirth, end of life, knowledge of prevention, immunizations, healthy living, avoid violating cultural taboos;
- knowledge of interplay of religion, spirituality in healthcare: astrology, fatalism, charms and amulets.

Which values are characteristic for a majority and for a minority culture? Please, tick the most appropriate.

Major culture		Minor culture
☐	*Master over nature*	☐
☐	*Personal control over environment*	☐
☐	*Doing/ activity*	☐
☐	*Time dominates*	☐
☐	*Human equality*	☐
☐	*Youth valued*	☐
☐	*Competition*	☐
☐	*Harmony with nature*	☐
☐	*Fate determines one's destiny*	☐
☐	*Being orientation*	☐
☐	*Personal relationships*	☐
☐	*Group welfare*	☐
☐	*Future orientation*	☐
☐	*Informality*	☐
☐	*Direct, open, honest*	☐
☐	*Practical, efficiency*	☐
☐	*Materialism*	☐
☐	*Past, present orientation*	☐
☐	*Formality*	☐
☐	*Indirect, "face," ritual*	☐

Activity 5 Developing intercultural sensitivity

The Developmental Model of Intercultural Sensitivity (DMIS) was created by Milton J. Bennett, Ph.D., (1986, 1993) as a framework to explain the reactions of people to cultural

difference.
Bennett describes six stages of development in intercultural sensitivity.
The first three stages are considered —ethnocentric in that one's own culture is seen as the only culture or to varying extents the —better culture.
The last three stages are considered —ethnorelative in that one's own culture is seen as equal among many other cultures

I. *Denial: Does not recognize cultural differences*
Bennett refers to the first stage of the model as —denial.‖ It means that people in this stage are very unaware of cultural difference. If medical staff are in this stage of intercultural sensitivity, a huge problem can be expected in the delivery of education, health, and social services for ethnic minorities, a gap that does currently exist when these groups are compared to Anglo Americans. The task for staff at this first stage of intercultural sensitivity is to recognize cultural differences that are escaping their notice.

II. Defense: Recognizes some differences, but sees them as negative
Whereas in the first stage we do not —see‖ cultural differences, in the second stage of cultural competence we do perceive cultural differences; however, differences from ourselves or the norms of our group are labeled very negatively. They are experienced as a threat to the centrality and —rightness‖ of our own value system. Bennett calls this stage —defense.

If medical staff achieve the second level of intercultural sensitivity, they still fail to communicate effectively with ethnic minorities. If they cannot communicate effectively, they cannot do the more complex task of collaborating effectively. The task in the second level of cultural sensitivity is recognizing to become more tolerant of differences and to see basic similarities among people of different cultures. However, little improvement in services can be expected if staff are below the third level of intercultural sensitivity.

III. Minimization: Unaware of projection of own cultural values; sees own values as superior
In the third stage of intercultural sensitivity, minimization, we try to avoid stereotypes and even appreciate differences in language and culture. However, we still view many of our own values as universal, rather than viewing them simply as part of our own ethnicity. The task at the third level of intercultural sensitivity is to learn more about our own culture and to avoid projecting that culture onto other people's experience. This stage is particularly difficult to pass through when one cultural group has vast and unrecognized privileges when compared to other groups.

IV. Acceptance: Shifts perspectives to understand that the same "ordinary" behavior can have different meanings in different cultures
A reasonable goal for many healthcare organizations is to ensure that all staff achieve at least the fourth developmental level in intercultural sensitivity. The fourth stage in Bennett's model requires us to be able to shift perspective, while still maintaining our commitments to values. The task in this stage is to understand that the same behavior can have different meanings in different cultures. Medical staff have to improve their intercultural sensitivity in this stage of development, in order for collaboration to be successful long-term.

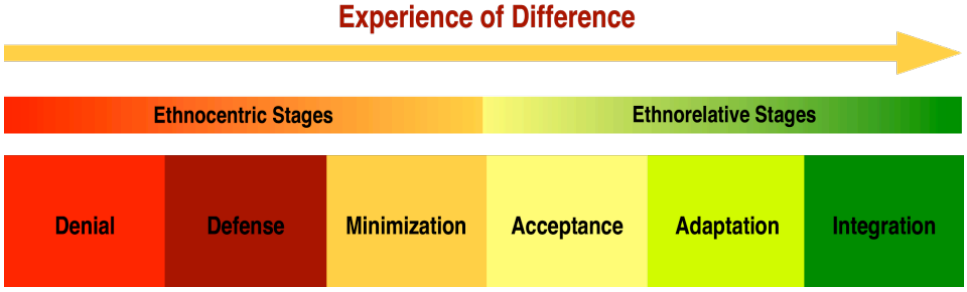
V. Adaptation: Can evaluate other's behavior from their frame of reference and can adapt behavior to fit the norms of a different culture.
In this stage, a person is able to take the perspective of another culture and operate successfully within that culture. It requires that the person knows enough about his or her own culture and a second culture to allow a mental shift into the value scheme of the other culture, and an evaluation of behavior based on its norms, not the norms of the first individual's culture of origin. This is referred to as —cognitive adaptation. The more

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advanced form of adaptation is —behavioral adaptation, ‖ in which the person can produce behaviors appropriate to the norms of the second culture.

VI. Integration: Can shift frame of reference and also deal with resulting identity issues.
In the sixth stage, the person can shift perspectives and frames of reference from one culture to another in a natural way. They become adept at evaluating any situation from multiple frames of reference. Some representatives in cross-cultural collaboration may reach this level, but most probably will not. Stage six requires in-depth knowledge of at least two cultures (one's own and another), and the ability to shift easily into the other cultural frame of reference. The task at this level of development is to handle the identity issues that emerge from this cultural flexibility.

Source: Multicultural Toolkit, Awesome Library (http://www.awesomelibrary.org



The stages provide a good framework for determining how to work with and improve the capacity for intercultural sensitivity and collaboration. Some of his stages of "cultural sensitivity" include behaviors or adaptations the authors include under the definition of "cultural competence."
1. How the first three stages can destroy communication and collaboration?
2. Identify, in each of these stages, arenas to deal with "own ethnicity", increase the level of intercultural sensitivity and improve the capacity for collaboration based behaviors level of intercultural sensitivity.
3. Why the development of intercultural sensitivity to the level 4 and 5, is necessary for successful cross-cultural collaboration and communication?
4. Which behaviors or adaptations in the sixth stage can be included under the definition of "cultural competence"?

Activity 6 : Improving your communication style?
To improve intercultural effectiveness :
Know yourself
Know your culture
Know your personal attitudes
Know your communication style
Monitor yourself
Consider timing, physical setting, and customs
Know your communication style in intercultural settings

Define your communication style using these questions:
1. Which communication tool do you feel more comfortable to use?
2. Which communication tool do you feel less comfortable to use?
3. It is an interesting experience for you to communicate with foreigners?
4. Usually, do you have a effective communication with people from another culture?
5. Are you inspired when you get involved into intercultural communication?

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6. Do you smile often?
7. Do you repeatedly interrupt?
8. Do you show sympathy when there's a crisis or problem?
9. What does your tone of voice suggest?
10. How do you react to being touched by a client?
11. How do you handle silence?
12. Do you appear rushed?

Activity 7. Develop strategies for effective intercultural communication with patients and families.

Recognize one's reactions to differences:
- Consider the origins of these reactions;
- Consider how might the specific communication barriers, challenges affect the ability to provide services;
- Consider how the clients/families might perceive one's behavior.

Develop empathy
Learn the culture-specific norms for nonverbal communication:
- Body behavior—attire, gestures, posture, facial expressions, eye contact, touch, smell, vocalizations (qualifiers), volume, noises, laughing, accents, dialects;
- Space & distance;
- Timing;
- Silence.

Improving intercultural effectiveness:
- Achieving clarity;
- State your information clearly and precisely;
- Adjust to listener's level of understanding without being demeaning;
- Explain jargon;
- Use idioms carefully;
- Slow down speaking;
- Speak in smaller units;
- Repeat key points;
- Encourage listener to ask questions;
- Check for understanding.

Ask questions:
- What do you call the problem?
- What do you think has caused the problem?
- Why do you think it started when it did?
- What does the illness do? How does it work?
- What kind of treatment should the patient receive? What are the most important results you hope the patient receives from the treatment?
- What are the chief problems the sickness has caused?
- What do you fear most about the sickness?

ASSESSMENT COMPONENT

Practical assessment.
Final assessment: Building a strategy and presentation of actions in different intercultural communication challenging situations.
Will be assessed: practical skills and capacity of building an action plan to remove barriers

and the values promoted: respect, tolerance, dignity and rights of patients.
Each trainee is to be assessed against the provided assessment sheet, which is to be completed by the trainer / assessor.
When the assessment has completed, the trainer give feedback to the trainees on their performance

Resources: Assessment Sheet

EVALUATION COMPONENT

The participants in piloting the tool (student nurses and registered nurses) will take part in the evaluation.
The evaluation criteria are:
- Does the tool help students' progress through their learning goals?
- Is it practical and easy to use by both teachers/trainers and students?
- Is it relevant, innovative and important to students learning pathway?

Evaluation will be made through an evaluation questionnaire containing a set of questions following with what extend the learning tool meet the criteria above.
The report on the evaluation will be shared to the trainers' team and will conduct a meta analysis of results, to identify the main themes which will guide the revision of the tool.

Resources: Evaluation Questionnaire

References:

Bennett, Milton J. , 1993 "Towards a Developmental Model of Intercultural Sensitivity" Hammer, M. R., Bennett, M. J., & Wiseman, R. (2003). Measuring intercultural sensitivity: TheIntercultural Development Inventory.

Neuliep, J.W., (2012). The relationship among intercultural communication apprehension, ethnocentrism, uncertainty reduction, and communication satisfaction during initial intercultural interaction: An extension of anxiety and uncertainty management (AUM) theory. Journal of Intercultural Communication Research, 41, 1-16.

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Spencer-Rodgers, J. & McGovern, T. (2002) Attitudes toward the culturally different: The role of intercultural communication barriers, affective responses, consensual stereotypes, and perceived threat. International Journal of Intercultural Relations, 26, 609-631

Spitzberg, B. H. (2000). "A Model of Intercultural Communication Competence", in: L. A. Samovar & R. E. Porter (Ed.) "Intercultural Communication - A Reader", 375-387, Belmont: Wadsworth Publishing.

Taylor G., Papadopoulos I., Dudau V., Maerten M., Peltegova A. & Ziegler M. (2011) Intercultural education of nurses and health professionals in Europe (IENE). International Nursing Review No. 58, 188–195

The Edunet Intercultural Communication Skills Tool Evaluation

CRITERIA	FULLY MET	PARTLY MET	NOT MET
a) Contained customised steps to help students progress through their learning goals	91%	9%	0%
b) Provided observable evidence of learning	93%	7%	0%
c) Clarified what students knew and did not know	91%	9%	0%
d) Allowed the teacher to see/hear (and intervene) when students did not understand	76%	24%	0%
e) Led to and connected with other tools in the process of meeting larger /higher level learning goals	67%	33%	0%
f) Helped students synthesize knowledge and meaning	93%	7%	0%
g) Provided building blocks that enable students to step into and through difficult concepts or processes to reach predetermined learning goals	76%	24%	0%
h) Provided pathways that led to depth and clarity in learning	76%	22%	2%
i)Adds to the meaning-making in the classroom	76%	22%	2%

NB: When the percentages do not add up to 100%, this indicates that some participants did not rate the specific item/s.

34. I am a student / qualified healthcare participant — 87

35. I am a teacher/trainer

36. I am a patient

Students' Comments:

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The Azienda Ospedaliera Universitaria Senese Intercultural Communication Skills Tool & Evaluation

by
Anna Coluccia, Claudia Rustici and Cristina Masoni
Italy

IN ORDER TO BETTER UNDERSTAND

THEORETICAL COMPONENT

Principles and values relevant to the tool

Understanding the language differences is essential for an effective take-over of the patient with different culture. The linguistic-cultural mediation is essential in the daily practice of nurses. The linguistic-cultural mediation facilitates the nurse's role and makes it stronger, aware and prepared to meet the challenges that multicultural societies offering health care professional.

Aims

- Increase safety and awareness in dealing with languages and different cultural health behaviours
- Understand that cultural differences are an asset.
- Implement the willingness of nurses to accept and understand patterns of behaviors different from their own.
- Overcome any prejudice against other cultures, and welcome cultures beyond and stereotypes.
- Increasing the opportunities to train in cultural-linguistic mediation.

Learning outcomes

- Enhance the safety and awareness in dealing with languages and new codes cultural health.
- Understand that cultural differences are an asset.
- Implement the availability of the nurse to accept and understand patterns behavior different from their own.
- Overcome any prejudice against other cultures, and enhance the culture hospitality beyond stereotype.
- Increasing the supply of training with the teaching of cultural-linguistic mediation

Relevant definitions and terms/ What the research says

Linguistic-cultural mediation: This is to facilitate access to services for immigrants; interventions to promote cultural and information aimed at the host population in order to prevent the spread of negative stereotypes and attitudes of rejection and discrimination; to encourage the maintenance of ties with the culture of origin Morniroli A. (2011) Progetto Casba.
DeWan Gibson; Mei Zhong (July 2005, 08) “Intercultural communication competence in the healthcare context”, International Journal of Intercultural Relations (Volume 29, Issue 5, September 2005, pages 621-634)

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*Abstract:*This study examined the intercultural communication competence of medical providers at a healthcare organization, including patient perceptions of the medical provider's ability to communicate with a diverse patient population. Surveys were given to medical providers and patients at a large healthcare organization. One survey asked medical providers to rate their own ability to communicate across cultures, and the other survey instructed patients to rate the intercultural communication competence of their medical providers. Analysis of variance and Pearson correlation coefficients were used to analyze the data from 45 medical providers and 91 patients. The findings demonstrate that empathy, bilingualism, and intercultural experience are related to intercultural communication competence.
http://www.sciencedirect.com/science/article/pii/S0147176705001069

Schouten, B., Meeuwesen, L., Tromp, F., & Harmsen, H. (2007). Cultural diversity in patient participation: The influence of patients' characteristics and doctors' communicative behaviour. Patient Education and Counseling, 67, 214-223.

Abstract: The primary goal of this study was to examine the extent to which patient participation during medical visits is influenced by patients' ethnic background, patients' culture-related characteristics (e.g. acculturation, locus of control, cultural views) and features of doctors' communicative behaviour. Furthermore, the mutual influence between patients' participatory behaviour and doctors' communicative behaviour was investigated. An additional goal was to identify the independent contribution of these variables to the degree of patient satisfaction and mutual understanding between GP and patient.
Communicative behaviour of patients (n = 103) and GPs (n = 29) was analysed with Roter's Interaction Analysis System, frequency of patient questions and patients' assertive utterances (e.g. making requests, suggesting alternative treatment options). Additional data were gathered using GP and patient questionnaires after the consultations.Results show that non-Western ethnic minority patients display less participatory behaviour during medical consultations than Dutch patients. GPs' affective verbal behaviour had most effect on degree of patient participation and patient satisfaction. Regression analyses indicate a significant mutual influence between patients' verbal behaviour and GPs' verbal behaviour. Overall, results of this study show some important differences between Dutch and non-Western ethnic minority patients in degree of patient participation. Furthermore, our results indicate that patient participation encompasses several aspects that are not necessarily interrelated. The necessity for continued education of GPs' communicative skills, particularly when dealing with non-Western ethnic minority patients, is reflected in the strong influence of GP's affective verbal behaviour on both patient participation and their satisfaction with the medical encounter.

Rosenberg Ellen, Richard Claude, (April 2005, 02) "Intercultural communication competence in family medicine: Lessons from the field", Patient Education and Counseling, (Volume 61, Issue 2, May 2006, Pages 236-245)

Abstract: To describe the challenges for immigrant patients and their physicians and their skills in intercultural communication (ICC).
We videotaped one clinical encounter for each of 24 psychologically distressed patients visiting their regular family physician. The physician and the patient, each separately, viewed the videotape of their clinical encounter and commented on important moments identified by the participant or the researchers.
Patients and/or physicians lacked knowledge of the effects of culture on the doctor–patient relationship and expressions of distress as well as the effects of immigrant-specific stress on health. Most subjects were motivated to have an interpersonal, rather than an intercultural encounter. Physicians and patients demonstrated the skills needed to achieve an

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interpersonal encounter. Some physicians and their patients achieved intercultural meetings as a result of their interpersonal interactions over a period of years.
Lack of formal training partly explains why most participants demonstrated an elementary level of ICC. In addition, Identity Management Theory and Co-cultural Theory explain some of the barriers to ICC.

Practice implications
http://www.sciencedirect.com/science/article/pii/S0260691705000216
Providing physicians with formal training in intercultural communication and empowerment training for patients is likely to improve the quality of care of immigrants.

Meeuwesen, L., Tromp, F., Schouten, B.C., & Harmsen, J.A.M. (2007). Cultural differences in managing information during medical interaction: how does the physician get a clue? Patient Education and Counseling, 67, 183-190.

Abstract: Consultations of ethnic-minority patients tend to result in poor mutual understanding between doctor and patient, which may have serious consequences for health care. For good communication, physicians have strong devices at their disposal to manage the information, such as agenda-setting and structuring the interview into segments. What are the cultural differences in the managing of information in medical conversation? What is the relation with level of mutual understanding?

Data of 103 transcripts of video-registered medical interviews (56 non-Western and 47 Dutch patients) were sequentially analysed, focusing on relevant segments of the medical interview (medical history, diagnosis and conclusion) and on agenda-setting.
Physicians set the agenda and lead the conversation firmly forward, while a considerable number of patients (mainly Dutch) 'put on the brakes'. The majority of the medical conversations was traditional (37%) or cooperative (37%), while another 25% was more or less conflicting or compliant in nature. Interviews of ethnic-minority patients were mostly traditional or cooperative, while Dutch patients showed a variety of types, especially in cases of poor mutual understanding. Further, conversational symmetry between patient and physician has increased over the years, due to the importance attached to patient autonomy. Physicians receive different conversational clues from Dutch and ethnic-minority patients in case of poor mutual understanding.
This points to the necessity for physicians as well as patients to become culturally competent.
Sargent Sara, Sedlak Carol (Decembre 2004, 12) Cultural competence among nursing students and faculty, Nurse Education Today, Volume 25, Issue 3, April 2005, Pages 214-221.

Abstract: Healthcare consumers are entitled to culturally competent care. Therefore, nursing curricula need to include cultural content and student nurses and faculty members need to be culturally competent. The purpose of the study was to describe cultural competence of students and faculty at a college of nursing and to discuss the implications for nursing curricula related to cultural competence. Campinha-Bacote's model (Campinha-Bacote, J., 1994. Cultural competence in psychiatric mental health nursing. Nursing Clinics of North America 29 (1), 1–8.) of culturally competent care provided the theoretical framework. The Inventory for Assessing the Process of Cultural Competence (IAPCC) (Campinha-Bacote, J., 1998. The Process of Cultural Competence in the Delivery of Healthcare Services: A Culturally Competent Model of Care. Transcultural C.A.R.E. Associates, Cincinnati, OH. Available from: <www.transculturalcare.net>.) was used to measure levels of self-reported cultural competence. A convenience sample of 88 first year, 121 fourth year baccalaureate students and 51 faculty members at a college of nursing was studied. Analysis of variance revealed a statistically significant difference ($F = 43.915$, $df = 259$, $p < .0001$) between the three groups. A positive correlation was found between IAPCC scores and several

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demographic variables. Findings suggest that cultural competence can be increased by including structured cultural content in nursing curricula.
http://www.sciencedirect.com/science/article/pii/S0260691705000213

De Maesschalck, S., Deveugele, M., & Willems, S. (2011). Language, culture and emotions: exploring ethnic minority patients' emotional expressions in primary healthcare consultations. Patient Education and Counseling, 84: 406-412.

Abstract: This study explores ethnic minority patients' expression of emotional cues and concerns in primary healthcare, and examines relationships with patient, provider and consultation attributes. 191 video-recorded consultations were analyzed using the VR-CoDES. Patients were interviewed before the consultation. Generalized Estimating Equations models (GEE) were used to test for associations. Psychosocial versus bio-medically oriented encounters contained significantly more cues ($p \leq 0.05$). Patients with poor versus good language proficiency expressed significantly less cues ($p \leq 0.001$). No significant correlations were found with patients' cultural values, patients' or physicians' gender or the presence of an interpreter. Female patients express more concerns ($p \leq 0.05$), female physicians have a higher number of concerns expressed by patients ($p \leq 0.02$). This study shows that independent of physician and diagnosis, patients' language proficiency has a more important impact on the number of cues expressed by the patient than cultural difference. Medical schools and Continuing Medical Education should focus on training programs for recognizing and handling linguistic barriers between physicians and patients. Patient education programs should encourage patients who experience language barriers to open up to physicians. In situations where language is a barrier, physicians and patients should be encouraged to use interpreters to enhance the expression of emotions.
Richard L. Street Jr., Gregory Makoul, Neeraj K. Arora, Ronald M. Epstein (2009)
How does communication heal? Pathways linking clinician–patient communication to health outcomes. Patient Education and Counseling, Vol. 74, Issue 3, p295–301

Abstract: Although prior research indicates that features of clinician–patient communication can predict health outcomes weeks and months after the consultation, the mechanisms accounting for these findings are poorly understood. While talk itself can be therapeutic (e.g., lessening the patient's anxiety, providing comfort), more often clinician–patient communication influences health outcomes via a more indirect route. Proximal outcomes of the interaction include patient understanding, trust, and clinician–patient agreement. These affect intermediate outcomes (e.g., increased adherence, better self-care skills) which, in turn, affect health and well-being. Seven pathways through which communication can lead to better health include increased access to care, greater patient knowledge and shared understanding, higher quality medical decisions, enhanced therapeutic alliances, increased social support, patient agency and empowerment, and better management of emotions. Future research should hypothesize pathways connecting communication to health outcomes and select measures specific to that pathway.
Clinicians and patients should maximize the therapeutic effects of communication by explicitly orienting communication to achieve intermediate outcomes (e.g., trust, mutual understanding, adherence, social support, self-efficacy) associated with improved health.
Richard L. Street, Vanessa Cox, Michael A. Kallen, Maria E. Suarez-Almazor, (2012)
Exploring communication pathways to better health: Clinician communication of expectations for acupuncture effectiveness. Patient Education and Counseling, Vol. 89, Issue 2, p245–251 - August 2, 2012.

Abstract: This study tested a pathway whereby acupuncturists' communication of optimism for treatment effectiveness would enhance patients' satisfaction during treatment, which in turn would contribute to better pain and function outcomes for patients with osteoarthritis of the knee. Secondary analysis from a 2 arm (real vs. sham acupuncture, high vs. neutral

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expectations) RCT. 311 patients with knee osteoarthritis received acupuncture over 10–12 sessions. Coders rated the degree to which acupuncturists communicated optimism for the treatment's effectiveness. Satisfaction with acupuncture was assessed 4 weeks into treatment. Pain and function were assessed 6 weeks following treatment.
Patients experiencing better outcomes were more satisfied with acupuncture during treatment, were younger, and had better baseline pain and function scores. Satisfaction during treatment was greater when patients interacted with more optimistic clinicians and had higher pretreatment expectations for acupuncture efficacy.
Acupuncturists' communication of optimism about treatment effectiveness contributed to pain and function outcomes indirectly through its effect on satisfaction during treatment.
Future research should model pathways through which clinician–patient communication affects mediating variables that in turn lead to improved health outcomes.
While clinicians should not mislead patients, communicating hope and optimism for treatment effectiveness has therapeutic value for patients.

Irene P. Carvalho, Vanessa G. Pais, Susana S. Almeida, Raquel Ribeiro-Silva, Margarida Figueiredo-Braga, Ana Teles, Ivone Castro-Vale, Rui Mota-Cardoso (2010)
Patient Education and Counseling, Vol. 84, Issue 1, p84–89.
Learning clinical communication skills: Outcomes of a program for professional practitioners

Abstract: To assess the effects of a communication skills program on professional practitioners' performance and self-confidence in clinical interviewing.
Twenty-five health professionals took 3 months of basic communication skills followed by 3 months of advanced communication skills. An additional quarter dealt with self-awareness and communication in special situations. Participants' performances were evaluated in clinical interviews with standardized patients before, during and after the program by external observers and standardized patients, using standardized instruments. Participants assessed their own confidence in their communication skills before and after the program. Data were analysed using GLM repeated-measures procedures in SPSS.
Basic communication skills and self-confidence improved throughout the 6 months; competencies declined but self-confidence continued to increase 4 months later. Compared with taking no course, differences were statistically significant after the 6 months (external observers only) and 4 months later (external observers and participants).
The program effectively improved communication skills, although significantly only when assessed by external observers. Four months later, effects were significant in communication skills (external observers), despite the decline and in self-confidence.
While periodical enrollment in programs for the practice of communication skills may help maintain performance, more knowledge on communication and self-awareness may enhance self-confidence.

Nancy Edwards, Wendy E. Peterson, Barbara L. Davies (2006)
Evaluation of a multiple component intervention to support the implementation of a 'Therapeutic Relationships' best practice guideline on nurses' communication skill.
Patient Education and Counseling, Vol. 63, Issues 1-2, p3–11

Abstract: To determine if there was an improvement in nurses' communication skills 5 months after a multiple component intervention to implement the Registered Nurses' Association of Ontario best practice guideline 'Establishing Therapeutic Relationships'.
A matched pair, before and after design was used. Eight client scenarios with corresponding client comments were read aloud to nurses who were asked to respond verbally, as though they were interacting with the client. Responses were audio-taped and transcribed. The frequency and quality of nurses' active listening, initiating and assertiveness skills were measured pre- and post-implementation of the guideline.
Twenty-two nurses responded at both time points. Active listening skills were most

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frequently used. There was a statistically significant decrease in the number of active listening skills used, but a statistically significant improvement in the quality of active listening and initiating statements and frequency of initiating skills.
Nurses demonstrated improvements in selected communication skills following the implementation of a multiple component intervention that included a best practice guideline. A combination of strategies that support the implementation of a best practice guideline is described. Results indicate some improvement in communication skills that are essential to the establishment of therapeutic nurse–client relationships.

What does national legislation and international/European treaties and conventions say on the topic?

Legge 6 marzo 1998, n. 40
Disciplina dell'immigrazione e norme sulla condizione dello straniero (in Gazzetta Ufficiale n. 59, del 12 marzo 1998)

Codice Deontologico dell'Infermiere.
Approved by Comitato Centrale della Federazione IPASVI by resolution n.1/09, January 10, 2009 and from Consiglio Nazionale dei Collegi IPASVI in the meeting of January 17, 2009.
In: http://www.ipasvi.it/norme-e-codici/deontologia/il-codice-deontologico.htm

Commentario al codice deontologico dell'Infermiere.
Edited by Federazione Nazionale dei Collegi degli Infermieri IPASVI.
In: http://www.ipasvi.it/norme-e-codici/deontologia/commentario.htm
The international code of ethics for nursing by the International Council of Nurses (ICN)
The international code of ethics for nursing adopted by the International Council of Nurses in 1953. Revised in 2012.
In: http://www.cnai.info/index.php/estero/icn/codice-deontologico

Code of Ethics for Nurses – American Nurses Association (ANA)
The Code of Ethics for Nurses was developed as a guide for carrying out nursing responsibilities in a manner consistent with quality in nursing care and the ethical obligations of the profession. In: http://www.nursingworld.org/codeofethics

International Council of Nursing Fact Sheet: ICN on Health and Human Rights
ICN Nursing Matters fact sheets provide quick reference information and international perspectives from the nursing profession on current health and social issues. In http://www.icn.ch/images/stories/documents/publications/fact_sheets/10b_FS-Health_Human_Rights.pdf

What do local policies say?

Legge regionale 08 giugno 2009, n. 29 Norme per l'accoglienza, l'integrazione partecipe e la tutela dei cittadini stranieri nella Regione Toscana. (Bollettino Ufficiale n. 19, parte prima, del 15.06.2009)

Delibera n° 697 del 14 luglio 2003 della Giunta Regionale della Regione Toscana. Il Patto con il cittadino: repertorio di impegni per la Carta dei servizi sanitari con relativi indicatori e standard. In: http://www.usl7.toscana.it/index.php/amministrazione-trasparente/servizi-erogati/standard-di-qualita

Carta dei Servizi - Azienda Ospedaliera Universitaria Senese: carta dei diritti e dei doveri degli utenti In: http://www.ao-siena.toscana.it/carta_diritti_utenti.htm

PRACTICAL COMPONENT

Classroom Activities

PTT/IENE Model introduction and discussion on skills needed to be a culturally communicative competent nurse.

Reflection on the definitions, conceptual framework, cognitive aspects. The state of art and a brainstorming on what the literature says. Recall of professional deontology. Readings and discussions on the notion of appropriate and effective intercultural communication. Communication skills for the most effective admission pathways.

The role of cultural mediators and interpreters in the intercultural communication with patients. Transcultural communication as the result of cultural communicative competence and intercultural communication. The importance of cultural values, behavioural patterns and rules for interaction in specific cultures. Cultural communicative competence as a mix of linguistic competence and communicative competence (body language).

Practical activities

Participants will be divided into 4 groups in order to simulate a real situation (role play) and explore the different approaches towards patients from different cultures.

The analysis of the videos of the 4 realities for the recognition of the main component of an effective therapeutic intercultural communications with patients.
The role play will end with a feedback coming from the patient/player.

ASSESSMENT COMPONENT

Theoretical assessment.
Teachers: anthropologist, clinical educationalist, tutors (nurses, obstetricians and representation of foreign associations) will create a written test (open-ended questions) to identify what has been learned. Participants, 20 nurses working in different wards, will answer individually and later they will discuss together on the various responses.

Practical assessment.
Evaluation through systematic observation (low degree of structure) carried out directly by the teachers for the full duration of the toolkit. The survey for the exploration of learning outcomes produces a true and complete description of the conditions in which it occurs.

EVALUATION COMPONENT

The evaluation of the toolkit is carried out by the learners. The evaluation is oriented to the recognition of the originality of the techniques and new contents learned in relation to estimates the effects in the employment context.

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Effective achievement of learning goals (theoretical and practical)
Quality of the theoretical content
Quality of teaching activities and facilitation
Relevance and quality of materials used
Time Management
Satisfaction questionnaire administered at the end of the toolkit.
At a distance of thirty days, revaluation of effective achievement of learning goals (theoretical and practical)
Reassessment of contents, methods and materials used in the toolkit.

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The Azienda Ospedaliera Universitaria Senese Intercultural Communication Skills Tool Evaluation

CRITERIA	FULLY MET	PARTLY MET	NOT MET
a) Contained customised steps to help students progress through their learning goals	94%	6%	
b) Provided observable evidence of learning	89%	11%	
c) Clarified what students knew and did not know	92%	8%	
d) Allowed the teacher to see/hear (and intervene) when students did not understand	90%	10%	
e) Led to and connected with other tools in the process of meeting larger /higher level learning goals	86%	14%	
f) Helped students synthesize knowledge and meaning	90%	10%	
g) Provided building blocks that enable students to step into and through difficult concepts or processes to reach predetermined learning goals	86%	14%	
h) Provided pathways that led to depth and clarity in learning	93%	7%	
i)Adds to the meaning-making in the classroom	95%	5%	

NB: When the percentages do not add up to 100%, this indicates that some participants did not rate the specific item/s.

37. I am a student / qualified healthcare participant [20]

38. I am a teacher/trainer [ ]

39. I am a patient [ ]

Students' Comments:

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The Volkssolidaritat Intercultural Communication Skills Tool & Evaluation

by
René Hildebrandt and Friederike Jung
Gera, Germany

RELIGION and COMMUNICATION QUIZ

THEORETICAL COMPONENT

Principles of the tool

- care is a process and a reciprocal relationship
- sensitivity for diversity between cultures
- open mind, willing to know/understand other cultures
- knowledge and communication helps to understand other cultures/certain reactions of patient
- humanity
- heart geniality
- patient is a own personality impressed by his culture
- religion could be one important factor for the behaviour of a patient
- empathy

Values of the tool

- equality
- dignity
- tolerance and acceptance

Overall Goal:

The patient should feel comfortable and establish confidence to the nurse, so that the care/therapy could be successful.

Only if the nurse is aware of that his patient has another cultural background which leads his behaviour e.g. attitude towards life/tenors, preferences, peculiarity, wishes and so on and she knows them, she could consider them and commit herself to the patient in care and could care in a compassionate way.

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Learning objectives

When you have worked through this tool, you will be aware that:

1. Every patient is different and his cultural background is the base of his behaviour and understanding of life/care/diseases/health and has to be considered/respected.

2. Knowledge of the culture of my patient helps me to care in a compassionate and successful therapeutic way.

3. Negative attitudes about the patient often depends on misunderstandings or no comprehension, and does not mean a general denegation or no-willingness.

4. I don‘t have to have fear of a patient with another culture, if I can face him/her with an open mind and without prejudice.

5. Intercultural Communication is more than sending and receiving of information. How, where and when I communicate is really important that means which relationship I can create.

Relevant Definitions and Terms

Intercultural communication due to the globalisation has long been discussed and its importance has been recognised. More and more elderly, foreign residents, the refugee theme and foreign care workers, also the significance of intercultural therapeutic communication grows. To ensure a successful care and therapy of the patient, patient and care workers have to understand each other, know how the other wants to be treated and create trust in each other.

Communication as Interaction:

Communicare is Latin and means „to do something together“. Out of this it‘s possible to to reason that communication isn‘t a one-dimensional sender-recipient-model and that it‘s not the pure content of communication that counts. But it is „what is told from whom, how and when“. Every sender is a recipient and vice versa.

Four components of communication:

- verbal (lexical, syntactical, rhetorical-stylistically,...)
- non-verbal (facial expression, gesture, posture, pictures, drawings...)
- preverbal (volume, pitch of the voice, laughing, typography...)
- extra verbal (z.B. time, place, context, frequency of publication..)

Culture (broad culture term):

Culture is more than art. Culture should be rather understood like a living environment which was artificially created but in interdependency with nature. A society does not have a culture, it is a culture. Thereby culture is not a keen delimited space but has flowing transitions like a frayed carpet. A culture doesn‘t begin or end with political frontiers. Its transitions are dynamic.

Quelle: Jürgen Bolten, Einführung in die interkulturelle Wirtschaftskommunikation, Vandenhoeck & Ruprecht, 2007

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Research findings regarding the issue

Comprehension promotes Healing, Gertrud Wagemann, Verlag für Wissenschaft und Bildung, 2005

Wagemann and her publishers are convinced that medical staff has to dispose of necessary background knowledge beside transcultural competence. Thus they have created a guideline with the most important religions in Germany and an overview of care relevant issues of each religion. These references in combination with the awareness that every person is an individual should help to find a suitable constitutional therapy for everybody.
The guideline was generated on the example of the english version: „Religious and Cultural Beliefs Handbook".

Quelle: Gertrud Wagemann, „Verständnis fördert Heilung", Verlag für Wissenschaft und Bildung, 2005

Relevant Content of laws, contracts/conventions regarding the issue

The code of social law XI (Social Sozialgesetzbuch (SGB)), regulates all care instructions in Germany

§ 2 Self-determination
(1) The services of care insurances should help persons in care of help to conduct a self-dipendent and self-determined life which accords to human dignity even if they need help. The help services should be aligned to recover or maintain the physical, psychological and mental forces of the person in need of care.

(2) Persons in need of care can choose between facilities and services of different organisations. According to the law of services („Leistungsrecht") their wishes regarding the design of help, if appropriated, should be fulfilled. Also if persons in need of care wish a same-gender care it should be considered if possible.

(3) Religious necessities of persons in need of care should be considered. On their demand they should have inpatient treatments where they could be assisted by reverends of their religious denomination.

(4) These rights according to the passages 2 and 3 have to be indicated to persons in need of care.

Source: http://dejure.org/gesetze/SGB_XI

Relevant content of local policies

Care guidelines of the Volkssolidarität contains following relevant contents (complete in annexe)

0. Our service offer applies to all help seeking persons whatever philosophy of world, colour of skin, disease, handicap or age. According to the code of ethics of the elderly and medical care we are looking for and carry out ways of supporting, maintaining and recovering health and wellbeing respectively relief of pain together with the patient, his relatives and physicians as well as departments and centres.

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1. To consider the persons in need of care as holistic, coequal and equal with all his experiences and personality and not just the problematic part of him.

2. Quality and orientation to the persons assisted by us. Warmness, humanness and heartiness are key aspects in the realisation of our work.

Practical aspects of the tool PRACTICAL COMPONENT

Practical Activities

The trainer/mentor-nurse gets the participants into the issue by giving a brief common introduction to intercultural communication using a powerpoint presentation. She mentions that in this context the overall goal of this tool is to learn how to:

- Make the patient feel comfortable and establish confidence to the nurse, so that the care/therapy could be successful.

Only if the nurse is aware of that the patient has another cultural background which leads his/her behaviour e.g. attitude towards life/tenors, preferences, peculiarity, wishes and so on and she knows them, she could consider them and commit herself to the patient in care and could care in a compassionate way.

Then she distributes the sheets with the ***religion-quiz***. The participants can now try to answer to all questions by themselves or in small groups.

When they finish answering the trainer/mentor-nurse discusses the answers with them and gives the right answers and additional details with the help of a powerpoint presentation.

This learning aims to raise the participants' awareness that:

1. Every patient is different and his cultural background is the base of his/her behaviour and understanding of life/care/diseases/health and has to be considered/respected.

2. Knowledge of the culture of the patient helps them to care in a compassionate and successfully therapeutic way.

3. Negative attitudes of the patient is often based on misunderstandings or no comprehension, and does not mean a general denegation or unwillingness.

4. Nurses don't have to have fear of a patient from another culture, if they face him/her with an open mind and without prejudice.

5. Intercultural Communication is more than sending and receiving of information. How, where and when I communicate is really important that means which relationship I can create.

ASSESSMENT COMPONENT

Theoretical and Practical Assessment: Every participant can keep his/her quiz sheet as short assessment overview.

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Additionally it is possible to use the powerpoint presentation and the guideline book at the care station.

EVALUATION COMPONENT

- The whole nurse staff of the Volkssolidarität Gera tool part in this.

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The Volkssolidaritat Intercultural Communication Skills Tool Evaluation

CRITERIA	FULLY MET	PARTLY MET	NOT MET
a) Contained customised steps to help students progress through their learning goals	22	28	
b) Provided observable evidence of learning	28	22	
c) Clarified what students knew and did not know	28	22	
d) Allowed the teacher to see/hear (and intervene) when students did not understand	32	18	
e) Led to and connected with other tools in the process of meeting larger /higher level learning goals	16	34	
f) Helped students synthesize knowledge and meaning	30	20	
g) Provided building blocks that enable students to step into and through difficult concepts or processes to reach predetermined learning goals	12	36	2
h) Provided pathways that led to depth and clarity in learning	32	18	
i)Adds to the meaning-making in the classroom	12	38	

NB: When the percentages do not add up to 100%, this indicates that some participants did not rate the specific item/s.

40. I am a student / qualified healthcare participant — 30

41. I am a teacher/trainer — 10

42. I am a patient — 10

Students' Comments:

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The Albeda College Intercultural Communication Skills Tool & Evaluation

By
Joyce van Dijk and *Marga Hop*
The Netherlands

INTERCULTURAL COMMUNICATION TOOL

THEORETICAL COMPONENT

Principles and Values

This lesson focuses on intercultural communication. Although scientists cannot agree on a definition for culture, they seem to be united in their belief that culture affects communication. The ability to provide good care begins with, among other things, when we understand the other person. Therefore, it is essential that healthcare providers can reflect on their own (cultural) norms and values with respect to the care they give to care recipients of another culture.

In 2000, the Raad voor Volksgezondheid (the Council for Public Health and Care) published its report, "Interculturalisation of Healthcare". In this report, the Council recommended that intercultural care provision (including intercultural communication) be given a permanent place in the training curriculum for healthcare providers. The Council believes that it would be even better if full attention be given to the ethnic - cultural diversity of care recipients in all subjects. "Competence and skills in the intercultural aspects of care should also be reflected in the final objectives of the program. New graduates will then be better prepared and equipped to provide tailored care and adopt a culturally sensitive attitude to the care they provide. Generally, attention to the diversity aspect will also improve the quality of their professional practice. Since intercultural policy in institutions depends largely on the management, it is important that management training courses also pay attention to (cultural) diversity," says the Council. (page 72-73 RVZ: Interculturalisation of Healthcare).

Intercultural care and communication has always been a theme in the training programs for training nurses and caregivers. In the qualification structure to be implemented before 1 August 2016, an optional "Diversity" element will be added to the care and welfare programs. This makes the subject even more explicit on the agenda for trainers and healthcare providers working in the health and social care sector. The PTT (Papadopoulos, Tilki, Tailor model) can be used to shape lessons and contribute to the development of a culturally sensitive attitude within healthcare providers and social workers.

This lesson about intercultural communication focuses on the area of interest ***- Cultural Awareness*** *from the Papadopoulos Tilki and Taylor (PTT) model*. Recognising and acknowledging **diversity** is a core concept in this lesson. Focusing on diversity acknowledges the fact that every person is different and that, within care relations, it is always necessary to get to know the **individuality** of the other person and tailoring their care accordingly. By doing so, a semantic discussion about what culture is can be avoided.

Professionally reflecting on your own values, norms, habits, etc., and stretching one's own 'mental models' regarding what good care is, form a central theme in this lesson.

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Using the above as a foundation, it is possible to focus and practise communication within the relationship of the healthcare provider and care recipient.

Didactic principles are:

- Exploring experiences
- Exploring and being open to the concept of diversity
- Introspection
- Learning to work as a team
- Stirring curiosity
- Intention and desire to understand what the other person wants
- Practising the stepping stone model

The tool is also informed by the following values:

- Caring
- Compassion
- Justice
- Integrity
- Accountability
- Equality

Aims

In theory, the student is able to discuss a cultural issue and use an approach that is based on the stepping stone model theory.

- The student is able express their own emotions/feelings toward cultural issues in words.
- The student is able to explore the issue by asking clarifying questions.
- The student is able to explore the issue during an oral conversation with a fellow student.
- Students can be as creative as possible in developing solutions, if possible, in consultation with the care recipient.

Relevant definitions and terms/ What the research says

Intercultural communication by W. Shadid,
Published in: Ethnic minorities and the multicultural society Penninx, R., H. Münstermann en H. *Entzinger*, 1998
In this article Mr. Shadid discusses the differing beliefs/views/definitions of different authors, scientists and researchers concerning culture, diversity and intercultural communication. One of the main principles and results of the article is that culture is a dynamic concept, and that there is no set type or amount of information that is transmitted from one generation to the next. In conclusion, he describes that ´culture is a self-generating mechanism´. Elsewhere in the article, it is stated that, as well as being taught and used daily, culture is being made and changed on a daily basis as well. This means that culture is not only an independent variable affecting the communication process, it is also a dependent variable; meaning communication affects and creates culture. In his conclusion, Shadid states: "processes of cultural communication cannot be fully understood while:
(1) cultures are separated from one another by means of regional and political boundaries,
(2) in the context of communications, reference is made only to a holistic concept of culture without taking into account the type of activity in which the communication partners are involved, and
(3) the affective and evaluative dimensions of culture are not involved in the analysis of the concept."
Shadid ends his conclusion with: "*nowadays, it is difficult to speak of a pure Dutch, Japanese, Moroccan or Turkish culture. These only exist in people´s perceptions of the*

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definition of the own territory and identity, as well as to protect their own interests through the exclusion of others."
In sum, reading the article can help us in the development of this lesson. We have chosen the concept of diversity. In our view, an understanding that fits within the philosophy that culture is a dynamic concept and constantly undergoing change as a result of communication with other people.
http://www.interculturelecommunicatie.com

Information Package - intercultural expertise in healthcare, Vilans/Trimbos Instituut/ZonMW/VenVN/Calibris, 2014

A brief summary of the core of the work:
This information package describes what being interculturally sensitive means; distinguishing cultures and the ability to experience cross-cultural differences. It involves a curious open attitude, the showing of respect for other cultures and the ability to think comparatively and outside the box. This is the foundation for intercultural competency. This information about cultural expertise is coupled with four generic, and five subject-specific, intercultural competencies.
http://www.zorgvoorbeter.nl/docs/PVZ/Onderwijs/Intercultureel_vakmanschap_nov_2013.pdf

What does national legislation and international/European treaties and conventions say on the topic?

Nursing and Caring Professions Code of Conduct
In addition to the principles of the profession, the Nursing and Caring Professions Code of Conduct describes the relationship between the Nurse and the patient, other caregivers and the community.
In article 2, relationship with the patient; it states that every patient has the right to receive care, and specifically states that ethnic origin, nationality, culture, age, gender, sexual orientation, race, religion, ideology, political conviction, socio-economic status, physical or mental disability, nature of health issues or lifestyle must never influence whether and what care someone is provided. [article 2.1]
The caregiver is central and the nurse upholds the interests of the patient.[article 2.2]
Provision of care is tailored as far as possible to the needs, standards and values, and cultural and ideological views of the patient [article 2.3]
Article 3 describes the relationship with other care recipients , with specific reference to the nurse protecting the patient against unethical, incompetent, unsafe or otherwise poor provision of care from other care providers. [article 3.6]
The Code; Standards of Conduct, Performance and Ethics for Nurses

PRACTICAL COMPONENT

Practical activities

Cultural Awareness: Diversity and Intercultural Communication
The students have followed lessons about compassion and courage. The lesson lasts 90 minutes in total.

Activity 1: Introduction
The teacher provides an introduction. On the basis of multicultural case histories inserted by

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the teacher, general rules for cultural conversation and the "cultural stepping stone model"[3] will be discussed. (see notes under the slides of the PTT entitled: 'intercultural communication')

Case Study 1
An Afghan lady would like to give you a gift. In her culture, refusing a gift is considered an insult. Discuss with the class about which intercultural values, behavioural patterns and rules they know about different cultures.

Outcome:
The students know the concepts of intercultural values, behavioural patterns and rules. The students are aware that it is impossible to understand the values, patterns, and rules of all cultures. The students know the concept of diversity. Students know and understand the intercultural stepping stone model and how to use it in communication.

Activity 2: Frame of reference offer. (5 minutes)
Teachers demonstrate through role play what happens when a conversation becomes difficult if the steps, ***opening up*** and ***explore*** are skipped.

Outcome:
It provides a reference framework to the students. Students are aware of and recognise the blockages that can have an effect in a conversation, and what the consequences are for both the healthcare provider as well as the patient when the steps, opening up and explore, are skipped.

Activity 3: Applying the stepping stone model
Group work (each group of 4 people/15 minutes)
Students use case histories to prepare and use the stepping stone conversation odel.(There are two cases available, each group prepares 1 case each).
Two students take on the role of person 1 and the other students take on the role of person 2. They receive the 'stepping stone model for conversations' on paper. For information, the stepping stone plan[4] from the lesson courage is also provided.
Students consider **what they want to say** and **what questions** they want to ask from the point of view of the person they represent.

Case Study 1:
Recipient of care: Terminal patient
Person 1: Healthcare professional
Person 2: Daughter of terminal patient
A terminal client you care for has expressed a preference for euthanasia or palliative sedation. She has an old reformed faith. Euthanasia is not allowed in this faith. In this terminal phase she is in a lot of pain, is restless, cries a lot and says several times a day that she wants to sleep.

The daughter of this lady has told you that they will not allow her mother to receive euthanasia or palliative sedation. She says: 'God will get her when the time is right'.
The patient continues to state that she wishes to sleep and continues to moan with pain. The care is agony for her. You can no longer afford for her to be in so much pain.
You want to talk to the daughter about her mother's desire for euthanasia/palliative sedation.

[3] Normal is different, -managing cultural dynamics in teams-, Kramer, J (2009)
4 Critical Checkpoints in using Moral Courage for Ethical Decision Making by Day, L (2009)

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Case Study 2:
Person 1: student care provider with a headscarf
Person 2: manager
You are a student and you work in a department with patients who have high psycho-geriatric demands. You wear a scarf in connection with your Islamic faith. This headscarf is tied from the front, under your chin. A piece of cloth from the headscarf hangs under your chin and over your neck and shoulders.In the institution where you work there is a directive that states headscarves may be worn but they must be closed behind the head. This is for health and safety reasons and to ensure the safety of personnel. As a student, you now have a dilemma. You do not want to wear your headscarf in a different way. You don't want to expose your neck. You decide to have a chat with your manager.

Outcome:
The students have used the stepping stone model.

Activity 4: Interviewing using the stepping stone model accompanied by teachers (25 min)
Two groups from the class hold a conversation that they have prepared while the classroom observes. Feedback will be provided by teachers and students about the use of the stepping stone model (both cases will be discussed in the same way).
The teacher encourages students to explore again further by turning to the class for questions and 'what if' comments. The educational conversation also concerns what the questions and answers uncover. Reflection on one's own emotions, values/standards and prejudice is an important part of the learning process.

Outcome:
Students have practised a conversation following the stepping stone model. The students can use these examples to customise their own application of the model.
Students have been able to reflect on their own contribution to the conversation.
Students have experienced the fact that exploration leads to deeper insight and better understanding of other people, which in turn can lead to new solutions/possibilities presenting themselves.

***Activity 5:** In groups working with the stepping stone model (20 min)*
The groups that have not held the conversation in front of the class hold the conversation independently. The students who held the conversation in front of the class act as observers of the discussions and provide feedback.

Outcome:
All students have practised the stepping stone model at least once.

***Activity 6:** Feedback discussions (15 min)*
Summarise the most important learning points with students and list the new learning questions.

ASSESSMENT COMPONENT

Formative assessment:
1. Students bring in case histories from their own experience, which are then discussed. Together they can discover which questions could have been asked, whether there was any prejudice, which cultural barriers there were, etc.

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Evaluation component

1. A feedback questionnaire that allows students/tutors to evaluate the lesson.

References:

Raad voor Volksgezondheid (the Council for Public Health and Care), July 2000, Interculturalisation of Healthcare *(Health care immigrants require structural attention: required infrastructure* Normal is different, -managing cultural dynamics in teams-, Kramer, J (2000) Intercultural communication by W. Shadid, Published in: Ethnic minorities and the multicultural society Penninx, R., H. Münstermann en H. Entzinger, 1998

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The Albeda College Intercultural Communication Skills Tool Evaluation

CRITERIA	FULLY MET	PARTLY MET	NOT MET
a) Contained customised steps to help students progress through their learning goals	88%	12%	
b) Provided observable evidence of learning	88%	12%	
c) Clarified what students knew and did not know	90%	10%	
d) Allowed the teacher to see/hear (and intervene) when students did not understand	99%	1%	
e) Led to and connected with other tools in the process of meeting larger /higher level learning goals	94%	6%	
f) Helped students synthesize knowledge and meaning	100%		
g) Provided building blocks that enable students to step into and through difficult concepts or processes to reach predetermined learning goals	100%		
h) Provided pathways that led to depth and clarity in learning	100%		
i)Adds to the meaning-making in the classroom	99%	1%	

NB: When the percentages do not add up to 100%, this indicates that some participants did not rate the specific item/s.

43.	I am a student / qualified healthcare participant	47
44.	I am a teacher/trainer	4
45.	I am a patient	

Students' Comments:

- An eye opener to use this way to ask questions, without prejudices. Very instructive, I can use this in my daily practice.
- it is an difficult subject, we should practice more through method acting
- I liked the lesson, it was very clear to me, during the method acting everybody acted in another way
- It is explained very well, you can really use it in your daily practice. It is an important issue for a nurse

Teacher/Trainers' Comments:

- It helps the students to recognise that they are prejudiced. The staptone model helps them to examine by questioning, still they find it hard to form the right questions. We should practice more through method acting with case studies.
-

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The Marmara University Hospital Intercultural Communication Skills Tool & Evaluation

by
Serpil Tural
Turkey

INTERCULTURAL COMMUNICATION TOOL

THEORETICAL COMPONENT

Principles and Values

Intercultural communication is a form of communication that aims to share information across different cultures and social groups. It is used to describe the wide range of communication processes and problems that naturally appear within an organization or social context made up of individuals from different religious, social, ethnic, and educational backgrounds. (Lauring, Jakob 2011)

- The principles and values that guide this tool include:
- Respect,
- Curiosity about different cultures,
- Tolerance,
- Dignity,
- Tolerance,
- Acceptance,
- Open mindedness.

Aims

The aim of this tool is to improve the cultural competence in the nursing practice. Cultural competence and respect for others becomes especially important in the nursing practice, because culture affects health care services that nurses provide, in school, most of nurses were taught to respect the rights and dignity of all patients. As the world becomes smaller and individuals and societies become more mobile, nurses are increasingly able to interact with individuals from other cultures.

Learning outcomes

At the end of this training, the nurses will be able:

1. To understand the importance of culture affects on health care,
2. To evaluate their knowledge, skills and attitudes across to patient from different cultures.
3. To identify the barriers against effective intercultural communication,
4. To identify strategies to have desirable communication at an intercultural level.

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Relevant definitions and terms/ What the research says

What is Culture?
There are multiple definitions, however Tylor provided a useful definition (Tylor, 1871:1) as "Culture that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society."
Most social scientists today view culture as consisting primarily of the symbolic, ideational, and intangible aspects of human societies. “The essence of a culture is not its artefacts, tools, or other tangible cultural elements but how the members of the group interpret, use, and perceive them. It is the values, symbols, interpretations, and perspectives that distinguish one people from another in modernized societies; it is not material objects and other tangible aspects of human societies. People within a culture usually interpret the meaning of symbols, artefacts, and behaviours in the same or in similar ways." Banks, J.A., Banks, & McGee, C. A. (1989). *Multicultural education*.

Culture is the characteristics and knowledge of a particular group of people, defined by everything from language, religion, cuisine, social habits, music and arts. Many countries are largely populated by immigrants, and the culture is influenced by the many groups of people that now make up the country. This is also a part of growth. As the countries grow, so does its cultural diversity.So while nurses define culture they begin to know the characteristics of different society, or people.

Communication is the process of conveying information from sender to a receiver with the use of a medium in which the communicated information is understood the same way by both sender and receiver.

Intercultural Communication is communication across cultures and social groups. It involves the formation is understanding of different cultures, languages and customs of people from different cultures. (Wikipedia)
Lew Bayer -an expert in the area of cross cultural communication says, “Every person is a walking culture. The social climate of the year we were born in, the country where we're raised, the traditions and customs of our family, and our experiences...all these factors and many more make each of us unique and special individual cultures.”

Why Communication in the Nursing Profession is Important?
We know that communication is the transfer of information between or among people. The practice of nursing utilizes constant communication between the nurse and the patient, the patient’s family, the nurse’s co-workers, supervisors, and many others. Communication in this profession can be a complicated process, and the possibility of sending or receiving incorrect messages frequently exists. It is essential that we know the key components of the communication process, how to improve our skills.
3 Major Components for Successful Communication: A sender, a receiver, and a message. We frequently have a great deal of information to send to others in a short period of time. To do this effectively, we need to know that there are factors which could influence how our message is interpreted. We must consider the setting in which the communication occurs, the past experiences and personal perceptions of both the sender and receiver, the timing of the message, etc.
Breakdown in communication can cause negative outcomes. We all know how important it is to give a thorough patient report to the oncoming nurse at shift change.

In situations where this does not occur and important information is not conveyed, treatments, medications, etc. may be missed. For example, in one situation, an oncoming nurse was not informed that a patient had fallen on the previous shift. The nurse, therefore, did not know to assess the patient for injuries or other complications from the fall, or to

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initiate fall precautions. The patient fell once again and was injured. This possibly could have been prevented had the communication between the nurses been complete. We know that the trust of our patients and their families is an important part of providing effective nursing care. If they don't trust us, any communication that we attempt to send to them may be disregarded. We can take steps to ensure that we have their trust. They may seem simple and self-evident; however, in our busy practice they are not always followed.

Honesty - The First Step towards **Effective Communication in Nursing**
Don't tell a patient that you are going to do something unless you mean it, and if you can't follow through, explain why. Promises, if made, must be kept. Other important factors are availability and responsiveness. Patients and families become impatient and sometimes angry when they feel that they are being ignored. Sometimes these feelings are not reasonable, but sometimes they are justifiable. If we encounter this type of complaint, we need to take a look at the communication process, timing, etc. between the nurse and the patient. If it appears inadequate, take corrective action.

It has been said that as much as 80% of our communication is non-verbal. We need to pay attention to our body language, eye contact, and tone of voice when addressing patients and families. This also is true when addressing nursing delegation with nursing supervisors, co-workers, and virtually everyone else.

Conflict among co-workers can impact patients and sometimes can be prevented or corrected if we are aware of how our attitude may be interpreted. Also, cultural awareness can be an important part of the knowledge base that we need to have when communicating as nurses. For example, we may want to pat the arm or hold the hand of a patient or family member, but we need to make sure that this behaviour is acceptable and not seen as inappropriate.

Most importantly, we must appear to be empathetic with those in our care and communicate as nurses. We are the face of nursing and the face of the facility to our patients and their visitors. We will encounter many people in our professional lives.
They may not remember our names, but they will remember how we treated them during a difficult time in their lives.

How Culture Affects Healthcare
Culture influences not only health practices but also how the healthcare provider and the patient perceive illness. *Knowledge* is being cognizant of the culture base of those in your service area, such as the shared traditions and values of that group. Being aware of your patients' ethnicity—common genetic elements shared by people of the same ancestry—is also important. For example, the epidemiology, manifestation of disease, and effects of medications vary in different ethnic groups. In fact, there's a whole area of study called *ethno pharmacology* that explores how different medications affect people from various ethnic groups (Wessling S, 2011) Research is also being conducted into how cultural beliefs impact medication choice and use.

We all begin the process of learning the behaviours and beliefs of our culture at birth. We become assimilated into that culture and the way that we express is often without conscious thought. Our culture can have a definite and profound effect on how we interact with others, and also how we relate to the healthcare system.

Diversity is prevalent in our society and the patients and our co-workers in our healthcare system today clearly demonstrate that fact. The development of cultural competence in the nursing practice first requires us to have an awareness of the fact that many belief systems exist. At times, the healthcare practices of others may seem strange or meaningless**.** The

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beliefs that others have about medical care in this country, and sometimes their aversion to it, may be difficult for us to understand. We must remember that we don't need to understand these beliefs completely, but we do need to respect them.

Culturally competent care includes knowledge, attitudes, and skills that support caring for people across different languages and cultures. (Seeleman C,2009) Culture influences not only health practices but also how the healthcare provider and the patient perceive illness. (Wessling S, 2011)

PRACTICAL COMPONENT

Practical activities

During our tool we try to improve the skills of nurses.

Activity 1: *Defining Culture by the nurses in-group study*

1. The nurses will try to find definition of culture as a group,
2. All the groups will write their definitions on flipchart,
3. They will present their group definition to the classroom.

Activity 2: *Group study:*

Awareness of cultural diversity, sharing different cultural aspect.
The nurses will talk about different culture characteristics. So they will highlight every person has different culture.

Activity3: *Cultural Diversity*:

Avoid cultural stereotypes while talking to people from other cultures. Multi Cultural Communication made easy.
Watch the following video, https://www.youtube.com/watch?v=XUO59Emi3eo

Then consider the following questions:

1.Discuss why we should avoid cultural stereotypes,
2. How we can understand the people from different cultures?
3.What are the main points you have learned from watching this short video and use in your own practise?

Activity, 4: *Why Communication in the Nursing Profession is Important?*

Discussion in-group.
Question: Is communication important?
Communication is an important part of being a healthcare support worker, as we are very often the first port of contact for patients attending the out patients department. Patients can feel vulnerable in a clinical setting that they are unfamiliar with. This can lead to the individual showing signs of behaviour that they wouldn't show under normal circumstances. Good communication skills can strengthen nursing care, with patients being able to share their worries and stories with the nursing staff (Sheldon 2004). Communication is important to offer a good service to the public. Complaints about health and social care have commented on failures in misunderstandings, inadequate information or failures in communication.

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Activity5: *How we show compassion in nursing care?*
Discussion.
Encourage nurses to tell their stories about showing compassion to patients from different culture.
Think about what are the barriers to show compassion to patients who come from different culture.

Activity 6: *Discover 5 Simple Tips to Improve Nursing Communication*
The definition of a good communicator is: openly and honestly expressing your thoughts and feelings while allowing the other person to openly and honestly express their thoughts and feelings.
To be a good communicator is a skill that is developed with practice. Consider writing these five essential techniques on an index card and carrying them around for a few weeks. This will give you a chance to practice each one until you have them mastered.

In this activty nurses will apply this five techniques following in the classroom as a group study, they will discuss the effect of the techniques, then they will continue for 3 weeks.

Here are five essential techniques to becoming a good communicator:
(Burns, D. (1999). The Feeling Good Handbook. Penguin Putnam Inc. New York.)

1. **Disarming**
   Find some truth in what the other person is saying, even if you feel they are totally wrong, unreasonable, irrational or unfair.
   Disarming sounds like this: “You’re right. I often make mistakes.”

2. **Empathy**
   Put yourself in the other person's shoes and try to see the world through their eyes. There are two kinds of empathy in nursing: thought empathy paraphrases their words and feeling empathy acknowledges how they feel.
   Thought empathy sounds like this: “I want to get this straight. Are you angry with the way I spoke to you?”
   Feeling empathy sounds like this: “You seem very hurt and frustrated with me.”

3. **Inquiry**
   Ask gentle, probing questions to learn more about what the other person is thinking and feeling.
   Inquiry sounds like this: “Can you give me an example?”

4. **“I Feel" Statements**
   Express your feelings with “I feel” statements rather than “you” statements – “you're wrong” or “you make me furious.”
   “I Feel” statements sound like this: “I feel upset.”

5. **Stroking**
   Find something genuinely positive to say to the other person. This indicates that you respect them even though you may be angry with them.
   Stroking sounds like this: “I really appreciate how much you care about your patients.”

Activity 7: *Having Advance Techniques for being good communicator:*

The students will understand how important it is to speak the patient’s language.
Learning to speak a few sentences of patient’s language, for example, Spanish, German etc. It has become a real need in order to better care for patients. Yes, you can get a co-worker

to translate for you or use professional translation service but for better patient care you should use, though poorly pronounced.

When you attempt to speak the patient's language, it tells the patient you care about them. This in turn increases compliance with treatment, discharge instructions, and fosters a positive perception of care. On the other hand if it is not understood with positive nonverbal behaviours it will communicate just the opposite. The encoded messages in our nonverbal behaviours apart from being a distraction to our words, sometimes speak louder than our spoken words. Our posture also has the ability to communicate arrogance, power, prestige, disrespect, or a sense of superiority.

Activity 8: *Importance of Body Language in Nursing Communication*

Thinking about body language and non-verbal communication through these explanation below, then they will try to understand the tips by role play.
Studies show that non-verbal communication represents over 55 percent of all communication. If that estimate is accurate, then positive body language is essential to nursing communication. Because we have a patient-nurse professional relationship, our conversations must be therapeutic, goal-directed and aimed at helping patients heal. Those conversations not only include what we say but how we say it. Kinesics is the study of non-verbal communication. This includes body movements such as nodding, smiling and expressions. Additionally, proxemics comes into play – the amount of physical space between you and the person you are speaking to.

Activity*: Step Body Check/Reality Check*

Nurses will understand at the end of activity the code of body check.

1. Face
It's no secret that the face conveys emotion. An excellent emergency nurse told me this week that one of her patients asked, "Are you upset with me? You look angry." This nurse said she was absolutely not upset with the patient, but because she was rushed, she had not paid attention to her facial expression while in the room. She had let her own experience spill over onto the patient.

Patients see our hearts though our eyes. It takes an incredible amount of nursing professionalism to appear relaxed, make eye contact and help our patient know - for that brief moment – we are "with them." And that we see them not just as a label, but as a human being.

Tip: If you are currently on EMR, practice speaking to the patient for a few moments prior to starting to document. Look up frequently and make eye contact with the patient, nodding and engaging them as you go.

2. Shoulders
Many people carry their stress in their shoulders. The more frustrated, rushed or tired you are, the more you may have a tendency to carry your shoulders high and tight. This posture is not only unhealthy, but will produce frequent back and neck pain.
Tip: Take frequent, slow cleansing breaths. As you exhale, drop your shoulders into a relaxing posture. Slowly move your head back and forth two to three times, as if shaking your head "no." Gently stretch your neck and then shrug your shoulders tightly to your face 2-3 times. Each time you do, take a slow deep breath and drop your shoulders as you exhale. Your patients will read your correct posture as non-aggressive and non-confrontational.

3. Hands
Make sure your hands are open and relaxed. In some cultures, it is rude to have your hands out of sight. Palms should be relaxed and facing the patient openly as much as possible. Try to not fidget with pens or equipment unnecessarily. Your movements should be smooth, rhythmic and purposeful. As you complete tasks with your hands, explain to the patient verbally what you are doing.

Tip. Hands can have a healing touch. If you have developed a quick rapport with the patient, a soft touch to the shoulder or hand – even a pat on the back – conveys confidence and reduces anxiety in most people. If in question, always ask permission before touching a patient.

4. Hips
Make sure your hips are facing towards the patient. Where your hips are pointed it is where your attention is focused. This kind of body language in nursing will let your patients know that you are listening and engaged in their needs, swivel your hips toward them as squarely as possible when speaking. If in a standing position, men may find this position aggressive, so adjust to a slight angle that is not confrontational. If possible, sitting is usually the most relaxed and open posture, with your knees pointing towards the patient.

Tip: If you want to appear totally relaxed to an angry or over anxious patient or family member, shift your weight to one hip. This automatically relaxes the spine and makes you appear in control but carefree at the same time.

5. Toes
Where are your toes in the room? Proxemics is how much space is between you and the person you are talking to. What are you conveying to the patient by where you are standing in the room? Body spacing and posture according to Edward Hall, author of “The Hidden Dimension,” are unintentional reactions to sensory fluctuations or shifts. These also include subtle changes in the sound and pitch of a person's voice.

Distance for communication:
The following summary shows how social distance between people correlates with physical distance as do intimate and personal distance:
•Intimate distance for embracing, touching or whispering: less than 6 - 18 inches
•Personal distance for interaction among good friends/family members: 1.5 feet to 4 feet
•Social distance for interaction among acquaintances: 4 to 13 feet

Although hospital rooms are not always condusive to appropriate proxemics, when you are discussing personal information with a client, strive to be close to their personal space. The conversation is more intimate for sharing and you can better observe facial expressions. This is not to say you can’t stick your head in a patient’s door to let them know you will be with them shortly. However, if you need to offer or request information, you should take the time to move closer to the bedside to show respect and open communication.
Tip: The same idea is true for the nurses’ station. If possible, you want to get your toes out from behind the nurses’ station and pointing towards whoever needs your attention. In a busy work environment, positive body language is difficult and takes practice. But if you will make an effort to correct any poor body language habits, you will find your nursing communication to be smoother and more efficient. Positive body language rarely costs time. In fact, it is a time saver and makes for happier, more relaxed patients. This in turn makes for happier and more relaxed nurses.
(Hall, Edward T. (1966). The Hidden Dimension. Anchor Books. ISBN 0-385-08476-5.)

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The Marmara University Hospital Intercultural Communication Skills Tool Evaluation

CRITERIA	FULLY MET	PARTLY MET	NOT MET
a) Contained customised steps to help students progress through their learning goals	100%		
b) Provided observable evidence of learning	94%	6%	
c) Clarified what students knew and did not know	88%	12%	
d) Allowed the teacher to see/hear (and intervene) when students did not understand	100%		
e) Led to and connected with other tools in the process of meeting larger /higher level learning goals	100%		
f) Helped students synthesize knowledge and meaning	100%		
g) Provided building blocks that enable students to step into and through difficult concepts or processes to reach predetermined learning goals	94%	6%	
h) Provided pathways that led to depth and clarity in learning	100%		
i)Adds to the meaning-making in the classroom	94%	6%	

NB: When the percentages do not add up to 100%, this indicates that some participants did not rate the specific item/s.

46. I am a student / qualified healthcare participant — 40

47. I am a teacher/trainer — 10

48. I am a patient —

Students' Comments:

Lifelong Learning Programme

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