

CROSS-CULTURAL CARE PROGRAM FOR AGED CARE STAFF

WORKBOOK FOR STAFF



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Disclaimer:

This document is an education resource for staff and educators in residential aged care homes. The program is designed to assist staff to improve cross-cultural care for residents and to work with co-workers from diverse cultural backgrounds. The views expressed in the program are those of the authors and not necessarily those of the Commonwealth of Australia. Readers should be aware that the information presented in the program is not necessarily endorsed, and its contents may not have been approved or reviewed by the Australian Government Department of Health who funded the program.

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WORKBOOK FOR STAFF

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INTRODUCTION

Cultural and linguistic diversity between residents and staff is significant in residential aged care homes in Australia. Residents are from over 170 countries with 31% born overseas and 20% born in a non-English speaking country (AIHW, 2016). Staff who care for residents are also from culturally and linguistically diverse backgrounds. It is estimated that 32% of staff were born overseas and 26% were born in a non-English speaking country (Mavromaras et al., 2017). The majority of overseas-born residents come from Europe while the majority of overseas-born staff come from Asian and African regions (Mavromaras et al., 2017, AIHW, 2016). This diversity generates many opportunities for aged care organisations to address equitable and culturally appropriate care for residents. However, the diversity can also be a challenge to achieving high-quality care for residents and to staff cohesion.

The program is developed from a 2-year action research project entitled 'Developing the multicultural workforce to improve the quality of care for residents'. The project is funded by the Australian Government Department of Health under the 'Service Improvement and Healthy Ageing Grants' in 2015. During the project life, the project team worked with residents and staff in four participating residential aged care homes to implement and evaluate the program. The details of the research project are presented in the project final report (Xiao et al., 2017). The program has been adapted into an online self-learning program using the Massive Open Online Course (MOOC) and is free to access. Instruction for accessing the online program is attached as Appendix 1: Instructions for accessing the online Cross-cultural Care Program for Aged Care Staff.

AIM

The aim of this program is to support staff in residential aged care homes to provide high-quality cross-cultural care for residents and to improve team cohesion.

LEARNING MODULES IN THE PROGRAM

This program includes five learning modules that cover most care activities in residential aged care homes.

Module 1 is designed for new staff to develop basic knowledge and skills in cross-cultural interactions. The module includes:

- Part 1: Introduction to cross-cultural care for residents.
- Part 2: Introduction to fostering team cohesion and collaboration.
- Part 3: Work related English language resources for staff.

Modules 2- 5 are designed for all staff who provide direct or indirect care and services for residents and who work with team members from different cultural backgrounds.

Each module includes two parts:

- Part 1: Learning to improve practice and performance. Staff will learn principles, knowledge and skills in cross-cultural interactions with residents and team members. Case studies are developed to support staff to apply new knowledge and skills to their practice context.
- Part 2: Unfolding case study. Staff will watch a short video, engage in self-reflection and respond to challenging questions.

CROSS-CULTURAL CARE TOOL KIT

The program has embedded current research evidence or evidence-based guidelines in cross-cultural communication, leadership, dementia care and end of life care into the learning modules. The cross-cultural care tool kit developed in the project are also incorporated in learning modules to facilitate changes in practice. The tool kit includes:

- Cross-cultural Care - Staff Self-reflection Tool.
- Cross-cultural Care - Leaders Self-reflection Tool.
- Cross-cultural Care Service Audit Tool.
- Multicultural Workforce Management Audit Tool.
- Organisational Support for Cross-cultural Care Services Audit Tool.

MODULE 1

An introduction to cross-cultural care for new staff

MODULE 2

Cross-Cultural Communication

MODULE 3

Cross-cultural leadership

MODULE 4

Cross-cultural dementia care

MODULE 5

Cross-cultural end of life care

TEAMWORK TO IMPROVE CROSS-CULTURAL CARE SERVICES

This program is designed for staff to work with a Facilitator appointed by the care home to learn and improve cross-cultural care services and team cohesion. The **Facilitator Manual** provides the Facilitator with planned learning activities, education tools and audit tools to work with staff to improve cross-cultural care and team work. Facilitators are encouraged to use the manual at a time when on the job training is required by individuals or a group of staff members. Some strategies we tested in the development phase are listed below and may be useful for Facilitators to apply to their own practice context:

- Undertaking internal cross-cultural care service audits to create expectations for improving quality of care and team cohesion.
- Identifying good practice and performance demonstrated by staff in cross-cultural interactions with residents or with team members and promoting them.
- Selecting learning activities to mitigate issues you identified in cross-cultural interactions.
- Embedding the program into workforce management and staff's day-to-day activities.
- Applying one-on-one mentoring, coaching, group learning and self-learning to engage staff in improving cross-cultural care for residents and team cohesion.

The **Workbook for Staff** is designed for staff to interact with the Facilitator and peers in sharing their experiences and engaging in case studies. Following each case study, multiple choice questions are developed to assist staff to consider the application of the learning to their practice.

Please note, the multiple choice questions are not test questions. Staff do not need to submit their answers, or their workbook to the Facilitator. They keep the workbooks as a resource for themselves as part of their own personal and professional development. Staff are encouraged to refer to this resource during the face to face sessions, but also at any time they would like to improve their performance in cross-cultural care services.

GROUND RULES FOR STAFF INVOLVED IN THE PROGRAM

Prior to each session, staff will need to be mindful of the following key points when working in a multicultural team:

- Confidentiality is paramount: What's said in the room stays in the room.
- Allow others to speak and also listen to others: you may learn something about another person's culture, their values and beliefs. Respect one another.
- Support one another: in cross cultural care this is referred to as cultural humility and may give you the confidence to speak about your own experiences.
- Have healthy discussions: be assertive however also be mindful that in some other cultures assertiveness could be defined as 'rude'. We encourage your discussion. Discussion, even if a little uncomfortable and in contrast to another's opinion, can lead to great innovation and resolution if done respectfully.
- Please be conscious of body language and non-verbal responses as these can be disrespectful. Body language can be effective for positive communication, as well as being harmful if negative. Please discuss with the Facilitator if you have questions about disrespectful body language.

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Xiao, L., Willis, E., Harrington, A., Gillham, D., De Bellis, A., Morey, W. & Jeffers, L. (2017) *Developing the multicultural workforce to improve the quality of care for residents: Final report*. Adelaide, Australia.

MODULE 1

AN INTRODUCTION TO CROSS-CULTURAL CARE FOR NEW STAFF



LEARNING OBJECTIVES

On completion of Module 1, new staff and their mentor will be able to:

1. Describe the Australian aged care system with respect to cross cultural care.
2. Explain cross-cultural care services provided by the care home.
3. Identify own strengths and the areas that need to be further improved in cross-cultural care and in working with team members from multicultural backgrounds through reflective self-assessment.
4. Identify the available information, resources, tool kits and supports for staff to provide high-quality cross-cultural support for residents and to work with team members from multicultural backgrounds in a cohesive and collaborative way.

PART 1

INTRODUCTION TO CROSS-CULTURAL CARE FOR RESIDENTS

Australia has one of the most diverse populations in the world. People come from over 200 different countries, practicing over 116 religions (Johnstone and Kanitsaki 2005), and speaking over 260 languages (Department of Immigration and Citizenship 2011). Based on the 2011 census, 46 per cent of Australians were either born overseas or have a parent who was born overseas (Australian Bureau of Statistics 2012).

The Australian population is rapidly ageing. The population aged 65 and over reached 3.57 million at June 2015 and this accounted for 15% of the total Australian population (Australian Bureau of Statistics 2016). Comprehensive aged care services have been developed to support older people to live well, be independent and achieve quality of life.



ACTIVITY 1: UNDERSTANDING THE AUSTRALIAN AGED CARE SYSTEM

The residential care homes in Australia are part of the aged care system and designed to support older people who have complex needs and require 24-hour comprehensive care services.

If you are not familiar with the Australian aged care system, reading Appendix 2 will help you understand the system you work in and how to contribute to aged care.



ACTIVITY 2: BE FAMILIAR WITH CARE SERVICES PROVIDED BY RESIDENTIAL AGED CARE HOMES

1. You will need to read Appendix 3 in order to understand care and support services provided by residential aged care homes and the required standards care homes need to meet.
2. Consider how you can contribute to high-quality care services for residents.

Residential services in Australia reflect the cultural and linguistic diversity of Australian society. Residents come from over 170 countries with 31% born overseas and 20% born in a non - English speaking country (AIHW 2016). The proportion of care workers born overseas is 32% with 26% born in non - English speaking countries (Mavromaras et al., 2017). The majority of overseas-born residents come from Europe (AIHW 2016) while the majority of overseas-born staff come from Asian and African regions (Mavromaras et al., 2017, AIHW, 2016). This population profile in residential care homes adds more complexities to ensuring high-quality care for residents and team cohesion.



ACTIVITY 3: CROSS-CULTURAL CARE SELF-REFLECTION

Before you commence this learning activity, please use the following self-reflection tool to identify your strengths and areas where opportunity for improvement exists.

1. Staff Cross-cultural Care Self-Reflection Tool (see Cross-cultural care tool kit).
This tool is suitable for all staff.

Please note, you can revisit the tool and perform self-reflection at any time. For example, you may perform self-reflection using the tool when you have completed other modules in this education program. You do not need to share your self-reflection results with others. The tool remains your property for personal and professional development. For Registered Nurses (RNs) and Enrolled Nurses (ENs), you may use the self-reflection records along with your completion of the learning module as evidence of continuing professional development (CPD) as required by the Nursing and Midwifery Board of Australia.



ACTIVITY 4: SET OUT YOUR PERSONAL AND PROFESSIONAL DEVELOPMENT GOALS IN CROSS-CULTURAL CARE

1. Discuss with your mentor and list the cultural backgrounds of residents.
2. Based on your self-reflection, consider how to use your strengths in order to contribute to cross-cultural care for residents.
3. Consider what opportunities exist for your personal and professional development.

WHAT IS CROSS-CULTURAL CARE?

Cross-cultural care for residents means staff provide care and support services for residents from other cultures, meet their care needs and achieve quality of care outcomes. It is widely recognised that the most effective way to achieve high-quality care in cross-cultural encounters is effective communication with residents, to identify and meet their care needs (Department of Health and Ageing 2012, Runci et al. 2012). Examples to address some of the challenges of cross-cultural care can be found in the following case studies.



CASE STUDY 1: MRS JONES IS UPSET WHEN BEING CALLED 'SWEETHEART'.

Catherine is a young woman who has successfully gained her first role as a personal care assistant in the residential aged care home. During orientation, she observed that residents are called 'sweetheart', 'dear' or 'love' by some of the other staff. This morning, she tries to assist Mrs Jones, an 88-year old resident, with morning care. When she is greeting Mrs Jones, she says, 'sweetheart, would you like to be dressed now?' Mrs Jones seems upset and says 'I am not your sweetheart'. She also turns her back to Catherine and does not want to talk to her.



Why is Mrs Jones upset and what is the appropriate way to address Mrs Jones?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. It is OK for Catherine to follow other staff's verbal and non-verbal behaviours to communicate with residents.
- ☐ b. Mrs Jones is upset because she does not like to be called 'sweetheart' or 'darling', 'dear' or 'love' as she feels this kind of language does not demonstrate respect for her.
- ☐ c. Residents should always be addressed by their preferred name.
- ☐ d. How a resident prefers to be addressed may differ between cultures.



CASE STUDY 2: MRS CHANG IS NOT HAPPY TO BE CALLED BY HER FIRST NAME.

Mrs Chang is an 85-year old resident from a Chinese background and can communicate with staff using simple English. Today she is cared for by a new personal care assistant, Ahsan, who is from an Indian background. This is also Ahsan's first job in Australia. Ahsan tries to learn as much as she can from other staff and she observes that staff usually call residents by their first name. When she approaches Mrs Chang, she greets her with her first name and says 'Meiying, would you like to have a shower now?' Mrs Chang appears unhappy and says 'This name is not for you to call me'.

Why is Mrs Chang unhappy and what is the appropriate way to address Mrs Chang?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. It is OK for Ahsan to call residents by their first name as other staff usually do this.
- ☐ b. Ahsan apologises for calling Mrs Chang by her first name and asks Mrs Chang how she would like to be addressed.
- ☐ c. Ahsan seeks help from her mentor, Mary, and asks why Mrs Chang does not want to be addressed by her first name. Mary is not sure of the reason and invites, Yan, a staff member from a Chinese background to help clarify.
- ☐ d. Yan discusses with Ahsan and Mary that older Chinese people would like the younger generation to address them with words that show their understanding of seniority, a core Chinese cultural value. Yan also documents examples of how to address residents from a Chinese background in the cross-cultural care resource folder.



WHAT IS CROSS-CULTURAL COMMUNICATION?

Cross-cultural communication is defined as a symbolic exchange process whereby individuals from two (or more) different cultural communities negotiate shared meaning in an interactive situation (Ting-Toomey 2010). All staff will encounter challenges in cross-cultural communication in their daily activities in the multicultural care environment regardless of their cultural background. The six components of competent cross-cultural communication as listed in Table 1 should also be taken into account:

Table 1: Six components of competent cross-cultural communication

SIX COMPONENTS	DESCRIPTIONS
Motivation	Has passion and self-determination for effective cross-cultural communication.
Cultural humility	Is culturally humble to empower others in cross-cultural communication.
English proficiency	Able to communicate with English speakers.
Uses language other than English	Able to communicate with non-English speakers.
Uses different resources	Able to use strategies, i.e. explanations, cue cards, translations, interpreters and family members to achieve effective cross-cultural communication.
Non-verbal	Able to use written communication and understand non-verbal communication.

Residents from culturally and linguistically diverse (CALD) backgrounds whose first language is not English usually encounter more difficulties in cross-cultural communication with staff in residential care homes than residents where English is their first language. Staff need to be aware that even if CALD residents have lived in Australia for a very long period, their English proficiency may be limited and they may lack confidence to communicate with staff in English. Staff need to assess residents' ability in English communication and enable them to choose the ways they feel confident to express their care needs, exercise their autonomy in care services and participate in quality care improvements.



CASE STUDY 3: AN ENABLING ENVIRONMENT FOR A CALD RESIDENT TO COMMUNICATE

Mrs Talbot is a French resident who came to Australia with her husband and three young children several decades ago and had always worked in the home. The family spoke French at home and, although Mrs Talbot could understand English well, she was never very confident speaking it. Sometimes, in her current environment, she feels frustrated when staff misunderstand her due to her accent or when she has trouble picking the right word when speaking English. Sometimes she cannot understand staff who have a very strong accent when they speak in English. She also feels lonely as there is nobody in the Residential aged care home who speaks French.

Apply the Six components of competent cross-cultural communication as listed in Table 1 to case study three and respond to these questions:

What can the staff do to communicate well with Mrs Talbot?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. Because Mrs Talbot has been living in Australia for a long time and understands English well, the staff would expect Mrs Talbot to speak to them in English because they do not speak French.
- ☐ b. The staff could encourage Mrs Talbot to speak English but also ask her to teach them some French words. Together they could develop a chart of French and English words that Mrs Talbot and the carers co-learn.
- ☐ c. Use the chart co-developed by Mrs Talbot and staff as a resource to enable cross-cultural communication if the accent of staff or Mrs Talbot is a factor.
- ☐ d. While assisting her with activities of daily living, staff could practice speaking French words and phrases and encourage Mrs Talbot to speak to them in English. When Mrs Talbot uses English they could give her positive feedback.





CASE STUDY 4: WRITTEN COMMUNICATION HELPS OVERCOME A DIFFICULTY WITH ACCENTS

Ming, a Chinese carer working on an evening shift, asked Mrs Finnegan, who is Irish, if she would like some assistance to get ready for bed. Mrs Finnegan could not understand what Ming was saying even though Ming repeated the question three times speaking as clearly as she could.

What can Ming do to improve her communication with Mrs Finnegan?

Please use ✓ to indicate a good response and ✗ to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. Ming could decide that it was too difficult for her to communicate with Mrs Finnegan and leave her for one of the Australian carers to assist her to go to bed.
- ☐ b. Ming could clean Mrs Finnegan's glasses, check that her hearing aid is turned on, and get a piece of paper and write down the question 'Do you want to go to bed?' in large letters. Ming could be patient and maintain eye contact with Mrs Finnegan as she showed her the written message. She could also gesture, for example by pointing to the bed and Mrs Finnegan's nightie.
- ☐ c. Ming could ask another staff member to help her practice the pronunciation of words.



CASE STUDY 5: NON-VERBAL CUES ASSISTS IN MANAGING PAIN FOR MRS PASCALE

Mrs Pascale is a Lebanese resident who has a diagnosis of dementia and no longer speaks any English. She also has arthritis and has a PRN order for Panadeine Forte tablets for joint pain. When a personal care assistant, Kerry assisted Mrs Pascale with her hairstyling and make up, Mrs Pascale grimaced as she raised her right arm to fix the comb in her hair. She also shows resistance to being assisted to style her hair.

What should Kerry and the care team do to better manage Mrs Pascale's pain?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. Kerry needs to continue her care activity and report Mrs Pascale's pain to the RN after she completes the activity.
- ☐ b. Kerry needs to ask Mrs Pascale whether she is in pain using a cue chart before assisting Mrs Pascale with her hairstyling and make-up.
- ☐ c. If Kerry notices that Mrs Pascale is in pain, she needs to report it to the RN and minimise activities that may make it worse.
- ☐ d. RN Ansh (from an Indian background) attends Mrs Pascale in a timely manner and assesses the pain utilising a tool specifically designed for people living with dementia (for example, Pain Assessment in Advanced Dementia scale (PAINAD) or the Abbey pain scale; please check the tool used in your care home.)
- ☐ e. RN Ansh also seeks help from a staff member who can speak Lebanese Arabic to assess the level of pain Mrs Pascale is experiencing.
- ☐ f. RN Ansh administers two Panadeine Forte tablets according to the care plan without further actions.
- ☐ g. In the handover and in the case notes, RN Ansh reminds staff that Mrs Pascale is to be assessed for pain ½ hour before assisting her with ADLs and PRN analgesia is to be offered before ADLs commence.



MEETING RESIDENTS' RELIGIOUS AND SPIRITUAL CARE NEEDS

Holistic care for residents aims at meeting residents' physical, psychological, social and spiritual care needs. Quality requirements for residential care services that are holistic are documented in the 'Quality of Care Principles 2014' (Australian Government ComLaw 2014). This document is available in residential care homes. New staff, particularly those who have supervision and management roles need to be familiar with these requirements.

Cross-cultural care services need to be respectful and acceptable to residents who have religious and spiritual preferences in their care needs and to improve their experiences and satisfaction with care services. Identifying and meeting resident's spiritual care needs is important to maintain residents' well-being. Respect for their religious and spiritual preferences is a basic human need. Religious and spiritual needs should be recorded in care planning in consultation with residents and their families.



ACTIVITY 5: IDENTIFY RESIDENTS' RELIGION AND SPIRITUALITY NEEDS

1. Discuss with your mentor, up to five residents who are from CALD backgrounds.
2. Check the care plan for these residents and summarise their religious and spiritual needs in Table 2.
3. Discuss with your mentor if you are not familiar with the care services utilised to meet residents' religious and spiritual needs.

Table 2: Summary of residents’ religious and spiritual needs

RESIDENTS *	RELIGIOUS AND SPIRITUAL NEEDS	CARE AND SERVICES TO MEET THESE NEEDS

Note: please use code, rather than the real name for residents in this table.



CASE STUDY 6: MEETING LEJA'S PREFERENCE IN SPIRITUAL CARE

Leja is a resident who recently moved from an independent living unit to residential care. She is from a Lithuanian cultural background and the lighting of candles is an important part of her ritual when she is praying. Scott, a Personal Care Assistant, recently found Leja lighting two candles in her room. The residential aged care service has a policy that no natural candles can be lit within the building due to the safety risk. Scott took Leja's candles away when he discovered them and this made her extremely upset. He reports this incident to RN Ralph, indicating that Leja was calling out loudly in another language and shaking her hands in the air passionately after he took the candles. He asked if something could be done to calm her.

How could the care team handle this situation with cultural sensitivity and without triggering distress for Leja?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. Scott could have asked Leja's permission to remove the candles immediately and explained the risk of leaving the burning candles in her room.
- ☐ b. Scott could have approached the situation as a 'workplace risk' and just reported the lit candles to the Workplace Health and Safety Officer.
- ☐ c. Registered Nurse Ralph could have taken the candles back to Leja and apologised on Scott's behalf for his taking them.
- ☐ d. Ralph could discuss the significance of the candles with Leja and offer her some electric candles that would be consistent with the home's safety policy.
- ☐ e. Ralph could record in Leja's care plan and also at handover to remind staff that the lit candles are of significance to Leja's spiritual well-being. Therefore, electric candles should remain in her room and be used as a substitute to real candles to meet Leja's spiritual needs.



PART 2

INTRODUCTION TO FOSTERING TEAM COHESION AND COLLABORATION

The Australian aged care workforce has become increasingly multicultural in the past decade (Mavromaras et al., 2017). Based on the aged care workforce census in 2016, the proportion of care workers born overseas and born in non - English speaking countries is 32% and 26% respectively with the majority of overseas-born staff coming from Asian and African regions (Mavromaras et al., 2017). The diversity of the workforce can have implications for care delivery in residential care homes and for fostering team cohesion and collaboration.



ACTIVITY 6: SET OUT YOUR PERSONAL AND PROFESSIONAL DEVELOPMENT GOALS FOR TEAM COHESION

1. Discuss with your mentor and identify the cultural backgrounds of team members.
2. Find out something about these cultures.

It has been recognised that a healthcare workforce that reflects Australia's diverse population is a strength in delivering culturally and linguistically appropriate healthcare and reduces healthcare disparity in a multicultural society (NHMRC 2006). The growing diversity of care workers in residential care homes creates opportunities to improve cross-cultural care for residents. Studies have shown that multicultural teams have advantages in that they are better prepared to generate new ideas and solutions to meet care needs for residents from CALD backgrounds (Runci et al. 2012, Runci et al. 2014). In addition, team members are able to act as cultural brokers or cultural advisors to address residents' care needs (Xiao et al. 2014, Dreachslin et al. 2000).



ACTIVITY 7: IDENTIFY YOUR STRENGTHS AND USE THESE IN CROSS-CULTURAL CARE

1. Revisit 'Cross-cultural Care Self-Reflection' (see Cross-cultural care tool kit) and identify your strengths and how to use these to contribute to a team approach to cross-cultural care.
2. Summarise your findings in Table 3 on page 19.

Table 3: My plan to contribute to a team approach to cross-cultural care

I HAVE THESE STRENGTHS IN CROSS-CULTURAL CARE	I CAN USE THESE STRENGTHS IN THE TEAM BY:

Culture also influences people's world views, actions, communication styles and expectation of others (Giger 2013). People also have a tendency to believe that one's own world view is superior to another's world view (or so-called ethnocentrism) (Giger 2013). People may also make assumptions that persons from the same culture are alike and share the same values and beliefs (so-called stereotyping). These assumptions do not take account of diversity within a cultural group, but contribute to interpersonal conflict, potential mistreatment towards team members and lack of team cohesion. These issues have a negative impact on cross-cultural communication, team collaboration, productivity and staff job satisfaction.



ACTIVITY 8: IDENTIFY WHAT YOU CAN DO TO CONTRIBUTE TO TEAM COHESION

Still use 'Cross-cultural Care Self-Reflection' (see Cross-cultural care tool kit) to identify the way to contribute to team cohesion and collaboration. Summarise your findings in Table 4 on page 21.



ACTIVITY 9: USE RESOURCES TO IMPROVE CROSS-CULTURAL COMMUNICATION

1. Check the 'Cross-cultural communication tips' (see Appendix 4) and keep these tips in your mind when communicating with residents and team members from other cultures.
2. Check the resource section listed in this module and identify those that are relevant to your learning needs in cross-cultural communication.

Table 4: My plan to contribute to team cohesion

I HAVE THESE STRENGTHS TO CONTRIBUTE TO TEAM COHESION	I CAN USE THESE STRENGTHS IN THE TEAM BY:



CASE STUDY 7: TEAM COHESION IS ACHIEVED BY ASSISTING DEKA IN CROSS-CULTURAL CARE

Deka is a personal care assistant from an African background who arrived in Australia as a refugee and has just commenced working in aged care. A resident, Mrs Hall, rang her call bell and asked Deka if she could get her slippers for her because the bunion on her right foot was hurting and she did not want to keep wearing her usual leather shoes. Deka had never heard the word 'slippers.' Although Deka tried to work out what Mrs Hall meant, she didn't understand and there was no-one else nearby to ask. Mrs Hall became annoyed, banged her walking stick on the floor, and told her to get an Australian carer. Deka was upset and ran from the room and found James, an Australian-born carer who was also new.

What can James do to assist team members?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. James could go into Mrs Hall's room, get her slippers from her wardrobe, change her leather shoes for her slippers and fix the problem.
- ☐ b. James could speak to Mrs Hall and explain the misunderstanding because Deka was not familiar with the word 'slippers'.
- ☐ c. He could show Deka the slippers and explain that they were a soft shoe, easy to put on, and that Australians usually wear them before bed and before changing to day clothes in the morning. He could then give the slippers to Deka to help Mrs Hall change into them from her leather shoes.
- ☐ d. James could report the incident to the Registered Nurse so that the word 'slippers' be added to a living dictionary for CALD staff that the multicultural care team were compiling to assist in cross-cultural communication with both staff and residents.



CASE STUDY 8: WHAT SHOULD JIA DO TO CONTRIBUTE TO TEAMWORK AND COLLABORATION

Recently the Residential Care Manager Lucy received a number of complaints from long term personal care assistants, Miguel, Princess and May, who originally emigrated from Philippines. The person they complained about is a new staff member, Jia an international nursing student from Malaysia, who works as a part-time personal care assistant in the care home. Jia had been quite bossy towards them and ignored their attempts at teamwork directives when working with them. They also overheard that Jia made comments to other staff that 'I am a nursing student and I would not be led by these Filipinos who usually work as maids in my country'. Miguel, Princess and May felt that Jia's behaviour also influenced other staff's attitudes towards them and they felt isolated in the workplace.

What can the Residential Care Manager Lucy do to resolve the tension between staff from different cultural backgrounds?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. Lucy could meet with Jia, Miguel, Princess and May and advise them that they are required to cooperate with each other at work because teamwork is necessary to provide good resident care.
- ☐ b. Lucy could introduce Jia to the Residential Aged Care Home's vision and the organisation's values. Together they could work through these, spending some time on the behaviours supporting the values that staff are expected to display in their work behaviours.

- ☐ c. Lucy could explain to Jia that in Australia and within the organisation, treating people based on social class is classified as discrimination. She could then give Jia a copy of the organisation's human resources policy on anti-discrimination, bullying and harassment and ask Jia to read this and put this into practice.
- ☐ d. Lucy could then explain to Jia that in the event that further reports on her discriminatory behaviour were received, she would have to place her on a Performance Management Plan.
- ☐ e. Lucy could inform Miguel, Princess and May that she has solved the problem they were having with Jia.
- ☐ f. Lucy could then meet with Miguel, Princess and May and ask that they let her know of any further concerns they have with Jia. She could also give them the details of the Employee Assistance Program in the event that any of them wish to talk about an event with a confidential external counsellor.
- ☐ g. Lucy could organise a staff development session and invite recognised peer role models in the organisation to share their experiences in supporting team members and contributing to team cohesion and the impact of teamwork on quality of care for residents and job satisfaction of staff.



ACTIVITY 10: BE FAMILIAR WITH POLICIES RELATED TO ANTI-DISCRIMINATION

Please complete the following activities:

1. Please find and familiarise yourself with your workplace policy related to anti-discrimination, bullying and harassment.





CASE STUDY 9: THE USE OF INCIDENT REPORTING TO FACILITATE CONTINUOUS QUALITY IMPROVEMENTS

Mr Green is a long term resident from Australia. Recently, Iman from Syria, commenced working at the care home. Mr Green was concerned that Iman was working in the home and he asked Annie, a long standing care worker to ensure Iman was not assigned to care for him as he did not like Muslims. Annie had received similar requests from Mr Green regarding staff from some CALD backgrounds. The RNs had also received reports in the past stating that Mr Green had referred to several staff with derogatory names.

During a busy evening shift, RN Tahlia asked Iman to answer Mr Green's call bell. Mr Green responded angrily and shouted at Iman telling her to 'go back home where you come from.'

Iman is upset by the comment and does not want to go near Mr Green again.

Tahlia explains to Iman that she should report the incident and helps explain what to report.

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. Tahlia should complete the incident report herself as she has the necessary knowledge about how to complete it.
- ☐ b. Iman should report exactly what happened and what was said.
- ☐ c. Tahlia should explain her version of events surrounding the incident.
- ☐ d. There is no need to complete an incident report because there was no physical damage or violence.
- ☐ e. The incident should not be reported because Mr Green is a resident and it is his right to refuse care.
- ☐ f. Tahlia could direct Iman to the Employee Assistance Program.
- ☐ g. Mr Green should complete the form.
- ☐ h. Iman could be approached later to see if she is still upset by the event.
- ☐ i. Tahlia needs to discuss with Mr Green and acknowledge that he experienced distress and a free counselling service will be provided for him to manage his distress. Tahlia also emphasises that he needs to respect staff as they are required to respect him.

PART 3

WORK RELATED ENGLISH

LANGUAGE RESOURCES FOR STAFF

The resources are available via: www.flinders.edu.au/aged-care-english

RESOURCES

A Fair Dinkum Aussie Dictionary: A collection of Aussie terms and sayings

<http://canguroenglish.com/site/wp-content/uploads/2016/09/AussieDictionary.pdf>

Aussie Slang

<http://aussieslang.org/stirne/r.php>

Australian Food and Drink

<http://www.australia.gov.au/about-australia/australian-story/austn-food-and-drink>

Australian Multicultural Council

<https://www.dss.gov.au/our-responsibilities/settlement-and-multicultural-affairs/programs-policy/a-multicultural-australia/australian-multicultural-council>

Charter of Care Recipients' Rights and Responsibilities - Residential care:

<https://agedcare.health.gov.au/publications-and-articles/guides-advice-and-policies/charter-of-care-recipients-rights-and-responsibilities-residential-care>

Communication Cards

<http://www.culturaldiversity.com.au/resources/multilingual-resources/communication-cards>

Diversity of older Australians:

<http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442454209>

Health Translations:

http://www.healthtranslations.vic.gov.au/bhcv2/bhcht.nsf/PresentDetail?Open&s=Cue_Cards

Meaningful Ageing Australia - Spiritual care in Aged Care:

<https://www.youtube.com/watch?v=LS06mPwU6HU>

National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse Backgrounds:

<https://agedcare.health.gov.au/older-people-their-families-and-carers/people-from-diverse-backgrounds/national-ageing-and-aged-care-strategy-for-people-from-culturally-and-linguistically-diverse-cald-backgrounds>

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https://www.sarmy.org.au/Global/SArmY/Social/econnect/issue71/olderaboriginal-torresstraitislander_people.pdf

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MODULE 2

CROSS-CULTURAL COMMUNICATION



LEARNING OBJECTIVES

On completion of Module 2, staff will be able to:

1. Describe the cultural and linguistic characteristics of residents and staff in the facility.
2. Explain the value of your own culture and the cultural diversity of others.
3. Define and explain 'cultural competence' and 'cultural humility' in cross-cultural communication.
4. Discuss challenges and opportunities in achieving cultural competency and cultural humility in staff-residents/their family and friends and staff-staff cross-cultural communication.
5. Identify useful information, resources and strategies to achieve cross cultural communication in the workplace.
6. Demonstrate an ability to apply effective cross-cultural communication.

PART 1

LEARNING TO IMPROVE PRACTICE AND PERFORMANCE

CULTURE

Culture is *'a learned, patterned behavioural response acquired over time that includes implicit and explicit beliefs, attitudes, values, rituals, customs, norms, taboos, arts/ artefacts and lifeways accepted by a community of individuals'* (Purnell, 2011, p. 528). Australia is a multicultural nation recognising the Aboriginal and Torres Strait Islander people as the first Australians together with years of immigration. The many different cultures mean that cross-cultural communication is extremely important.



ACTIVITY 1: COMPARE SOME OF THE VALUES, BELIEFS, CUSTOMS AND NORMS

1. Bring 1-2 pieces of art or artefacts from your culture to share and explain the meaning associated with these pieces with other staff in your workplace.
2. Discuss and compare some of the values, beliefs, customs and norms that come from your culture and a different culture to your own and record them in Table 1.

Table 1: Compare some of the values, beliefs, customs and norms that come from your culture and a different culture to your own

CULTURE	EXAMPLES OF VALUES, BELIEFS, CUSTOMS AND NORMS
Your culture	
Another culture	

CULTURAL AND LINGUISTIC DIVERSITY

The term ‘culturally and linguistically diverse’ or CALD background has been widely used in Australia and refers to a person who differs from the mainstream culture according to their country of birth, religion, spirituality, racial background and ethnicity, as well as language (Ziaian and Xiao, 2014).



ACTIVITY 2: SUMMARY OF CULTURAL AND LINGUISTIC DIVERSITY IN THE FACILITY

Ask the Care Co-ordinator or other resource persons about the cultural and linguistic diversity of residents and staff in your facility. Briefly record your discovery in Table 2.

Table 2. Summary of cultural and linguistic diversity in the facility

LIST RESIDENTS’ CULTURES YOU KNOW	LIST STAFF’S CULTURES YOU KNOW	CULTURAL MATCHING BETWEEN RESIDENTS & STAFF

CROSS-CULTURAL COMMUNICATION

Cross-cultural communication is defined as a symbolic exchange process whereby individuals from two (or more) different cultural communities negotiate shared meanings in an interactive situation (Ting-Toomey, 2010). Competent cross-cultural communication has six components as listed in Table 3.

Table 3. Six components of competent cross-cultural communication

SIX COMPONENTS	DESCRIPTIONS
Motivation	Has passion and self-determination for effective cross-cultural communication.
Cultural humility	Is culturally humble to empower others in cross-cultural communication.
English proficiency	Able to communicate effectively in English.
Uses language other than English	Able to communicate with non-English speakers.
Uses different resources	Able to use strategies, i.e. explanations, cue cards, translations, interpreters and family members to achieve effective cross-cultural communication.
Non-verbal	Able to use and understand non-verbal communication.



CASE STUDY 1: CALD RESIDENTS-STAFF CROSS-CULTURAL COMMUNICATION

Stefano, a 78 year old Italian resident, is known to hit out at care staff when they try to assist him with his morning shower. A recent progress note states 'Stefano was approached and asked if he would like a shower, and responded 'me no speak English'. He hit both personal care staff, Elly and Len, when they tried to transfer him from his bed to a shower chair and yelled 'Abbastanza, Abbastanza ABBASTANZA!'

What could Elly and Len do if their approach does not work?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

Elly and Len could:

- ☐ a. Leave Stefano unattended.
- ☐ b. Use a cue card with a picture to show that they have come to assist Stefano with showering.
- ☐ c. Insist he has to have a shower as his incontinence pad is soiled.
- ☐ d. Seek advice from staff who know how to communicate with Stefano effectively.
- ☐ e. Use cue cards to encourage Stefano to choose a shower or a wash in the bed.
- ☐ f. Use non-verbal communication such as eye contact, a smile and gently touching his hand while explaining the procedure of showering using the cue card.
- ☐ g. Learn to speak a few words in Italian to greet and facilitate showering when approaching Stefano.

- ☐ h. Approach the family for help via phone or other means of communication if it is possible.
- ☐ i. For the management group: Assign staff who can speak Italian to assist Stefano with a shower when it is possible.



CASE STUDY 2: AUSTRALIAN-BORN RESIDENTS CALD STAFF CROSS-CULTURAL COMMUNICATION

Mrs Jan Smith is very deaf, but is cognitively intact. She described how she communicates with CALD staff:

Very often, you know, they ask - 'do you want a shower?' I say yes. I can say yes and then if I want my hair washed I do this sort of thing (gesture of washing hair.) But of course some of them know now, but with the new ones you've really got to sort of try and explain. I always say, 'Look I'm very deaf so just watch what I do' (gestures.)...

What could staff do to meet Jan's cross-cultural communication needs?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

Staff could:

- ☐ a. Follow Jan's instructions and the care plan to complete tasks.
- ☐ b. Check if Jan is wearing a hearing aid correctly prior to communicating with her.
- ☐ c. Use written English or pictures to clarify Jan's care needs if oral communication is difficult.
- ☐ d. Talk towards the better ear.
- ☐ e. Speak distinctly, slowly, and directly to Jan.
- ☐ f. If Jan does not understand, repeat the message using different words.
- ☐ g. Raise the volume of your voice when talking to Jan.
- ☐ h. Use body language to show what you are trying to communicate with Jan.
- ☐ i. Avoid or eliminate background noise.



CULTURAL SENSITIVITY

When people are open to cultural diversity without judgement of right or wrong or good or bad, and when people use both verbal and non-verbal communication in a way that is respectful and acceptable for people from other cultures, people demonstrate cultural sensitivity (Purnell, 2008). It is about being open and accepting of difference.



CASE STUDY 3: STAFF-STAFF CROSS-CULTURAL COMMUNICATION

Delara is a young woman who came to Australia as a refugee from Afghanistan. She has just completed Certificate III in aged care and has been employed to work as a personal carer in a residential aged care home. She is identified by her co-workers as 'very quiet', 'slow' and barely asks questions even if she does not know how to find things or complete care activities. Her co-workers talk about her behind her back.

What are some ways her co-workers could react differently?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

The co-workers could:

- ☐ a. Make complaints to the supervisor and request not to work with Delara.
- ☐ b. Ask Delara to demonstrate how she greets older people and shows them respect in her home country.
- ☐ c. Confront Delara and tell her that her performance is poor and that she puts a burden on other team members.
- ☐ d. Ask Delara to discuss how older people are respected and addressed in her home country.
- ☐ e. Engage Delara to share with team members, the similarities and differences of caring for older people in Delara's home country and in Australia.
- ☐ f. Share difficulties that you had encountered when you began to work in the care home in order to encourage Delara to share her experiences and seek help.
- ☐ g. Assign Delara to tasks that she can do alone and that won't affect others.

CULTURAL AWARENESS

When people are knowledgeable about the similarities and differences of cultures and have an appreciation of diversity and inclusion, people demonstrate cultural awareness (Purnell, 2008). Cultural awareness involves being inclusive of people from other cultural backgrounds, being curious and asking questions about other cultures and sharing your own culture with others.

CULTURAL COMPETENCE

Cultural competence in health care is a set of attitudes, behaviours, knowledge, skills, approaches and actions aiming for effective cross-cultural care, cultural safety, cultural awareness, cultural sensitivity and cross-cultural communication that emphasises inclusion and tolerance rather than exclusion and intolerance (Cross et al., 1989, Campinha-Bacote, 2002). Cultural competence is about accepting, being non-judgmental, curious and sensitive to others' cultures.

CULTURAL HUMILITY

Cultural humility is an important attribute of cultural competence and it is defined as developing a reciprocal and equal partnership for mutual benefit and is based on self-awareness of the power imbalance in cross-cultural interactions (Hook et al., 2013). Staff who are culturally humble usually encourage CALD residents to express their care needs as well as meet their other needs.



CASE STUDY 4: CULTURAL INCLUSION IN STAFF COMMUNICATION

Recently an incident took place in the staff room over lunch. Dave and Tilly, both personal care workers, were having lunch and felt intimidated by a group of CALD staff members (who were all originally from Greece) as they were talking in their native language. Dave and Tilly reported to the Registered Nurse in Charge, Elizabeth, that they were sick and tired of this group talking in a 'foreign' language whilst in the staff room and felt they were being talked about as at times, this group would look at them, say something, and then laugh.

How might this situation be resolved to improve cultural inclusion and workforce cohesion?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

Staff could:

- ☐ a. The Registered Nurse, Elizabeth could take action by stopping the group of staff speaking in Greek and ask them to speak English.
- ☐ b. Elizabeth could discuss this issue with the care home manager and suggest that the organisation's cultural inclusion policy and examples of good practice in this area, need to be introduced to new staff.
- ☐ c. In the staff meeting, the care home manager could also encourage staff to discuss the situations where they may need to speak in their first language rather than English while avoiding situations where it affects other staff.

CULTURAL DIFFERENCES

The major barrier to effective cross-cultural communication between persons is driven by cultural differences aimed at a person's ethnicity, culture or religion. This can present as stereotyping, discrimination, prejudice, abuse, exclusion, intolerance and/or marginalisation. It can be obvious or hidden and can sometimes occur without the person knowing they are involved in such behaviours. It is important that staff are made aware of what constitutes undesirable behaviour so that it can be addressed when and if it arises.

It is important that staff are aware of all Australian laws in relation to equal opportunity, human rights, work health safety and the prevention of racial discrimination. These laws are as applicable in the work place as they are in the general community and everyone involved in a residential aged care facility - from residents, to families, staff to visitors have an obligation to maintain respectful relationships consistent with these laws. A culturally safe workplace will be built when all behaviour is consistent with such laws and tolerance and understanding practiced.



CASE STUDY 5: PROMOTING INCLUSIVE BEHAVIOUR FOR CALD STAFF

When discussing discrimination, Karl, a careworker, disclosed the following:

'I've been called a chocolate drop several times by some residents. Other times they say to staff - I don't want that negro coming to my room. Sometimes I'll go into a room and as somebody who's very dark skinned, the resident will look at me and say, 'get out of here,' quite bluntly. I do know that a lot of them (CALD staff) get racially discriminated against by the residents but they don't talk about it. For me I didn't report it because I feel that people are sort of not really aggressive but they look like they will not accept somebody they don't know.'

How might these situations be resolved to improve cultural inclusion and resident-staff relationships?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

Staff could:

- ☐ a. Ignore these racially negative comments and behaviours.
- ☐ b. Report every incident that staff believe are associated with racially negative comments and behaviours.
- ☐ c. Avoid residents who have negative attitudes and behaviours toward CALD staff.
- ☐ d. Organise cultural days and events to allow residents/their families and staff to get to know each other and share their stories and cultures in a positive way.
- ☐ e. Use multiple resources, for example posters, food recipes and utensils, movies and travel documents to raise awareness of cultural diversity, respect and tolerance in the workplace.

PART 2

AN UNFOLDING CASE STUDY - MRS NIKOU

COMMUNICATION DIFFICULTIES AFFECTING THE TRANSITION INTO RESIDENTIAL CARE



VIDEO 1: AN UNFOLDING CASE STUDY: MRS NIKOU

Play the following video (4:20) via: <https://youtu.be/UaCs6tb9FLQ>

INTRODUCTION TO MRS NIKOU

Mrs Nikou is an 89 year old lady from a Greek background who was admitted to the residential home recently. She migrated to Australia with her husband in 1959 as part of the influx of Greek immigrant's post World War II. The Greek Government encouraged emigration to solve poverty and unemployment issues and the Australian Government accepted a high intake to meet labour shortages. Mr and Mrs Nikou used to run a market garden and raised five children. Two daughters live abroad and two sons are interstate.

After Mrs Nikou's husband died in 2010 and until recently, she lived with her fifth son, Costa, and her daughter in law, Eleni. At home, the Nikou family always speak Greek. Mrs Nikou completed three years of primary school education in Greece and has limited skills in English. She is Greek Orthodox and still attends services regularly.

Since having a minor stroke two years ago she has developed swallowing difficulties and requires a special diet. She has hearing and vision impairments and requires assistance with activities of daily living. She is able to manage her meals independently however, she takes longer to complete her meals. She enjoyed growing vegetables for the family when she lived with Costa and Eleni. Eleni was her primary carer prior to Mrs Nikou's admission to the home. Eleni was recently diagnosed with Alzheimer's disease and is no longer able to care safely for Mrs Nikou. Costa can't care for his mother as he has commitments to meet; working and caring for his wife. The family made a difficult decision to move Mrs Nikou into an aged care home.



ACTIVITY 3: IMPROVING TEAM COHESION

Brainstorm and discuss the following in a group:

- a. Mary the Care Coordinator suggests that the home appoints Registered Nurse Karen to champion cross-cultural care by leading and coordinating the development, implementation and evaluation of a care plan for Mrs Nikou and other residents when needed.
- b. If staff have an accent that affects how Mrs Nikou understands them, they must use written English instead.
- c. Mrs Nikou's family should prepare a communication booklet for staff on the first day that she moves into the care home.
- d. Costa offers to write the main elements of the day in Greek for Mrs Nikou to follow. Karen, the cross-cultural care champion, converts Costa's information regarding common words that Mrs Nikou uses, onto cue cards for the staff to use.
- e. Staff need to use a cue card with Greek/English text and pictures to communicate with Mrs Nikou. Using the cue cards, they can ask her about preferences for her care and get her permission before taking action.
- f. Staff need to put signs with pictures in Mrs Nikou's room and in her bathroom.
- g. Staff need to learn a few words in Greek and use these words to greet Mrs Nikou when they approach her.
- h. If possible, staff from a Greek cultural background who speak Greek will be assigned to care for Mrs Nikou.
- i. Karen organises a Volunteer Community Visitor who is from a similar area in Greece as Mrs Nikou and who also has similar interests, to visit her.
- j. Karen learns that Mrs Nikou's son Costa used to take her to the Greek Orthodox Church every week before her admission to the nursing home. Mrs Nikou is too frail to attend and has to stop going now.
- k. The kitchen staff have a minimal role to play in meeting Mrs Nikou's dietary preferences, as they must not exceed the food budget.
- l. Costa requests a home meal delivery service for Mrs Nikou three times a week via the local Greek Welfare Centre. The family is happy to pay for the additional services. Karen needs to contact the service provider and arrange for the services.



ACTIVITY 4: GROUP DISCUSSION

Discuss the following questions in small groups and feedback to the larger group:

1. What problems have you identified in this case study?
2. What specific care needs have you identified for Mrs Nikou based on the information provided?
3. What care and services are available and accessible to meet Mrs Nikou's specific care needs in the facility and what are your suggestions for enhancing the care services?
4. What knowledge, skills and attitudes are required by staff in order to meet the care needs identified for Mrs Nikou?
5. What are the workplace policies, procedures, personnel and resources available that relate to the cross-cultural care service requirements of Mrs Nikou?
6. Are there continuous improvement opportunities that you have identified from this case to help promote an enabling environment in the facility? What are they and how are you going to progress with these?

MRS NIKOU IS MAKING PROGRESS TO ADJUST TO HER NEW HOME

The RN, Karen, observed that staff learned how to greet Mrs Nikou in Greek and used cue cards and body language to communicate with her to meet her care needs. Mrs Nikou gradually developed an interpersonal rapport with staff and even taught staff words in Greek and talked about Greek food and artefacts in her room. Mrs Nikou also enjoyed having a Greek Community Visitor who brought some photographs of Greece and conversed with Mrs Nikou in her first language. In a conversation with Mrs Nikou assisted by her son Costa to interpret, Mrs Nikou told Karen that she appreciated being able to go out to the Greek Orthodox Church for a service every Sunday morning and that she felt better now that the Greek Orthodox priest was visiting her in the aged care home.

Mrs Nikou was enjoying the Greek lunches that were being delivered to the home for her. She thanked Karen for rostering a Greek carer for her ADLs whenever possible and had discovered that she knew the mother of one of the Greek carer's. She was also starting to make friends with another Greek resident who had only been admitted a fortnight ago. She told Karen that having some Greek staff and another Greek friend in the home made her feel much happier.



ACTIVITY 5: SUMMARY OF THE CASE STUDY

In small groups, summarise the cross-cultural communication knowledge, skills and attitudes of staff. Write up these attributes and provide feedback to the larger group.

RESOURCES

Aged Care Signage, Centre for Cultural Diversity in Ageing

<http://www.culturaldiversity.com.au/resources/multilingual-resources/aged-care-signage>

Calendar of Cultural and Religious dates

<http://www.harmony.gov.au/events/calendar/>

Centre for culture, ethnicity and health

<http://www.ceh.org.au/>

Communication Cards, Centre for Cultural Diversity in Ageing

<http://www.culturaldiversity.com.au/resources/multilingual-resources/communication-cards>

Working Cross Culturally: A Guide

<http://www.ecald.com/Portals/49/Docs/Publications/Working%20Cross%20Culturally.pdf>

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MODULE 3

CROSS-CULTURAL LEADERSHIP



LEARNING OBJECTIVES

On completion of Module 3 staff will be able to:

1. Provide a definition of a leader and leadership within the Australian Health Leadership Framework.
2. Demonstrate abilities to apply leadership attributes to their own practice in cross- cultural care services.
3. Lead and engage with others to identify and meet residents' care needs in cross- cultural interactions.
4. Lead and engage with others to identify and resolve potentially negative cross-cultural interactions in a timely and culturally appropriate manner.
5. Demonstrate an ability to mentor new staff, promote self-care in the workplace and identify culturally and linguistically appropriate counselling services for others.
6. Work in partnership with residents, their families and other stakeholders to enable an inclusive and culturally competent workforce.

PART 1

LEARNING TO IMPROVE PRACTICE AND PERFORMANCE

This module focuses on leadership in cross-cultural care services. The definitions of leader and leadership are adopted as described in the following:

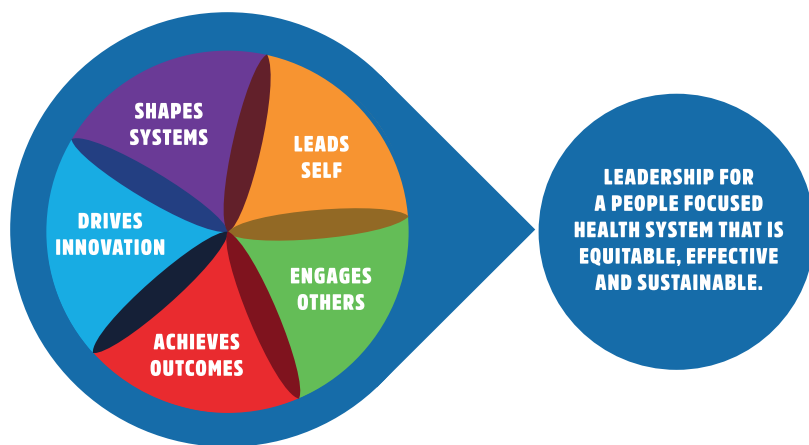
LEADER: 'A leader is a person with responsibility for directing or influencing the work of others' (Australian Government and Department of Industry, 2014, p. 5). In this project every staff member is considered a potential leader.

LEADERSHIP: 'Leadership refers to the behaviour of those with responsibility for directing or influencing the actions of others' (Australian Government and Department of Industry, 2014, p. 5). In this project every staff member is considered to have leadership capabilities to direct or influence team members, residents or their family members to achieve and/or improve quality of care.

THE AUSTRALIAN HEALTH LEADERSHIP FRAMEWORK AND LEADERSHIP ATTRIBUTES

Residential aged care is part of the health care system.

The Australian Health Leadership Framework was developed by Health Workforce Australia to support leadership in health, well-being and the quality of care in the Australian Health Care system (Health Workforce Australia, 2013). This leadership framework also promotes cultural diversity, and equitable, effective and sustainable care services by encouraging everyone in the health care system to demonstrate leadership. The framework is adapted in this module. The leadership attributes are organized under the five elements in the framework: (1) Leads self, (2) Engages others, (3) Achieves outcomes, (4) Drives innovation, and (5) Shapes systems.



Source: Health LEADS Australia: the Australian Health Leadership Framework, p. 7

Reflect on your leadership

The 'Cross-Cultural Care - Leaders Self-reflection Tool' (see Cross-cultural care tool kit) has been developed to assist you to reflect on your leadership performance in cross-cultural care services for older people and working with team members from different cultural backgrounds. It is designed to be used as a reflective tool to support your leadership development.

THE APPLICATION OF THE LEADERSHIP ATTRIBUTES TO CROSS-CULTURAL CARE SERVICES AND WORKFORCE COHESION

In this section, the leadership attributes under each element are described. Examples of how to apply these attributes within cross-cultural care services and to achieve workforce cohesion are given. Staff are invited to engage in activities and reflections that help them develop these leadership attributes.

LEADS SELF

Cross-cultural care services are provided either by individual staff or through a team approach in an aged care work environment. Therefore, staff will need to demonstrate these attributes (capabilities) in ‘leading self’ as outlined in Table 1:

Table 1: Leadership attributes in ‘leading self’

CAPABILITIES	DESCRIPTORS
Is self-aware.	Understands and manages the impact of their background, assumptions, values and attitudes on themselves and others.
Seeks out and takes opportunities for personal development.	Actively reflects on their performance and assumes responsibility for engaging in learning and growth.
Has strength of character.	Is honest, trustworthy and ethical and models integrity, courage and resilience.

Source: Health LEADS Australia: The Australian Health Leadership Framework, p. 7



ACTIVITY 1: AGED CARE AND CULTURAL DIVERSITY

Sometimes it may be difficult to notice the culture-related judgements, assumptions and conclusions you draw, particularly in a busy workplace where there is little time for reflection. It may also be harder to identify these factors if your background is from the most common cultural group. For example if you have an Australian or Anglo-Saxon background.



VIDEO 1: AGED CARE AND CULTURAL DIVERSITY

View the Aged Care and Cultural Diversity Video via: <https://www.youtube.com/watch?v=tSdqWvLKglc>. Identify situations where your own cultural background may have influenced your behaviour without you realising it.

Complete the activities from the Cultural Advantage website via: <http://www.culture-advantage.com/awarenesspage2.html>. Did these activities help you to more specifically identify your own values and beliefs and how these may be influenced by your own culture?



CASE STUDY 1: SELF-AWARENESS IN CROSS-CULTURAL INTERACTIONS

Mary is an Australia-born Registered Nurse (RN) and is completing a medication round. She is approaching Mrs Ali, an 84-year-old resident, who is a devout Muslim from Malaysia. Mrs Ali is new to the care home for respite care and speaks very little English. She has severe Parkinson's disease and depends on the nurse to place medication in her mouth. She is receiving digoxin treatment for her heart conditions. RN Mary's left hand is her dominant hand. After washing her hands, Mary uses her left hand intending to place the digoxin tablet in Mrs Ali's mouth, Mrs Ali refuses to open her mouth. This situation is observed by a carer, Hana, who is also a devout Muslim. Hana suggests that Mary needs to use her right hand to place medication in Mrs Ali's mouth.

How can Registered Nurse Mary respond to carer Hana's suggestion?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. RN Mary is willing to learn more from Hana about why the right hand should be used to place the digoxin tablet in Mrs Ali's mouth.
- ☐ b. RN Mary uses her right hand to place the digoxin pill in Mrs Ali's mouth after learning from Hana that the Muslim faith has particular rules. The left hand is used for personal hygiene and should not be used to provide food.
- ☐ c. RN Mary and carer Hana do not need to take further action after this cross-cultural experience with Mrs Ali.
- ☐ d. RN Mary and carer Hana reflect on their experiences on this cross-cultural experience with Mrs Ali. They suggest, in a staff meeting, that a 'Cross-cultural care knowledge exchange folder' could be established as a platform to allow staff to document and exchange their cultural knowledge in the care of older people.



CASE STUDY 2: TAKING OPPORTUNITIES FOR STAFF DEVELOPMENT USING CULTURAL ASSETS IN THE WORKFORCE

RN Lyn is originally from the UK and cares for Mrs Chen an 85-year-old resident, who is originally from China. Mrs Chen has been living with her daughter's family after her husband passed away a few years ago. Mrs Chen is new to the care home following a severe stroke 3 months ago, left her unable to be cared for at home. She speaks very little English. Mrs Chen also has a urinary tract infection and needs to drink more water as recommended by her doctor. During the lunch time medication round, RN Lyn finds that the water jug is still full since giving it to Mrs Chen earlier that morning. She tries to assist her to drink more water.

When RN Lyn pours a glass of water from the jug and passes it to Mrs Chen, she uses a cue chart to explain that Mrs Chen needs to drink more water, Mrs Chen refuses to take the glass. A Chinese carer, Mei, who is present in the room observes the situation and suggests that Lyn should try to give warm water to Mrs Chen.

How should Registered Nurse Lyn respond to the carer Mei's suggestion?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. RN Lyn rejects Mei's suggestion as there is no medical reason for providing Mrs Chen with warm water.
- ☐ b. RN Lyn invites Mei to help her to communicate with Mrs Chen and find out if Mrs Chen would like to drink warm water and why.
- ☐ c. RN Lyn provides warm water for Mrs Chen after learning that Mrs Chen believes in 'Ying (cold) and Yang (hot)' in maintaining health and well-being. She does not drink cold water because it adds too much 'Ying' to her body and is harmful for her health. She would like to drink warm water to maintain the balance of 'Ying and Yang'.
- ☐ d. No further action needs to be taken.
- ☐ e. RN Lyn documents the specific care needs in Mrs Chen's care plan.
- ☐ f. Carer Mei suggests that they contact Mrs Chen's daughter to bring a thermos to Mrs Chen's room so that Mrs Chen has access to warm water at all times.
- ☐ g. RN Lyn suggests to the care coordinator in the RNs' meeting that the admission assessment should add questions about residents' preferences for drinking cold or warm water.
- ☐ h. RN Lyn suggests to the care coordinator that staff from culturally and linguistically diverse (CALD) backgrounds should be invited to an in-service session to share their experiences in caring for older people of various cultures.



CASE STUDY 3: USING STRENGTH OF CHARACTER TO SETTLE INTO A NEW ROLE

Delara is a young woman who came to Australia as a refugee from Afghanistan. She has just completed Certificate III in Aged Care and has been employed to work as a personal carer in a residential aged care home (You may recall Delara from Module One). While she was initially 'very quiet' and rarely asked questions, Delara has been working with a workplace buddy, Betty, to build on her confidence and workplace knowledge and time management. However it is becoming difficult to roster Betty on the same shifts as Delara.

How can Care Coordinator Bronwyn help Delara settle into her role?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. Suggest Delara be more confident and less shy in the workplace.
- ☐ b. Explore other ways that Betty can mentor Delara such as scheduled informal mentoring sessions. This is a positive workplace strategy to assist CALD staff members to improve their practice.
- ☐ c. Tell Delara that the home does not have the resources to keep providing a mentor for her after the current roster.
- ☐ d. Encourage Delara to ask all staff members' questions.
- ☐ e. Bronwyn encourages staff to support Delara to assimilate by supporting and influencing Delara to work in an effective way with the team.
- ☐ f. Suggest that Delara pushes herself to work faster.
- ☐ g. Bronwyn asks a CALD staff member who has successfully adapted to practice in the care home to share her experiences with Delara.
- ☐ h. Discuss with Delara the positive cultural attributes and contributions she brings to the workplace such as respect, helping others, caring and resilience.
- ☐ i. Encourage other staff to verbally acknowledge Delara's positive contributions.

REFLECTION ON LEADERSHIP IN RELATION TO SELF-AWARENESS

Identify 5 key ideas on how you would support another staff member to deal with an incident which occurred with a resident due to a cultural misunderstanding.

Reflect on your own reaction to the incident above and write an outline of how you would seek out opportunities for your own personal development.

Finally, consider how these actions and opportunities would influence your cross cultural communication.



CASE STUDY 4: RESIDENTS OR THEIR FAMILY MEMBERS AS LEADERS

Aunty Bindi is an Aboriginal woman who is an Elder in her community. She was admitted to a residential aged care facility because she has glaucoma and is now blind and needs assistance with activities of daily living. Both Australian and CALD staff do not know that in Aunty Bindi's culture, older adults are referred to as 'Aunty' or 'Uncle' due to their extensive kinship systems and relationships with each other. On admission, staff were calling her Mrs Thomson, which may be culturally inappropriate even though it is her married name. Some staff also call her 'dear' or 'love', which she finds demeaning.

Susan, an Australian born Registered Nurse, realised that they had just admitted their first Aboriginal resident. When Aunty Bindi's daughter Rosie visited her mother, RN Susan spoke to her and asked about culturally appropriate care. Rosie told RN Susan about her custom of referring to each other according to the appropriate kinship term, and that her mother preferred to be called 'Aunty Bindi'. Rosie also explained that, although staff meant it kindly, calling her mother 'dear' or 'love' was talking down to her because it was not considered respectful.

How can Registered Nurse Susan enable Aunty Bindi to direct and influence staff in care services?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. Ask Aunty Bindi why she does not use her married name 'Mrs Thompson'.
- ☐ b. Staff demonstrate cultural humility (see the definition in module one) by enabling Aunty Bindi to lead staff in providing care and activities to meet her personal preferences in the care home, for example, spiritual activities, dressing, putting on makeup, personal care, diet and leisure activities.
- ☐ c. Ask Aunty Bindi to share her experiences as an Aboriginal Elder in resident-staff cultural activities.
- ☐ d. Ask Aunty Bindi's daughter, Rosie to share her experience of caring for her mother prior to admission to the home at a staff meeting.

Further reflection

Consider your own background, attitudes and respect for the elderly that arise from your own culture. Have these changed since you have been working in aged care?

Reflect on the Aunty Bindi case study. How can residents and their families also be leaders in relation to culture?

More aged care resources for Aboriginal and/or Torres Strait Islander people can be accessed via my aged care website: www.myagedcare.gov.au/aboriginal-and-or-torres-strait-islander-people

ENGAGES OTHERS

In a multicultural workplace, staff benefit from engaging with others to share and act in accordance with values and skills that embrace diversity, facilitate cross-cultural communication and promote culturally and linguistically appropriate care services and workforce cohesion. Staff can demonstrate these attributes (capabilities) in engaging with others as outlined in Table 2:

Table 2: Leadership attributes in engaging others

CAPABILITIES	DESCRIPTORS
Values diversity and models cultural responsiveness.	Recognises first Australians and ensures all people, consumers and workers, are treated with dignity and respect in all healthcare settings.
Communicates with honesty and respect.	Is approachable, listens well, presents ideas and issues clearly, and participates in difficult conversations with consumers and colleagues with humility and respect.
Strengthens consumers, colleagues and others.	Inspires and enables others to share ideas and information, to take opportunities to grow, lead and to collaborate for high performing groups and teams.

Source: Health LEADS Australia: The Australian Health Leadership Framework, p. 8



CASE STUDY 5: ENGAGING THE TEAM TO IMPROVE DIETARY INTAKE FOR A RESIDENT

Mrs Chen is a Chinese resident who often leaves most of her food on her plate at mealtimes. When the carers ask her if she would like to eat some more, she just shakes her head and says 'No, thank you'. Sarah, an Australian born Registered Nurse, is concerned because Mrs Chen is losing weight. RN Sarah discusses Mrs Chen's weight loss with the Care Coordinator Sam and then talks with Mrs Chen to find out why her appetite is so poor. She discovers that Mrs Chen has two main concerns with the food she is served. Firstly, she misses eating Chinese food, particularly rice. Secondly, when she is served rice, it is not cooked in the way she likes.

Who may help resolve this situation and what actions could they take?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. Care Coordinator Sam could ask Mrs Chen's relatives if they would like to bring food in for Mrs Chen as she misses home-cooked meals.
- ☐ b. Registered Nurse Sarah could explain to Mrs Chen that it is not possible to have all food options available for each individual resident as it will cost too much.
- ☐ c. Mrs Chen's daughter can contribute by explaining her mother's food preference and the usual utensils Mrs Chen uses, for example chopsticks and bowls.
- ☐ d. Care Coordinator Sam could meet with Catering staff to discuss how Mrs Chen's dietary needs can be met.
- ☐ e. Care Coordinator Sam could meet with Catering staff to discuss facility wide strategies to review and improve dietary options from nutritional and cultural perspectives.
- ☐ f. Care Coordinator Sam could meet with Registered Nurse Sarah to continue to monitor and document in the care plan, whether Mrs Chen's dietary preferences have been met and whether the dietary changes have had an impact on her health and well-being.
- ☐ g. Care Coordinator Sam could meet with the Lifestyle Manager to organize a Chinese Cultural Day at the care home including some Chinese food to facilitate cross-cultural understanding.

ACHIEVES OUTCOMES

Cross-cultural interactions that include cross-cultural communication are associated with uncertainty and add complexities in identifying and meeting residents’ care needs. Leadership attributes that assist in overcoming difficulties include motivating one’s self and others through effective communication, using evidence-based practices, ensuring there are adequate resources and that every effort is made to engage in continuous quality improvement to achieve and sustain a better quality of care services. These attributes are described in Table 3.

Table 3: Leadership attributes in achieving outcomes

CAPABILITIES	DESCRIPTORS
Influences and communicates the direction.	Collaborates with consumers, colleagues and others to identify, influence and set goals that achieve the vision.
Is focused and goal oriented.	Influences alignment of resources and decisions with goals and evidence to enable quality, people-centred health work and continuous improvement.
Evaluates progress and is accountable for results.	Continually monitors and improves, celebrates achievements and holds self and others accountable for individual and service outcomes.

Source: Health LEADS Australia: The Australian Health Leadership Framework, p. 8





CASE STUDY 6: A REGISTERED NURSE'S LEADERSHIP IN ACHIEVING POSITIVE CARE OUTCOMES

Mrs Blake grew up in a family where good manners at mealtimes were important. No one was allowed to speak when someone else was talking and everyone had to display good manners and say 'please' when they wanted someone to pass them something. Mrs Blake looks forward to having her meals in the dining room. She knows the other residents who sit at her table and she likes to have a chat with them. However, today, a few new staff were speaking loudly and calling out to each other in a language that was not English as they moved around the tables. It was difficult for Mrs Blake to hear what her friends were saying. Registered Nurse Karen noticed that Mrs Blake was not happy with the loud exchanges between staff. She also noticed that the staff were very new to the facility and may not have been fully aware of the expected standards in regard to the dining experiences in the residents' home and how this might differ to other workplaces.

How can Registered Nurse Karen resolve this situation by demonstrating leadership?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. RN Karen should immediately, in front of residents, explain to the new staff that their behaviour is unacceptable because they are talking too loudly making it difficult for residents to communicate with each other.
- ☐ b. Karen should instruct new staff that they are not permitted to speak in any language other than English when working in the facility.
- ☐ c. Karen should discuss expected standards for the dining experience and ask CALD staff to explain their mealtime culture, using this to ensure acceptable mealtime behaviour is understood.
- ☐ d. As an ongoing activity RN Karen can evaluate whether suggestions to CALD staff about communication approaches have been effective.

EVIDENCE FOR CROSS-CULTURAL CARE SERVICES

A general understanding of evidence is accurate information that helps to inform a conclusion, judgement or action. Using evidence to inform better cross-cultural care services is one of the leadership attributes valued in residential aged care. Evidence used in developing and improving cross-cultural care services includes, but is not limited to (1) assessment data collected from residents in daily practice; (2) measurement data collected by auditors in quality improvement activities; (3) findings from the investigation of incidents in the residential aged care home; and (4) research evidence and evidence-based guidelines.

Reflection

Give examples of each type of evidence listed below that you have collected, used or engaged in when caring for residents from a culture that is different from your culture:

1. Assessment data.
2. Data collected by auditors.
3. Findings from the investigation of incidents.
4. Evidence-based guidelines.

RESOURCES FOR CROSS-CULTURAL CARE SERVICES

One of the leadership attributes in cross-cultural care services is to locate and use relevant resources to enable culturally and linguistically appropriate care for residents. For example, when you admit an Italian resident who is unable to speak English, you will need to identify resources to enable cross-cultural communication with the resident.

Reflection

Reflect on the resources that are available in your facility for cross-cultural communication. For example, do you have communication cards or IT Apps available?

What languages do they cover?

What other resources do you have?

Do you know how to access the cross-cultural resources in your facility?

ASSESSMENT FOR CROSS-CULTURAL CARE SERVICES

Effective interventions to improve cross-cultural care services are based on culturally and linguistically appropriate assessment for residents. One of the leadership attributes by Registered Nurses (RNs), Enrolled Nurses (ENs) or other health professionals involved in assessment for residents is to identify and apply culturally and linguistically appropriate assessment tools to practice and interpret results. For example, when you admit a Greek resident with dementia, you will need to identify which cognitive assessment tool is suitable for the resident and how to undertake the assessment and interpret the results.

Although Personal Care Assistants (PCAs) do not conduct assessment, they assist with data collection. Therefore, RNs, ENs and other health professionals will need to work in a collaborative way with PCAs if culturally-specific assessment tools and observations are used, for example explaining the cross-cultural assessment tools to a PCA and giving them examples for data collection during the assessment period.

Reflection

There are a number of cultural assessment tools. Can you find one that may help in the assessment of residents' preferences that are related to their culture?

Is the cognitive assessment tool in the ACFI, the PAS (Psychogeriatric Assessment Scale), adequate for residents from CALD backgrounds? If not, what culturally and linguistically appropriate tools do you recommend and how would you advocate the use of these tools in your facility?

USEFUL AUDIT TOOL KIT

Three audit tools have been developed in our project to help with data collection:

1. Cross-cultural Care Service Audit Tool.
2. Multicultural Workforce Management Audit Tool.
3. Organisational Support for Cross-cultural Care Services Audit Tool.

Data collected using these tools can be used to improve cross-cultural and multicultural workforce development. These tools are enclosed in this book (see Cross-cultural care tool kit).

DRIVES INNOVATION

The cultural diversity of residents and staff adds more complexity and challenges in meeting residents’ culturally and linguistically appropriate care needs in care homes (Nichols et al., 2015, Xiao et al., 2016). One of the leadership attributes for management groups to address cross-cultural challenges is to champion changes by exploring, implementing and disseminating new care practices, care models and workforce models. Other staff need to be supportive of the management group by providing feedback, identifying issues and challenges and by being willing to try and feedback quality improvement activities. The leadership attributes in driving innovation are outlined in Table 4.

Table 4: Leadership attributes in driving innovation

CAPABILITIES	DESCRIPTORS
Champions the need for innovation and improvement.	Collaborates with consumers, colleagues and others to identify, influence and set goals that achieve the vision.
Builds support for change.	Influences alignment of resources and decisions with goals and evidence to enable quality, people-centred health work and continuous improvement.
Positively contributes to spreading innovative practice.	Initiates and maintains momentum for assessing, sharing and celebrating changes for people-centred service and systems improvement.

Source: Health LEADS Australia: the Australian health leadership framework, p. 9



CASE STUDY 7: CHAMPIONING THE NEED FOR IMPROVEMENT IN CROSS-CULTURAL CARE

Nathra has lived at the home for the past two years. Coming from a Lebanese background, Nathra's family were known around the home for bringing in beautiful food to share with Nathra such as baklava, kinafa, and salads such as pomegranate and tomato. Recently Nathra was referred to the Speech Pathologist because of several episodes of choking. The Speech Pathologist requested that Nathra be given a soft diet consisting of blended food. The change in Nathra's diet plan was communicated to Nathra's family. However, on several occasions staff found family members giving Nathra baklava and other treats.

When family members were approached by staff they said: 'Nathra said she would rather die than eat that mush for the rest of her life'. The Care Co-coordinator, Terry, was informed by the Registered Nurse of these events.

What actions could be considered in meeting Nathra's special dietary care needs?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. It is appropriate to take risks so a resident's preference is met.
- ☐ b. Base Nathra's dietary care plan on food that is already being cooked in the facility.
- ☐ c. Include the resident and their family.
- ☐ d. Develop a coordinated plan including management and specialist approval.
- ☐ e. Enlist support from other team members regarding their ideas.
- ☐ f. Terry arranges for a family conference with Nathra's family, the Speech Pathologist and Registered Nurse.
- ☐ g. Based on their experience in this case, Terry, the Speech Pathologist and Registered Nurse work in collaboration to develop and present an in-service session for staff on meeting care needs for CALD residents who have problems swallowing and require a modified diet.



SHAPES SYSTEMS

Changes in one part in the residential aged care home may have implications for other parts of the aged care organisation. One of a leader's attributes is to think in a systematic way to maximise the potential benefit of changes while minimizing unintended consequences. The leadership attributes in shaping the system are outlined in Table 5.

Table 5: Leadership attributes in shaping the system

CAPABILITIES	DESCRIPTORS
Understands and applies systems thinking.	Communicates systems awareness and negotiates within and across health teams, services and sectors to improve individual and local health outcomes.
Engages and partners with consumers and communities.	Involves consumers and communities in decision making for health policy, education and training and health care delivery and improvement.
Builds alliances.	Promotes understanding, respect and trust between different groups, professions, organisations, sectors and points of view to enable effective collaboration, enhance connectivity, and minimise unintended consequences.

Source: Health LEADS Australia: The Australian Health Leadership Framework, p.9



CASE STUDY 8: LEADERSHIP IN RESOLVING CULTURE AND GENDER ISSUES

Mrs Chea is an 86-year old Cambodian lady who is newly admitted to the care home for respite care. She is from a refugee background, cannot speak English and was cared for by her daughter at home prior to the admission. However, her daughter was recently diagnosed with cancer. The respite care is arranged by a social worker employed by a care crisis organisation in order to allow Mrs Chea's daughter to receive cancer treatment in hospital. On admission, her daughter prepared a simple communication booklet with some basic sentences in both English and Cambodian to help staff know Mrs Chea's daily care needs.

Mrs Chea has urinary incontinence and requires assistance with changing continence pads and showering in the morning. Aamod is a male carer originally from India and he is assigned to care for Mrs Chea on the morning shift. When Aamod arrives in Mrs Chea's room with a shower chair, Mrs Chea is in her bed with her night-gown on. Aamod uses the communication booklet to explain to her that he will help her to change pads and give her a shower. When Aamod tries to touch Mrs Chea to remove

the soiled incontinence pad, she refuses and begins to yell at Aamod and tries to hit him. Aamod reports the incident to the Registered Nurse, Robyn.

What actions could Registered Nurse Robyn and Aamod take to address this situation?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. RN Robyn explains to Aamod that he needs to be more polite when helping female residents with showering.
- ☐ b. RN Robyn approaches Mrs Chea and insists that she should have a shower as she has a soiled pad.
- ☐ c. RN Robyn approaches Mrs Chea and uses the communication booklet to ask her if she feels better and if she would like to have her pad changed or a shower.
- ☐ d. When Mrs Chea agrees to have a shower, RN Robyn introduces Aamod to Mrs Chea again and uses the booklet to tell her that Aamod will help her with showering.
- ☐ e. RN Robyn recognises that Mrs Chea may resist being showered by a male carer and confirms her assumption by asking a female carer, Kate, to assist Mrs Chea.
- ☐ f. If Mrs Chea resists being showered by Aamod again, RN Robyn assigns a female carer to assist Mrs Chea with showering and observes if Mrs Chea resists a female carer.
- ☐ g. If Mrs Chea accepts a female carer to help her shower, RN Robyn assigns Aamod to perform other non-personal care activities in Mrs Chea's room.
- ☐ h. RN Robyn and Aamod are satisfied with the outcomes of Mrs Chea's care and do not report the incident.
- ☐ i. RN Robyn works with Aamod to complete the incident form and documents a description of Mrs Chea's behaviours of yelling and hitting a male staff member when she is touched. RN Robyn also takes a leading role in recommending further investigation about the impact of culture on Mrs Chea's gender preference of carers which is needed in order to avoid future incidents.
- ☐ j. Care coordinator Mary analyses the incident report carefully and books an interpreter to help her to assess Mrs Chea's care needs associated with her culture.
- ☐ k. Care coordinator Mary also offers support for Aamod.

With the interpreter's assistance, care coordinator Mary learns that Mrs Chea was raised in a very traditional family in Cambodia and was educated with Chinese Confucianist tradition. One of the principles of Confucianism is that non-blood relatives or spouses should not touch each other's hand unless one needs to be rescued in a life-threatening situation.

What the care team could do to address the cultural influence on Mrs Chea's care needs?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. Care coordinator Mary should document in Mrs Chea's care plan and also put a sign in her room to remind staff not to hug or shake hands, but to note that smiling and words in her language to greet her are appropriate.
- ☐ b. The RNs could discuss during their meetings, questions that need to be added to the cross-cultural care assessment which would detect culturally-associated factors affecting residents' gender preference of care staff.
- ☐ c. People who are from the Cambodian community and know Mrs Chea should be contacted to visit her and provide social support for her considering that she is separated from her daughter and familiar surroundings.
- ☐ d. People who are from the CALD community and who are knowledgeable in Cambodian culture should be invited to an in-service session to share their experiences in caring for older people from various cultural backgrounds.

Reflection

Reflect on the case study involving Mrs Chea but consider whether the response would be different if she was an Iranian lady with Muslim beliefs.

Consider the response to an older Australian resident.

Is your response different according to your cultural background or is this solely related to gender?

INCIDENT REPORT DATA AS EVIDENCE TO HELP IDENTIFY THE NEED FOR SYSTEMATIC CHANGE

Incident report data has been used as essential evidence in the healthcare system to identify the need for systematic change and quality improvement. However, this approach to systematic change largely relies on staff awareness of the role that reporting has and their commitment to include this as part of their daily practice. In addition, analysis by management of incident reports, their openness to staff comments on issues and barriers associated with the system and their efforts to facilitate systemic changes are crucial to improving care for residents in cross-cultural care settings.



CASE STUDY 9: NO ONE REPORTS THE INCIDENT

Kim, a Vietnamese-born Enrolled Nurse who has worked in aged care for nearly 15 years, went to administer an insulin injection to Mr Harris. Mr Harris was sometimes verbally abusive to her which may have been triggered by Kim's cultural background as Mr Harris had been a soldier in the Second World War fighting in Asia. Apart from being verbally abusive, it was known by care staff that Mr Harris was becoming confused and sometimes would not let the Australian born staff care for him either. Kim said good morning with a big smile and told Mr Harris that she had his insulin for him. Mr Harris said 'Go away, I'm not letting the likes of you touch me.'

Kim went to the Registered Nurse Evelyn and reported that Mr Harris had refused to let her give him his insulin. RN Evelyn checked the insulin and administered it to Mr Harris. Kim did not report that Mr Harris would sometimes not let her near him. She assumed it was because she was Vietnamese. Similar incidents were happening with other CALD staff in the home and most of them did not report the incidents.

One day, a CALD resident's family member, Ms Day from an Indian heritage reported that her mother was verbally abused by Mr Harris stating 'I don't want to sit with black people' when they sat in the lounge to watch TV programs. Ms Day asked that Mr Harris apologise to her mother. It was then evident that more action was needed to stop such incidents happening in the home.

What are the most important actions that should be taken by the respective members of the team?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. In regular staff meetings, the Care Coordinator should explain the importance of reporting any incidents when rude remarks were made about any staff member or residents' skin colour, manner or cultural background.
- ☐ b. The Care Coordinator should instruct the staff to see that Mr Harris is not seated in the dining room or lounge near a resident from a CALD background.
- ☐ c. The Care Coordinator should tell Mr Harris's family that his behaviour is unacceptable and he must accept care from any staff member irrespective of race or cultural background.
- ☐ d. Kim is correct not to report incidents of this type formally because they happen all the time and it takes too long to complete the documentation needed.
- ☐ e. The management group needs to ensure reports are confidential for staff, residents or their family when reporting incidents in cross-cultural encounters.

PART 2

AN UNFOLDING CASE STUDY IMPROVING TEAM COHESION



VIDEO 2: IMPROVING TEAM COHESION

Overview

Michael is a facility manager at a site where many new employees from non-English speaking backgrounds have been employed. There have been a few challenges getting the residents and existing staff to accept the new staff members despite what they have to offer. Michael needs to manage a complaint made by a resident, John, about a new employee Lin. Lin is trying hard to be accepted by John and is worried about her English. Lin also hates being corrected in front of other people. Jeffrey, who is an experienced personal care assistant, says that Lin struggles with her English and he finds that she doesn't like to be corrected all the time.

Play the following video (5:26): <https://youtu.be/LRvCbr6VYxQ>



ACTIVITY 2: IMPROVING TEAM COHESION

Discuss what other leadership actions can be taken to improve teamwork in this situation?

- a. Arrange a staff meeting to discuss the incident and strategies that could be used to improve the cross cultural care of residents.
- b. Michael could consider activities and workshops that allow staff to discuss their cultures, values, beliefs and the language used, and how these might influence staff communication and their interactions with residents and team members.
- c. Lin's mentor Kim can provide opportunities for her to share her views and experiences in staff cultural exchange activities. Lin could share what is considered 'good care practice' for older people in her home country and the way she transfers this practice to her role in this residential aged care home.
- d. Lin needs to use the self-directed cross-cultural communication learning module that Michael has told her about. Lin and Kim should discuss how she can apply the cross-cultural communication principles to her own practice. Lin can also approach Kim for advice if she encounters difficulties with her interactions with residents and team members.
- e. Due to the increased cultural and linguistic diversity at the facility, Michael needs to facilitate cultural exchange between residents and staff. He also needs to survey residents or their families regularly to find out whether they are satisfied with staff's cross-cultural communication and what suggestions they have for improvement.
- f. Michael reports the cross-cultural communication issues to the Executive Manager of Residential Care at his organisation. Based on his success in resolving these issues, the Executive Manager has made recommendations that the induction and orientation program for new staff should include cross-cultural communication and team cohesion.

OUTCOME: CROSS-CULTURAL LEADERSHIP TO SMOOTH THE TRANSITION

Discuss the positive impact of cross-cultural leadership on residents and staff in the facility.

Here are some examples from Lin and Jeffery's discussions in the staff meeting:

LIN: *'The hardest part is at the beginning; you need to develop the residents' trust and build a relationship with them. Good communication with residents helped me to get to know each of them; what they like and dislike. I now have developed good relationships with many of the residents. Some of them have offered to help me to learn English. I also learned, from my mentor Kim, how to contribute to team work. I did my first presentation in the cross-cultural care workshop. I found my team, including Jeffery, were very interested in the culture and tradition of my home country. They even asked me to teach them a few greeting words in Chinese and they use them when they interact with residents from a Chinese background.'*

JEFFERY: *'The reality is that we have a strong multicultural representation in our team. I see this fact as a strong positive factor in the care of our residents. I learned how to care for residents from culturally and linguistically diverse CALD backgrounds from Lin and other team members. I also shared my experience in caring for our Australian-born residents with the multicultural team. Lin is a hard worker and learns quickly. She is a valuable team member and I enjoy the shifts I work with her.'*



ACTIVITY 3: FACILITATION ACTIVITY

Explore your perspectives on how to resolve issues in the team and improve team cohesion:

1. Is it appropriate for staff to talk about their peers in the presence of residents or their families? If not, how would you manage this situation?
2. Is the nurses' station the right place for staff to report a resident's complaint about other staff to their team leader or supervisor? If yes, why? If not, how should the staff report the resident's complaints about other staff and to whom?
3. Is the nurses' station the right place for a team leader or supervisor to inform a staff member about the resident's complaint and commence performance management? If yes, why? If not, how should the team leader or supervisor deal with this and where?
4. Check your organisation's policies and procedures and find out the correct procedure for reporting an incident such as this.
5. Is it appropriate that a staff member made negative comments about other staff in the staff room? Use Table 1: 'Leadership attributes in 'leading self'' to discuss strategies to support staff to develop self-awareness and to positively support their peers.

OPTIONAL LEARNING MATERIALS FOR STAFF WITH A LEADERSHIP AND SUPERVISORY ROLE

INTERCULTURAL CONFLICT MANAGEMENT

Intercultural conflict exists in any multicultural workplace and impacts on team cohesion, collaboration, harmony and productivity. Staff with responsibility in managing multicultural teams must be capable of managing intercultural conflict using leadership to foster team cohesion and competent intercultural communication.

Studies of different cultures have identified that people from the same cultural background share some patterns of thinking styles and behaviours. In order to simplify these patterns, cultures are grouped into an individualist culture and a collectivist culture (Ting-Toomey 2010). No one culture is purely individualistic or collectivist but cultures will have a tendency towards one or the other.

People raised in western countries, such as western European and North American countries, usually hold individualist values. Individualists are primarily motivated by their own preferences, needs, rights, and the contracts they have established with others. Individualists give priority to their personal goals over the goals of others, and emphasise rational analysis of the advantages and disadvantages of associating with others.

People raised in eastern countries, such as Asia, eastern European, some Mediterranean (Greece), South American and African countries usually hold collectivist values. Collectivist individuals are actively encouraged to make sacrifices in order to satisfy the group goal. Collectivist individuals are primarily motivated by the norms and duties imposed by these collectives. Further information on how this cultural knowledge could help staff deal with intercultural conflict can be gained from further readings as listed in the resource section.

MAINTAINING A GOOD FACE IN INTERCULTURAL CONFLICT MANAGEMENT

Each culture has different views of good face, face-losing and face-saving. The views of maintaining a face within a culture impact on emotions, respect, pride, shame, dignity and guilt (Ting-Toomey, 2010). Individuals regardless of culture tend to take actions to maintain a face in interpersonal situations although the strategies they use are significantly different and influenced by their own cultures. These views need to be taken into consideration when the management group are involved in intercultural conflict resolution.

The Management group will need to find out staff's views on maintaining face in a team, their preferred process and resources used in resolving intercultural conflicts and document these in their management portfolio. Engaging in managing intercultural conflicts may add stress to the management group. Peer support, debriefing with supervisors and gaining the organisation's support and resources will help the management group to cope with stress and improve their capability of resolving intercultural conflicts.

RESOURCES

The Department of Social Services provide a Charter of Care Recipients Rights and Responsibilities - Residential Care with translations into multiple languages.

Accessed Online, July 7, 2016

<https://agedcare.health.gov.au/publications-and-articles/guides-advice-and-policies/charter-of-care-recipients-rights-and-responsibilities-residential-care>

The Department of Health provides information on all aspects of the aged care system in Australia Ageing and Aged care

Accessed Online, July 11, 2016

<https://agedcare.health.gov.au/>

The Department of Health provides information about Harmony Day, a day for all Australians to embrace cultural diversity

Accessed Online, July 7, 2016

www.harmony.gov.au

Equal Opportunity at Work describes good practice in relation to equal opportunity in the workplace.

Accessed online July 7, 2016

www.eoc.sa.gov.au/sites/eoc.sa.gov.au/files/attachments/eo_at_work_handbook_for_businesses_in_SA.pdf

Health LEADS Australia: The Australian Health Leadership Framework

Accessed online July 4, 2016

www.aims.org.au/documents/item/352

Further readings on intercultural conflict resolution

Ting-Toomey, S. (2010) Intercultural conflict interaction competence: From theory to practice. In Guilherme, M., Glaser, E. & García, M. a. d. C. M. (Eds.) *The intercultural dynamics of multicultural working*. Bristol, Multilingual Matters.

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Ziaian, T., & Xiao, L. (2014). Chapter 4 Cultural diversity in health care. In M. Fedoruk & A. Hofmeyer (Eds.), *Becoming a Nurse: Transition to Practice* (2nd ed., pp. 35-50): Oxford University Press (OUP).

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Xiao, L., Willis, E., Harrington, A., Gillham, D., De Bellis, A., Morey, W., Jeffers, L., 2016. Residents and family members' perceptions of cultural diversity in aged care homes. *Nursing & Health Sciences* 19 (1), 59-65.

MODULE 4

CROSS-CULTURAL DEMENTIA CARE



LEARNING OBJECTIVES

On completion of Module 4, staff will be able to:

1. Explain the influence of culture in dementia care by reflecting on their own experiences in cross-cultural interactions with residents and family members.
2. Demonstrate responsiveness to residents from CALD backgrounds, including the use of culturally and linguistically appropriate assessment tools.
3. Apply effective communication principles in cross-cultural interactions with residents with dementia.
4. Apply person-centred dementia care principles to foster the quality of cross-cultural dementia care.
5. Demonstrate an ability to identify unmet needs in cross-cultural dementia care, work with the team to identify possible causes of changed behaviours and apply a person-centred approach to address changed behaviours.
6. Demonstrate an ability to identify and report other health conditions residents with dementia may have developed, for example pain, in cross-cultural interactions.

PART 1

LEARNING TO IMPROVE PRACTICE AND PERFORMANCE

INTRODUCTION TO DEMENTIA CARE

It is estimated that about 52% of residents (or 86,640 people) in residential care homes in Australia have dementia. Of these residents approximately 31% were born overseas with 19% coming from non-English speaking countries (Australian Institute of Health and Welfare, 2012). The definition of dementia below is provided by the World Health Organization:

Dementia is a syndrome due to disease of the brain - usually of a chronic or progressive nature - in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement (World Health Organization, 2012, p. 7).

Information about the causes of dementia and the common forms of dementia can be found from 'Help Sheets' developed by Alzheimer's Australia. Alzheimer's disease is the most common form of dementia. Information about the stages of Alzheimer's disease are available from 'Help Sheets' by Alzheimer's Australia.

The cultural diversity of residents with dementia and the staff who care for them, can create additional complexities and challenges. In this module you will engage in learning activities that introduce aspects of cross-cultural dementia care. Your participation in this module will contribute to quality improvements in cross-cultural dementia care.

THE INFLUENCE OF CULTURE ON DEMENTIA CARE

Although dementia is well defined in western culture other cultural groups may define dementia differently. For example, there is no word for 'Dementia' in Vietnamese, but the words 'lú lđn' (confusion) are commonly used by Vietnamese people to describe the symptoms of dementia (Alzheimer' Australia, 2008). Different perceptions may influence staff's attitudes towards residents living with dementia. It may be reflected in the way staff communicate with residents living with dementia or their families and their approaches to care.



ACTIVITY 1: EXPLORING STAFF'S PERCEPTIONS OF DEMENTIA

1. Work individually and write down the word that is used to describe dementia symptoms in your culture and in your native language and explain the meaning in English.
2. Work in small groups and share your findings of dementia from the perspective of the cultural group to whom you are related (including the Australian culture).
3. Discuss within the group the different attitudes toward dementia and how dementia care is approached or addressed within your culture.
4. Reflect on the activities and your learning needs in cross-cultural dementia care.
5. Summarise the activities in Table 1.
6. Share your discussions across all groups.

Table 1: Summary of activity on dementia perceptions and the impact of the perceptions

The meaning of 'dementia'	In my culture	
	In another culture (one example)	
Examples of positive attitudes towards dementia	In my culture	
	In another culture (one example)	
Examples of stigma attached to dementia	In my culture	
	In another culture (one example)	
How family care for people with dementia within your culture		
What are some of the things I need to learn in order to meet the care needs for residents with dementia from other cultures?	<ol style="list-style-type: none">1.2.3.4.	

CONSIDERATIONS IN CROSS-CULTURAL COMMUNICATION WITH RESIDENTS LIVING WITH DEMENTIA

Dementia affects language and comprehension. Residents living with dementia who have English as a second language may lose their ability to speak English and revert back to using their first language. Therefore, they lose some ability to communicate across different cultures. However often they will have some ability to communicate with staff using pictures, photos, clear and uncomplicated signage and body language, for example a friendly posture and facial expression.

Staff need to be aware that communication is a two-way process. There are other factors that may lead to barriers in cross-cultural communication with residents living with dementia. For example, residents from English-speaking backgrounds who live with dementia may also experience difficulties and challenges in understanding CALD staff who may have a strong accent, construct sentences differently or use unfamiliar words.

The main consequences of ineffective cross-cultural communication with residents includes, but is not limited to:

1. Failure to identify and meet residents' care and service needs in a timely and effective manner.
2. Frustration and certain behaviours that may be triggered by unmet needs.
3. Dissatisfaction with care services by residents and family members.



ACTIVITY 2: USING 'TALK TO ME' AS A RESOURCE

1. Work within a small group and identify barriers in cross-cultural communication with residents living with dementia in your residential facility.
2. Using the Alzheimer's resource, 'Talk to me' as your resource, suggest actions that could be taken to effectively address barriers in cross-cultural communication with residents living with dementia.
3. Summarise group suggestions in Table 2 and give your group work to your Facilitator.

Table 2: Summary of Activity

TALK TO ME PRINCIPLES	BARRIERS IN CROSS-CULTURAL COMMUNICATION WITH A RESIDENT LIVING WITH DEMENTIA	SUGGESTED ACTIONS
Talk to me		
Please speak clearly to me		
Please keep questions simple		
Treat me with dignity and respect		
Don't question my diagnosis		
Distractions		
Be patient and understanding		
Break it down		
Signage		



CASE STUDY 1: HOW TO UNDERSTAND WHAT MRS BOCZEK WANTS

Studies reveal that people living with dementia who are not able to communicate in their preferred language have a significantly higher rate of unmet needs (Runci et al., 2012, Runci et al., 2005). They may also exhibit agitation, fear and frustration leading to escalated responses when compared to those who are able to communicate in their preferred language (Runci et al., 2012, Runci et al., 2005).

Mrs Boczek is a resident with a Polish background who does not speak English. She has dementia and is unable to walk due to left sided paralysis following a stroke. She is sitting in a chair in the lounge room in the late afternoon and calling out loudly repeating the words, 'chcę wody'. Jo, a personal care assistant, is in the lounge and can only speak English.

How can Jo provide an appropriate response to meet Mrs Boczek's need?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. Jo ignores Mrs Boczek because she believes that Mrs Boczek is demonstrating a behaviour problem or is attention seeking.
- ☐ b. Jo approaches Mrs Boczek and tries to assist her, but asks her to speak English so that she will understand what Mrs Boczek wants.
- ☐ c. Jo knows that Mrs Boczek cannot speak English and uses a communication booklet which has been previously prepared by Mrs Boczek's daughter together with cue cards. This enables Mrs Boczek to express what she wants from the pictures.
- ☐ d. Jo asks another staff member who can speak Polish to communicate with Mrs Boczek and to assist in identifying her needs.
- ☐ e. Jo notes the words Mrs Boczek is using and seeks a translation ('chcę wody' means, I want water) through a dictionary and creates a card which can then be used by staff in the future to identify Mrs Boczek's needs.



APPLYING A PERSON-CENTRED APPROACH TO CROSS-CULTURAL DEMENTIA CARE

A person living with dementia should receive the same level of care as any resident. Because individuals living with dementia may find it difficult to communicate and express themselves, they may exhibit behaviours such as anxiety, frustration or agitation. In other words a changed behaviour is viewed as a way to express their unmet needs. The best way to think about person centred dementia care is to imagine being in the shoes of the person living with dementia; how would you like to be treated and how would you feel in the same situation? If the person living with dementia is from a CALD background, using a person-centred approach can help staff to avoid interactions that may cause distress and will enhance residents' experiences of care and their quality of life, as well as facilitate the work experience of staff.

A person centred approach to dementia care focuses on the person including their cultural background. It is not a collection of dementia symptoms (Alzheimer' Australia, 2016). It involves individualised care that takes into account the needs, wishes, culture, religion, spirituality, socialisation and personality of the person living with dementia. At the very core of this concept is the philosophy of personhood, that is, a person being promoted in a positive image by being valued by others and treated with respect while maintaining and protecting their dignity.

A person-centred care approach has been widely recognised as the gold standard in dementia care and has been integrated into the governments' dementia strategies, policies, guidelines and protocols for dementia care services (Australian Government and Department of Health and Ageing, 2012, Australian Government and Department of Health, 2015, NHMRC Guideline Adaptation Committee, 2016). Dementia care literature that describes the principles and frameworks used to facilitate person-centred care is abundant. In this learning module we adapt the 'Valuing People' in cross-cultural dementia care framework developed by Alzheimer's Australia (Alzheimer' Australia, 2016). This framework is outlined in Table 4.



ACTIVITY 3: USE A CALD RESIDENT'S PERSONAL PROFILE TO COMPLETE TABLE 3 AND DISCUSS IN A GROUP

Table 3: Summary of how to preserve a positive image and promote dignity for a CALD resident living with dementia

INFORMATION ABOUT A CALD RESIDENT	YOUR FINDINGS	HOW TO PRESERVE A POSITIVE IMAGE/PROMOTE DIGNITY
Birth place		
Language spoken at home		
Values & beliefs		
Life experience		
Relationships		
Achievements & activities that are significant to the resident		

Table 4: Outline of ‘Valuing people’ framework

GUIDING VALUES	ELEMENTS
Valuing people	A commitment to valuing people involves being aware of and supporting personal perspectives, values, beliefs and preferences incorporating the variety of characteristics that make individuals unique, including race, ethnicity, gender, sexual orientation, age and physical abilities.
Autonomy	Autonomy involves the provision of choice and respect for choices made; recognition of when a person requires support in decision-making; and optimising a person’s control through sharing of power, decision-making and responsibility.
Life experience	Life experience is the connection between a person’s past, their present-day experience, and their hopes for the future.
Understanding relationships	A commitment to developing collaborative relationships across the organisation, including between the service provider and those receiving services and their carers, and between all levels of staff. All parties work in partnership and understand the importance of community connections in designing and delivering services.
Environments	Person-centred principles underpin the organisational values that describe what is important to an organisation and how people should approach their work. Person-centred organisations have a systematic approach to knowledge and skill development that is inclusive of the experiences of staff, consumers and the people who care for them.

Source: Alzheimer’s Australia (2016) Valuing people (<http://valuingpeople.org.au/>)

This framework is also used to assist staff to assess their achievements in providing person-centred care and identifying areas for further improvements. The self-assessment tools for staff with different roles in their organisation are available on the ‘Valuing people’ website. As described in the activity below, we use one of the self-assessment tools for staff who provide direct care for residents. This is an example to help to facilitate self-reflection in cross-cultural dementia care.



ACTIVITY 4: USING THE 'VALUING PEOPLE' AS A TOOL FOR SELF-ASSESSMENT

Table 5: Summary of your assessment using the 'Valuing People' self-assessment tool

THE VALUING PEOPLE FRAMEWORK	USE THESE STATEMENTS TO THINK ABOUT YOUR PERFORMANCE WHEN YOU CARE FOR RESIDENTS LIVING WITH DEMENTIA FROM OTHER CULTURES	RECORD THE AREAS YOU HAVE DONE WELL	RECORD THE AREAS YOU WOULD LIKE TO IMPROVE
Valuing people	I value them as individuals. I respect their personal values and beliefs. I take the time to listen to them.		
Autonomy	They are involved in decisions about their support . They are supported to do the things that are important to them . Their life choices are respected.		

THE VALUING PEOPLE FRAMEWORK		USE THESE STATEMENTS TO THINK ABOUT YOUR PERFORMANCE WHEN YOU CARE FOR RESIDENTS LIVING WITH DEMENTIA FROM OTHER CULTURES	RECORD THE AREAS YOU HAVE DONE WELL	RECORD THE AREAS YOU WOULD LIKE TO IMPROVE
Life experience		<p>I know who they are and what's important to them.</p> <p>I respect and value them for who they are.</p>		
Understanding relationships		<p>I have good relationships with them.</p> <p>I encourage them to be a partner in the support team.</p> <p>I support them to maintain relationships and activities that are important to them.</p>		
Environments		<p>I have the flexibility to provide the support that they need .</p> <p>When there are issues, I work with them to address these.</p> <p>I acknowledge and act on their feedback.</p>		





CASE STUDY 2: PERSON-CENTRED APPROACH APPLIED TO INTERACTIONS WITH A CALD RESIDENT

Rosa is an 85-year old resident from an Italian background. She divorced her husband in her mid-60s after experiencing long-term domestic violence during her relationship with him. She worked in hospitality services and raised a daughter and a son. She was diagnosed with Alzheimer's disease 6 years ago and has been cared for by her daughter at home. However, her condition deteriorated a year ago after a hip fracture following a fall at home. Her daughter Maria is in her 60s and has a number of chronic health conditions. Rosa came to live in the residential care home three months ago.

Rosa exhibits behaviours during lunch and dinner that disturb other residents who are sitting at the table with her. Rosa often tries to help residents by adding pepper and salt to their plates. She gathers the plates of others before they have finished their meal. Dianne, a personal care assistant, usually assists residents in the dining room. She tries to stop Rosa's behaviour in a friendly way by saying, 'You are a good girl. Please don't do this'. However, as Rosa ignores her, sometimes Dianne raises her voice and says 'Can you please stop doing this'!

Rosa also exhibits other behaviours that disturb other residents. Sometimes, she takes clothing from her wardrobe and puts them in other residents' rooms. Sometimes she shouts at male residents in Italian when they walk past her.

What can staff do in the situation above to assist Rosa?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. Separate Rosa from other residents during lunch and dinner so that other residents won't be disturbed by her behaviour.
- ☐ b. Move the pepper and salt away from Rosa seeing as these items may trigger her behaviour.
- ☐ c. Work in partnership with Rosa's daughter Maria to create a profile of Rosa by using photos or pictures of significant events in her life that she still enjoys. The profile will enable staff to know Rosa's past history and identify and accommodate her individualised needs. For example, by providing opportunities for Rosa to help staff set tables in the dining room will provide Rosa with a sense of accomplishment.
- ☐ d. Help Rosa stay in her room by closing the door so that she won't disturb other residents.
- ☐ e. Set the environment up to simulate a dining out experience for Rosa which helps to make her life meaningful and could potentially reduce the number of unmet needs.

- ☐ f. Praising Rosa in terms of 'you are good girl' is appropriate as it demonstrates that staff care for her.
- ☐ g. Ask her daughter how Rosa would like to be addressed and ensure that all staff understand that they should address her in the same way.

Reflections

1. Share your descriptions of what 'personhood' means with people in your group and what this means when relating to a resident from a CALD background.
2. Share your experiences of positive interactions with a CALD resident living with dementia.
3. Share your experiences of poor interactions with a CALD resident living with dementia (Note: be careful not to name people).
4. Describe how you apply a person-centred approach to improve interactions with residents living with dementia from a CALD background in your care home and write these down in Table 6.

Table 6: Summary of reflections

EXAMPLES OF POSITIVE INTERACTIONS WITH CALD RESIDENTS WITH DEMENTIA	EXAMPLES OF POOR INTERACTIONS WITH CALD RESIDENTS WITH DEMENTIA	USING A PERSON-CENTRED APPROACH TO IMPROVE INTERACTIONS WITH CALD RESIDENTS WITH DEMENTIA

LATE STAGE OF DEMENTIA: A PERSON-CENTRED APPROACH

All types of dementia involve having short-term memory loss making it difficult to learn and retain information, particularly in the late stage of dementia (Goode and Booth, 2012, Nasso and Celia, 2007) For example, a useful strategy is 'reality orientation' for the person with an early to moderate stage of dementia which reinforces the name of a place and the time, etc, and is used to reduce their confusion. (Normann et al., 1999, Edvardsson et al., 2008). However, studies have identified that people in the late stage of dementia appear lost in the present, but live in their past (Edvardsson and Nordvall, 2008, Normann et al., 1999). When interacting with residents in the late stage of dementia, using a reality-oriented approach is viewed as emphasising residents' disability and is associated with excessive demands or corrections for residents (Edvardsson et al., 2008, Normann et al., 1999). Studies also identified that residents in the late stage of dementia can appear confident in the past and can be engaged in meaningful interactions with staff (Edvardsson and Nordvall, 2008, Edvardsson et al., 2008). Knowing a residents' life history and applying a person-centred approach enables staff to honour and promote a residents' ability, preserve their positive image and protect their dignity.

For CALD residents in the late stage of dementia, what they say or do may be related to their life experiences prior to migration to Australia. In Mrs Lan's case, as described below, you will study the person-centred approach in dementia care and how this approach contributes to high-quality dementia care for residents with a CALD background.



CASE STUDY 3: APPLY A PERSON-CENTRED APPROACH TO IDENTIFY AND MEET MRS LAN'S CARE NEEDS

Mrs Lan is a Chinese resident in the late stage of dementia who is new to the residential home. Mrs Lan is able to converse in English but only uses a few basic words and this communication is becoming less frequent. The staff rely on her daughter Jingyin to obtain information and to determine care needs for Mrs Lan. Mrs Lan repeatedly walks to the exit door and speaks loudly in Chinese and the staff are unable to understand what she is saying. Mrs Lan becomes agitated when staff try to encourage her away from the exit door.

What can care staff do in the above situation for Mrs Lan?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. Leave Mrs Lan alone until she is calm as it is normal for her to be acting in this way.
- ☐ b. Seek help from Mrs Lan's daughter who is bilingual or alternatively other staff members who are also bilingual so that we can improve our understanding of her behaviour.

The unfolding of the case:

Ning is a nursing student from China who works as a personal care worker in the residential aged care home. When Mrs Lan tries to open the exit door and speaks loudly, Ning asks her what she can do to help her. Mrs Lan says that she wants to go home to feed her chickens because she is worried that they will die without her and the family relies on these chickens to live. Mrs Lan's daughter confirmed that Mrs Lan did indeed care for chickens when she lived in China.

- ☐ c. Tell Mrs Lan that she is in Australia and she no longer has a chicken farm and therefore does not need to go and feed the chickens.
- ☐ d. When Mrs Lan tries to go out of the area, forcibly stand in her way and guide her back to her room.
- ☐ e. Organise a meeting with her daughter Jingyin to explore Mrs Lan's history, likes and dislikes and what she enjoyed doing in the past.
- ☐ f. When Mrs Lan tries to go out of the area, divert her attention to a picture of chickens, such as a person caring for chickens and start using the words in Chinese for 'farm' and 'chickens' and ask her if she would like to look at the pictures some more.

- ☐ g. Ask the family to bring in some family photos or Chinese music that they know she likes.
- ☐ h. For the management group: Assign staff who can speak Chinese such as Ning, to assist Mrs Lan with her care when it is possible.
- ☐ i. For the management group: Consider whether Mrs Lan can be taken to visit a chicken farm or visit a place where there are live chickens on a regular basis.
- ☐ j. For the Lifestyle Manager: work with Mrs Lan's family to arrange to hire a chicken incubator with eggs under warm lights so that Mrs Lan could watch them hatch.



APPLYING A PERSON-CENTRED APPROACH TO THE CARE OF A CALD RESIDENT WHO DEVELOPS ESCALATED BPSD

Up to 90% of residents living with dementia in residential care homes show behavioural and psychological symptoms of dementia (BPSD) such as wandering, agitation and aggression (Brodaty et al., 2003). There are a range of behaviours that persons living with dementia may have but in general these are viewed as being caused by an unmet need or a trigger (Cohen-Mansfield et al., 2015). The person living with dementia may find it difficult to express themselves, however, this does not mean that they do not have needs or are affected by what is going on in their environment. The basic needs of security, meaningful activities, socialising, eating, and drinking are common to all people regardless of their backgrounds. Many behaviours can be prevented by taking the time to know the person living with dementia, their daily routine and what they like to do, their life history, their cultural and spiritual needs and how they best communicate (NHMRC Guideline Adaptation Committee, 2016). Knowing about routine, cultural background, life history and how to communicate with residents from CALD backgrounds is extremely important to help staff understand the unique person they are caring for and to use a person-centred approach to identify which unmet needs and triggers contribute to BPSD.

In the 'Clinical Practice Guidelines and Principles of Care for People with Dementia', it is recommended that (2016, p. 15):

People with dementia who develop behavioural and psychological symptoms should be offered a comprehensive assessment at an early opportunity by a professional skilled in symptom assessment and management. This should involve their carer(s) and families as appropriate and include:

- *Analysis of the behaviours (e.g., antecedent (triggers), behaviour description and consequence (ABC approach)), frequency, timing and presentation.*
- *Assessment of the person with dementia's physical and mental health.*
- *Their level of pain or discomfort.*
- *Whether they are experiencing side effects of medication.*
- *The influence of religious and spiritual beliefs and cultural norms.*
- *Physical environmental and interpersonal factors.*
- *An assessment of carer(s) health and communication style when interacting with the person with dementia should also be undertaken.*
- *Understanding the behaviour as a form of communication.*



These recommendations are applied to case study four as presented in the following.

CASE STUDY 4: CARING FOR A CALD RESIDENT LIVING WITH DEMENTIA WHO HAS DEVELOPED BPSD

Angela is 86 years old and is from a Greek background. She moved to the care home recently for permanent care due to the late stage of Lewy Body Dementia. This type of dementia has many similarities with Alzheimer's disease, but is characterised by visual hallucinations and fluctuating cognition (or having 'good days' and 'bad days'). The characteristics of changed behaviours among people who are diagnosed with Lewy Body Dementia can be found from 'Help Sheets' developed by Alzheimer's Australia. More details related to Lewy Body disease are available from the Alzheimer's Australia website.

Angela and her husband migrated to Australia from Greece in the 1950s. They met and married in Australia and worked for a car manufacturer until their retirement. They raised four children and have ten grandchildren. Their home had a big garden as both of them liked to work in the garden and enjoyed growing trees, fruit and vegetables, flowers and seeing birds in their garden. Angela's husband passed away seven years ago. Five years ago when Angela developed Lewy Body Dementia, Vik, her 60 year old daughter became the main carer. Vik is also her Guardian and is bilingual, speaking both English and Greek.

Although Angela could speak some English previously, she can no longer speak or understand English and now only speaks in the Greek language. Angela also experiences deafness in her right ear. The deafness combined with Angela's inability to communicate in English sometimes causes her distress when care staff attempt to provide her with assistance. In recent days, staff identify that Angela talks to herself and tries to repeatedly check her wardrobe, removes her dresses from the wardrobe and places them on the bed or leaves them on the floor. She also refuses to be assisted with morning care and yells at staff. In addition, she repeatedly walks to the exit door and tries to follow staff out of the secure unit.

RN David informs Angela's daughter Vik of the situation and seeks her assistance in identifying possible triggers for Angela's changed behaviours and in developing a care plan to meet Angela's needs. Vik reports to David that Angela tells her when she visits, that she is seeing 'strangers' in her room. The strangers are hiding in the wardrobe and trying to steal her dresses and jewellery. Angela also wants to go home and does not want to be with strangers in a strange place.

Discuss the triggers of changed behaviours

Using the ABC approach (antecedent — behaviour description—consequence) to interpret the behaviours from Angela's viewpoint, record your discussions in Table 7 and share your discussion with other groups:

Table 7: Using the ABC approach to interpret behaviours from Angela’s viewpoint

ANTECEDENT (TRIGGERS)	BEHAVIOUR DESCRIPTION	CONSEQUENCE

Please note, the answers listed in the table are suggestions only. The Facilitator will need to encourage staff to discuss antecedent, behaviour description and consequence based on their experiences.

What can the care team do in this situation to meet Angela's needs?

Using the 'Clinical Practice Guidelines and Principles of Care for People with Dementia' on BPSD management as described above, discuss a person-centred approach to meet Angela's needs. 'Valuing People' framework as described in Table 4 also needs to be considered.

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. The RN needs to contact Angela's doctor for further assessment to identify possible triggers of changed behaviours.
- ☐ b. Work in collaboration with Angela's daughter to make Angela's room environment look like that of her own home, for example by decorating the walls with family photos, pictures or artefacts that are meaningful to Angela.
- ☐ c. Work in partnership with Angela's daughter to create a profile of Angela by using photos or pictures of significant events in her life that she still enjoys. The profile will enable staff to know Angela's past history and identify and accommodate her individual needs.
- ☐ d. Take out Angela's hearing aid because it might be causing her distress and she cannot understand English anyway.
- ☐ e. Assign a staff member who can speak Greek to assist Angela when possible.
- ☐ f. Work in collaboration with Angela's daughter to create a communication booklet that enables Angela to express her needs for her care in the morning and have autonomy to say when she is ready to receive morning care.
- ☐ g. Use cue cards with pictures of Greek words as prompts to communicate with Angela to help to understand her needs; and use non-verbal communications such as miming, eye contact, a smile and gentle touch while explaining any care.
- ☐ h. Commence a pain assessment utilising a tool specifically designed for people living with dementia (for example Pain Assessment in Advanced Dementia Scale (PAINAD) or the Abbey pain scale; please check the tool used in your care home) to determine if there is any correlation between pain and changed behaviours.
- ☐ i. Lifestyle staff to work with Angela's daughter to assess Angela's social and spiritual needs, identify activities that Angela still enjoys and provide Angela with opportunities to choose the activities she would like to participate in. For example Lifestyle staff could design activities that reflect her hobby of gardening.

CULTURALLY AND LINGUISTICALLY APPROPRIATE ASSESSMENT FOR RESIDENTS LIVING WITH DEMENTIA

Note: This section is optional for RNs, ENs and other health professionals who have a leadership role in conducting regular cognitive assessments, care plan development, evaluation and continuous improvement in dementia care.

Staff need to visit the 'Dementia Collaborative Research Centre' website to look at Generic Guidelines & Policy: <http://dementiakt.com.au/?ct=1> and choose appropriate tools to undertake a cognitive assessment for residents from CALD backgrounds. Staff also need to refer to the organisation's requirements on cognitive assessment and discuss with their supervisors when considering an alternative cognitive assessment tool.

In the 'Clinical Practice Guidelines and Principles of Care for People with Dementia' and the DCRC website, the Rowland Universal Dementia Assessment Scale (RUDAS) is used as an example of a culturally and linguistically appropriate tool for cognitive assessment for people from CALD backgrounds (NHMRC Guideline Adaptation Committee, 2016). This tool is a short cognitive assessment instrument designed to minimise the effects of levels of education, cultural learning and language diversity. Using RUDAS as an additional tool for CALD residents along with the PAS (Psychogeriatric Assessment Scale which is required as part of ACFI assessment) could demonstrate best practice by the care home. By using RUDAS, the care home could more accurately assess cognitive function for CALD residents at admission (baseline score) and throughout a periodic care plan, review points in the residential care home in order to compare the score and detect cognitive decline and trigger further investigation on the causes of cognitive decline.

Consider the 'Key Considerations' in dementia care by the Centre for Cultural Diversity in Ageing (2016), the preferences of residents and their families and the expertise of the project team members. Some suggestions for staff are listed below:

- Ensure assessments are culturally appropriate by asking the family to assist care plan development. This may include working with the family to identify triggers for changes in behaviour. This way staff can identify the cultural, linguistic and spiritual needs of people with dementia in their care and lifestyle plans.
- Know staff, family and professional interpreting services that can be used as necessary to assist in communication.
- Provide people living with dementia and their families, with dementia information in their preferred language.

- Implement culturally appropriate activities with therapies that are designed to promote and enhance the quality of life for people living with dementia - eg culturally appropriate music therapy and reminiscence therapy.
- Ensure the living environment is appropriate and supports people living with dementia by providing culturally safe, comfortable, familiar and an orientating environment.



ACTIVITY 5: GROUP WORK AND DISCUSSION ON IMPROVING CULTURALLY AND LINGUISTICALLY APPROPRIATE ASSESSMENT FOR RESIDENTS LIVING WITH DEMENTIA

1. Check the care plan for a resident with a CALD background and identify how culturally and linguistically appropriate cognitive assessment has been used. If not, what are the barriers? What actions could be taken in order to initiate continuous improvement in dementia care?
2. Discuss how the residential care home develops and reviews care plans for residents who cannot speak English or who have limited English. If a culturally appropriate language has not been tried, what are the barriers? What actions could be taken in order to initiate continuous improvement in dementia care and language services?

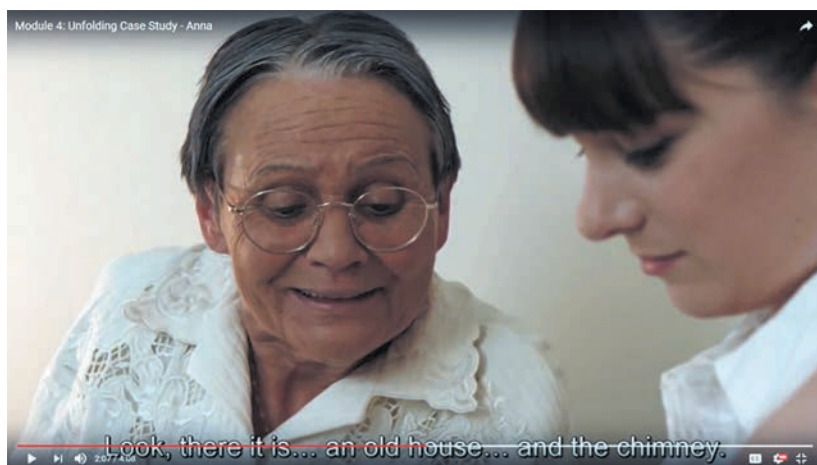
PART 2

AN UNFOLDING CASE STUDY: ANNA A POLISH RESIDENT WHO HAS DEMENTIA

INTRODUCTION TO ANNA

Anna is a Polish resident with dementia who was formerly a high school teacher who loved reading. Recently, her dementia has progressed and, although Anna can speak English, staff have noticed that she is reverting back to Polish. Anna has also become increasingly anxious, recalling frightening events from her past.

Jenny shows us how applying a person-centred approach can help. She looks over Anna's photographs asking about the relatives in the photos, acknowledging Anna's feelings and making her feel valued.



VIDEO 1: ANNA, A POLISH RESIDENT WHO HAS DEMENTIA

Play the following video (4:08): https://youtu.be/CxQQ7id_Tdl



ACTIVITY 6: PERSON-CENTRED CARE FOR A CALD RESIDENT WHO HAS DEMENTIA AND HAS REVERTED TO THEIR FIRST LANGUAGE

Discuss what other actions can be taken to improve dementia care for a resident who comes from a non-English speaking country?

- a. Staff can develop cue cards with both Polish and English words written underneath pictures to communicate with Anna.
- b. Staff can ask Anna's family to develop cue cards with both Polish and English words written underneath pictures to communicate with Anna.
- c. Care staff should continue to speak in English to Anna and not attempt to understand what she is saying in Polish, as this will encourage her to speak in English.
- d. Care staff report on Anna's progress and her ability to communicate during team handover, and also by documenting it in her progress notes. This feedback for other staff helps everyone involved to know what is working and what is not working when they are communicating with Anna.
- e. Care staff should be instructed to approach Anna in a friendly, unrushed and positive manner, and to only ask questions and give instructions that are simple. This will give Anna time to respond and answer any questions she is asked.

TEAM APPROACHES TO STRENGTHEN CROSS-CULTURAL DEMENTIA CARE

Based on care improvements for Anna, the Facilitator gains support from the care coordinator and organises a training and information session for staff to share their successful stories in caring and interacting with residents living with dementia from various cultural backgrounds. The Facilitator asks participants to work in small groups and focus on a resident who has unmet needs. Each group appoints a team leader to facilitate discussions on the causes of unmet needs for the resident, person-centred and culturally appropriate interventions to prevent unmet needs and the way outcomes can be monitored.



ACTIVITY 7: HOW TO IMPROVE CROSS-CULTURAL DEMENTIA CARE

On completion of the group work, groups share their discussions using a template as shown in Table 8.

Table 8: Summary of group activities on how to improve cross-cultural dementia care

RESIDENT NAME	CULTURAL BACKGROUND		LANGUAGE USED
	POSSIBLE TRIGGERS	INTERACTIONS THAT ARE WORKABLE	

RESOURCES

Alzheimer's Australia - Cultural Diversity

via <https://fightdementia.org.au/about-us/cultural-diversity>

Alzheimer's Australia Help Sheets

via <https://fightdementia.org.au/about-dementia/resources/help-sheets#bulkdownloads>

Clinical Practice Guidelines and Principles of Care for People with Dementia

via http://sydney.edu.au/medicine/cdpc/documents/resources/LAVER_Dementia_Guidelines_recommendations_PRVW5.pdf

Culturally Appropriate Dementia Assessment Tools - Alzheimer's Australia

via <https://fightdementia.org.au/about-dementia/resources/culturally-appropriate-dementia-assessment-tools>

Dementia Collaborative Research Centre - Online Resources

via <http://www.dementiaresearch.org.au/bpsdguide.html>

Dementia Training Study Centres - Online Resources

via <http://dtsc.com.au/resources/online-resources/>

Good Care in a Residential Aged Care Facility - Alzheimer's Australia

via https://fightdementia.org.au/files/helpsheets/Helpsheet-ResidentialCare04-GoodCareInAResidentialFacility_english.pdf

Introduction to Assessment and Management of Behavioural and Psychological Symptoms of Dementia for Novice Clinicians - Online Educational Resource

via <http://dtsc.com.au/resources/online-resources/>

National Cross Cultural Dementia Network: A Knowledge Network

via https://fightdementia.org.au/files/NCCDN_background_paper_100719_final.pdf

Dementia Dynamics Tool kit

via <http://www.dementiodynamics.com.au/>

Resources for CALD dementia care

<https://www.fightdementia.org.au/publications/papers-and-evaluations/cald-publications>

Rowland Universal Dementia Assessment Scale (RUDAS)

<https://fightdementia.org.au/about-dementia-and-memory-loss/cultural-diversity/culturally-appropriate-dementia-assessment-tools/RUDAS>

Understanding Dementia MOOC

<http://www.utas.edu.au/wicking/understanding-dementia>

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MODULE 5

CROSS-CULTURAL END OF LIFE CARE



LEARNING OBJECTIVES

On completion of Module 5, staff will be able to:

1. Explain the influence of different cultures, spiritualities, religions, traditions on end of life care for the resident and their families.
2. Apply the principles, guidelines and tool kit to support optimal end of life care and death for residents and their families from various cultural backgrounds.
3. Apply effective communication principles to interactions with residents and their families to enable high-quality cross-cultural end of life care.
4. Explain how grief and loss is expressed by the resident's family and friends from various cultural backgrounds.
5. Apply culturally and linguistically appropriate support for the resident's family and friends who experience loss, grief and bereavement.
6. Apply peer support and self-care strategies to cope with loss, grief and bereavement that staff experience.

PART 1

LEARNING TO IMPROVE PRACTICE AND PERFORMANCE

WHAT IS PALLIATIVE CARE?

The Australian Government (2016) has adopted the definition of palliative care developed by the World Health Organization:

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (World Health Organization 2014, P. 4).

In the 'Guidelines for a Palliative Approach in Residential Aged Care' (Commonwealth of Australia 2006), there are three types of palliative care:

1. **A palliative approach.** This type is suitable for the resident when the resident's condition is not amenable to cure and the symptoms of the disease require effective symptom management.
2. **Specialised palliative service provision.** This type of palliative care involves referral to a specialised palliative care team or health care practitioner.
3. **End of life (terminal) care.** This type of palliative care is provided for residents in their final days or weeks of life using a palliative care approach.

WHAT IS CROSS-CULTURAL END OF LIFE CARE?

Cross-cultural end of life care in this learning module is defined as a culturally and linguistically appropriate palliative care approach to achieve optimal physical, psychosocial and spiritual well-being for residents at the end of their life, as well as support for their family.

It is widely recognised that cross-cultural interactions add more complexities for staff to achieve high-quality end of life care (Frahm et al. 2012, Johnson 2013, Johnstone 2012). In this learning module, four case studies are presented as described in Table 1. Staff are encouraged to select case studies to meet their learning needs.

OPTIMAL PAIN MANAGEMENT FOR CALD RESIDENTS WITH ADVANCED DEMENTIA

Residents who are from a CALD background, who no longer speak English and are in the late stage of dementia may not be able to communicate with staff about their pain and their satisfaction with the level of comfort in the final days and weeks of life. They may experience distress because of uncontrolled pain. Uncontrolled pain is also the cause of family strain and dissatisfaction with care services. Optimal pain management requires a team approach and each team members' knowledge and awareness of the best practices and guidelines in pain management.

THE 'SEE - SAY - DO - WRITE - REVIEW' MODEL

Staff can provide comfort to residents by managing pain using the 'See - Say - Do - Write - Review' model based on the 'Guidelines for a Palliative Approach in Residential Aged Care'. The model is outlined in Table 1.

SELF-REFLECTION:

Reflect on your recent experience in end of life care for a resident from a CALD background.

Use the 'See-Say-Do-Write-Review' model for self-assessment.

Take notes to help you recognise your strengths and areas that need to be further developed.

CONSIDERATIONS FOR RESIDENTS WITH DEMENTIA WHEN MANAGING PAIN

Dementia adds more complexities for staff to determine whether the resident is in pain and the effectiveness of pain management. Table 3 outlines the recommended practice from Alzheimer's Australia on pain management for residents with dementia in end of life care (Alzheimer's Australia 2013).

SELF-REFLECTION:

Reflect on your recent experience in end of life care for a resident from a CALD background with late stage of dementia.

Use the 'Pain management considerations for dementia' for self-assessment.

Take notes to help you recognise your strengths and areas that need to be further developed.

Table 1: Pain management using the 'See - Say - Do - Write - Review' model

'SEE': RECOGNISE AND ASSESS		SELF-ASSESSMENT NOTES
See if the resident appears to be in pain, particularly when they are moving - e.g. being dressed, turned in bed, walking.		
Ask the resident if they have any pain/ache/soreness, where it hurts and how bad it is.		
'SAY': REPORT YOUR ASSESSMENT		
Report the resident's pain to the RN or EN in-charge.		
Be as clear and detailed as possible.		
Immediately report any worsening pain or new signs that could be due to pain.		
'DO': MANAGE		
Gently help the resident to get into a more comfortable position and/or		

'SEE': RECOGNISE AND ASSESS		SELF-ASSESSMENT NOTES
Gently massage the painful area if specified in the residents care plan.		
'WRITE': DOCUMENT YOUR ACTIONS		
Write down what you did in the resident's assessment chart/clinical record, if that is part of your role.		
'REVIEW': EVALUATE AND REASSESS AS NECESSARY		
Review your actions. Did they help? If 'yes', keep doing them regularly; if 'no', tell the RN or EN in-charge.		

Source: Pain (Brisbane South Palliative Care Collaborative 2016b)

Table 2: Considerations for residents with dementia when managing pain

CONSIDERATIONS FOR RESIDENTS WITH DEMENTIA	SELF-ASSESSMENT NOTES
Facial expression (e.g. grimacing, flushing of skin).	
Body language (e.g. restlessness, agitation, guarding a part of the body, rocking, muscle tenseness).	
Change in vital signs such as increase in pulse rate, breathing rate, blood pressure and sweating.	
Repetitive noises or inconsolable moaning.	
Use a pain assessment tool(s) for residents with dementia in your facility, for example: Pain Assessment in Advanced Dementia Scale (PAINAD) or the Abbey pain scale.	

TIPS ON PAIN MANAGEMENT FOR RESIDENTS FROM CALD BACKGROUNDS

Culture, religions and language use have a role to play in pain assessment and management. For example, staff may not be able to determine whether the resident is experiencing pain and the effectiveness of pain management due to poor cross-cultural communication. Furthermore, a resident may refuse to use a certain medication for pain management because they have a fear of particular drugs or would like to pray without the influence of opioids (Commonwealth of Australia 2006). Staff need to develop a shared understanding of pain management with the resident or the family and negotiate a solution. Table 4 outlines tips in pain management for CALD residents.

SELF-REFLECTION

Reflect on your recent experience in end of life care for a resident from a CALD background.

Use the 'Tips in cross-cultural communication in pain management for CALD residents' for self-assessment.

Take notes to help you recognise your strengths and areas that need to be further developed.

Table 3: Tips in cross-cultural communication in pain management

CROSS-CULTURAL CONSIDERATIONS IN PAIN MANAGEMENT	SELF-ASSESSMENT NOTES
Use interpreter services or family members to assist pain assessment.	
Use cue charts in the resident's first language and pictures to know whether the resident is free from pain.	
Do not assume that just because the resident or their family can understand spoken English that they can read it as well.	
Use different communication strategies to clarify whether the pain management is effective.	
Communicate in ways that are clear and appropriate - e.g. try to avoid using jargon and use more common words to describe pain that they will understand.	
Ask the resident and their family what is appropriate for the resident so you can be sensitive to their needs and traditions while achieving optimal pain management.	





CASE STUDY 1: MAINTAINING MRS LALIA BRUNO TO BE PAIN FREE

Mrs Lalia Bruno is an 85 year old resident from an Italian background who has a diagnosis of late stage dementia and terminal breast cancer with bone metastasis. She was a home-maker most of her adult life and raised five children. She speaks Italian at home and very little English. She was diagnosed with dementia five years ago, and is no longer able to speak English. Her husband died 20 years ago and for the past five years, she has been cared for by her oldest daughter, Rosa. She was admitted to the care home 3 months ago as she had a number of falls, was bed-bound and required 24 hour care and pain management.

In recent days staff have reported that Mrs Bruno has been unable to eat and drink. The family have made a decision not to use artificial feeding. An end of life care plan that focused on maintaining comfort and ensuring Mrs Bruno was pain free was discussed in a family conference. Rosa requested time to stay with her mother in her final days of life. Mrs Bruno receives medication for continuous pain relief over 24 hours. On the morning shift, when a personal care assistant Jo, assisted Mrs Bruno with her mouth care, she observed that Mrs Bruno was restless, waving her arms and grimacing. Rosa who was holding her mother's hand was in tears.

What should the care team do to maintain comfort for Mrs Bruno?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. Jo needs to comfort Rosa first and reassure her that this is a part of a normal dying process.
- ☐ b. Jo needs to ask Rosa to assist communication by asking Mrs Bruno whether she is in pain and also report the restlessness to the RN in a timely manner.
- ☐ c. Jo needs to continue her mouth care and report Mrs Bruno's restlessness to David, the RN in charge after she completes the activity.
- ☐ d. RN David needs to attend to Mrs Bruno in a timely manner, assesses the pain utilising a tool specifically designed for people living with dementia and following assessment, determine the need for the administration of PRN pain management medication.
- ☐ e. RN David needs to document the PRN medications in the medication chart without taking any further action.
- ☐ f. RN David reassures Rosa that the GP will be contacted to review the medication if the symptoms persist in spite of best efforts or if pain reoccurs frequently.
- ☐ g. In the handover and in the case notes, David, the RN reminds staff that Mrs Bruno is to be assessed for pain ½ hour before assisting with her ADLs and if pain is evident then PRN Morphine as per care plan is to be offered before ADLs commence.

MEETING RESIDENTS' SPIRITUAL CARE NEEDS IN END OF LIFE CARE

WHAT IS SPIRITUAL CARE?

In this learning module, the definition of spirituality is described as:

Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose and transcendence, and experience relationship to self, family, others, community, society, nature and the significant or sacred. Spirituality is expressed through beliefs, values, traditions and practices (Meaningful Ageing Australia 2016, p. 14, Puchalski et al. 2014, p. 646).

This definition considers that every resident has spiritual needs whether they practice a religion or not (Harrington 2016). This definition also acknowledges that the resident's cultural world view, traditions and religion have an impact on their spiritual care needs.

It is evident in the palliative care literature that residents' spirituality plays a crucial role in lessening the fear and anxiety experienced in responses to death and dying (Commonwealth of Australia 2006, Johnstone 2012). Spirituality also has a therapeutic effect helping residents achieve a meaningful or dignified death by transcending death, for example by connecting death with nature, a place, afterlife or other symbols that have a significant meaning in their lives (Commonwealth of Australia 2006, Johnstone 2012, Harrington 2016). Meeting residents' spiritual needs contributes to their spiritual well-being and quality of life at the end of their lives (Commonwealth of Australia 2006).



ACTIVITY 1: IDENTIFYING AND MEETING RESIDENTS' SPIRITUAL NEEDS IN END OF LIFE CARE

1. Work in a small group and identify a CALD resident.
2. Gain their consent to discuss his/her spiritual needs.
3. Use the HOPE assessment tool as a framework to identify the resident's spiritual needs and summarise the needs in Table 4.
4. Check the spiritual needs in the care plan and if necessary, suggest modifications to the Facilitator based on your findings.
5. Share your findings with your peers in other groups.

Table 4: Summary of residents' spiritual needs

RESIDENT NAME	CULTURAL BACKGROUND	RELIGION
THE HOPE FRAMEWORK*	FINDINGS FROM RESIDENT INTERVIEW	SUGGESTED CHANGES OF SPIRITUAL NEEDS IN THE CARE PLAN
H = Sources of hope, meaning, comfort, strength, peace, love and connection.		
O = Organised religion.		
P = Personal spiritual beliefs and practices independent from organised religion.		
E = Effects of medical care on spiritual practices.		

**Source: Anandarajah & Hight (2001).*



ACTIVITY 2: SELF-REFLECTION

Reflect on recent experiences in end of life care.

Use the 'Spiritual interventions to support residents' (see Table 5) as a guide to identify your own strengths and areas that need to be further developed.

Table 5: Spiritual interventions to support residents

INTERVENTIONS	FURTHER EXPLANATION	SELF-ASSESSMENT NOTES
Allow the resident to guide all interventions:	Do not impose your own world-views of spirituality on residents.	

INTERVENTIONS	FURTHER EXPLANATION	SELF-ASSESSMENT NOTES
<p>Silent support:</p>	<p>Be with the resident; Provide a supportive presence; Avoid judgment.</p>	
<p>Liaison:</p>	<p>Depending on staff's role and responsibility, coordinate services and people (e.g. chaplains/pastoral care workers, family, friends) as requested by the resident; Ensure access to spiritual activities (e.g. Bible study, worship ceremonies); Obtain requested spiritually related items (e.g. books, rosaries, statues, videos, music); Avoid interrupting the resident during spiritual activities.</p>	

INTERVENTIONS	FURTHER EXPLANATION	SELF-ASSESSMENT NOTES
<p>Active listening:</p>	<p>Engage in conversation with the resident;</p> <p>Be alert to the resident's comfort level — watch for eye contact, bodily movement (turning away, restlessness) and disengagement from conversation;</p> <p>Repeat themes of the conversation to ensure accurate interpretation.</p>	

APPLYING A CULTURAL SAFETY CONCEPT TO END OF LIFE CARE FOR ABORIGINAL RESIDENTS

When caring for residents from an Aboriginal background, staff will need to be aware that they need to apply a cultural safety concept of cultural competency to their practice. Cultural safety was originally developed in New Zealand more than two decades ago to respond to the concerns about unmet care needs of the Maori people (Nursing Council of New Zealand 2011). This cultural competency emphasises Aboriginal residents' perspective as to whether care services are culturally appropriate. Cultural safety is described as:

The effective nursing practice of a person or family from another culture, and is determined by that person or family... Unsafe cultural practice comprises any action which diminishes, demeans or dis-empowers the cultural identity and well being of an individual (p. 7).

This description points out that cultural safety in end of life care can only be achieved through staff's critical reflection as to the impact of their own culture, and the relations of power between staff and the Aboriginal residents on culturally appropriate care services. A culturally safe approach requires staff to respect Aboriginal residents' choices and enable residents to participate in all aspects of end of life care at all levels in a culturally safe manner (SA Health 2016, Vines 2015), for example:

- whom they would like to yarn with to complete advance care directives;
- where they would like to die, for example the residential health care team and the health care providers located in their lands;
- how they would like to die, for example, refusal of life-prolonging interventions.



CASE STUDY 2: MEETING SPIRITUAL CARE NEEDS FOR AN ABORIGINAL RESIDENT

Edna, is an Aboriginal woman from the Anangu Pitjantjatjara Yankunytjatjara (APY lands: a large Aboriginal local government area located in the remote north west of South Australia). She has been a resident in the facility for two years. She has a diagnosis of end stage renal failure and is undergoing dialysis. She also has diabetes and congestive cardiac failure. In recent days, Edna's condition has deteriorated due to severe pneumonia and she shows signs and symptoms that indicate death is approaching. For example, it is becoming more difficult for her to breathe. In a morning shift, Edna has indicated to Personal Care Assistants, Lin and Marina that she does not want to continue to have any further dialysis.

What can the care team do in the above situation for Edna?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. Lin and Marina need to explain to Edna that going back to the APY lands would not be possible and she would receive the best care if she remained in the residential aged care facility.
- ☐ b. Lin and Marina need to report Edna's requests to management and the nurse in charge to discuss end of life care options for Edna.
- ☐ c. As Edna has the capacity to make decisions, staff do not need to contact Edna's family, but document the decision made by the resident.
- ☐ d. Management needs to ask Edna 'Who in your family do we need to talk to?' and, 'Would you like to talk to them first?' The person(s) can then be contacted and informed of Edna's current condition, her wishes in end of life care, organise a meeting to discuss the end of life plan and the best way to meet Edna's spiritual care needs and to support the family.
- ☐ e. Interpreting services for the meeting with the family member that Edna appointed does not need to be considered as Edna can speak English.
- ☐ f. Management need to contact the Aboriginal Liaison Officer (ALO) who know Edna and also the local Aboriginal Community Controlled Health Organisation to discuss the resources and the best way to meet Edna's needs in end of life care.
- ☐ g. Management needs to contact the local Aboriginal Community Controlled Health Organisation to discuss the resources and the best way to meet Edna's needs in end of life care.
- ☐ h. Talk to Edna about her country and wishes to return to her home to die and also if Edna wishes, consider utilising the services of an Ngangkari, a traditional spiritual healer to assist Edna with her end of life care journey.



THE INFLUENCE OF RELIGION ON THE END OF LIFE CARE

WHAT IS RELIGION?

There are many different religions in Australia that people believe in and practice. Some examples of religions that residents and staff may practice include the Christian (Catholic or one of the Protestant churches), Hindu, Buddhist and Jewish religions as well as the Islamic faith. In this learning module, the definition of religion is explained in the following:

Religion is an organised system of beliefs, practices, rituals and symbols designed to facilitate closeness to the sacred or transcendent (Lucchetti et al. 2011, p. 235).

Staff need to be aware that residents from the same cultural background may not share the same religion and there are many subgroups within each religion who have slightly different beliefs, rituals and traditions. It is important to know each resident's religious beliefs in order to provide high-quality end of life care for them, work with and support their families.

RELIGIOUS PRACTICE IN END OF LIFE CARE

Caring for older people at the end of life has many similarities across different religious groups in the world. For example, a prayer will be recited by family members, friends, or clergy such as a chaplain, nuns, monks, rabbi or mullah depending on the religion or faith, in order to maintain spiritual well-being and enable a dignified death for the dying person.

However, the practice of praying and the required materials and environmental support for praying may differ amongst each religion. For example, in the Christian faith, a chaplain may be present to discuss any concerns and to help the person to prepare for death while in some Buddhist faith, a group prayer by nuns or monks may occur in a decorated room with a statue of a Buddha and the burning of incense.



ACTIVITY 3: EXCHANGE OF KNOWLEDGE OF RELIGIOUS PRACTICE IN END OF LIFE CARE

1. Work in small groups and choose two religions expressed by group members.
2. Compare the similarities and differences of religious practice in end of life care.
3. Summarise your comparisons in Table 6.

Table 6: Summary of the similarities and differences of religious practice in end of life care

ASPECTS OF RELIGIOUS PRACTICE	RELIGION 1:	RELIGION 2:
Members to be included in prayer.		
Materials used in prayer.		
Environment required to enable prayer.		
Is there a direction that the dying person needs to face?		
Who cleans and dresses the deceased?		
What clothing does the deceased need to wear?		
Who should or should not touch the body of the deceased?		
How should the body be laid out?		
Others:		

THE INFLUENCE OF RELIGIONS AND CULTURES ON ADVANCE CARE PLANNING

Religion and culture also has an impact on people's perceptions and actions towards a meaningful death (or good death). For example people who hold strong Western individualist cultural views, value autonomy in choosing where they would like to die and how they would like to die (i.e. refusal of life-prolonging interventions). This may be how they achieve a meaningful death (Johnstone 2012). Therefore, they may have developed written wishes regarding a treatment decision or 'Advance Care Planning' and have appointed an advocate to act on their behalf, particularly if they no longer have the capacity to make decisions for themselves (Commonwealth of Australia 2006).

People from some religions or faiths, for example Catholic, Muslims and Buddhists, may believe that life and death is God's will. A meaningful death is to follow God's wishes in order to achieve an afterlife (Johnstone 2012, Palliative Care Australia 1999). Therefore, some interventions in end of life care such as withdrawing from active treatment to preserve life via Advance Care Planning or by an advocate (family members) may not be received well or considered appropriate. Staff may experience distress when they observe an end of life decision that does not reflect their own values and beliefs.



ACTIVITY 4: COMPARISON OF ADVANCE CARE PLANNING OF RESIDENTS FROM DIFFERENT RELIGIONS

1. Work in small groups and select two residents who are from different religious backgrounds.
2. Check their care plan and identify whether they have Advance Care Planning.
3. Check their care plan and identify their wishes for end of life care.
4. Compare the similarity and differences of Advance Care Planning or wishes for end of life care and summarise in Table 8.

Table 8: Summary of the ACP and wishes for end of life care for two residents

ASPECTS OF ACP OR WISHES	RESIDENT 1*	RESIDENT 2*
Does the resident have ACP?		
What are the resident's wishes for end of life care?		
Who is nominated as the surrogate decision maker?		

*Note: ACP= Advance Care Planning *please use a pseudonymous name*



SUPPORTING THE FAMILY WHOSE RELIGION DIFFERS TO STAFF'S

It is evident that 'families who witness a difficult or poorly managed death may experience more grief, guilt and regret in the bereavement period' (Australian Government 2016, p. 133). Staff may encounter more challenges to achieve high-quality end of life care when caring for residents whose religions differ from their own. Including the family in end of life care planning, developing trusting relationships, and supporting the family throughout the end of life care journey via effective communication are crucial elements to enable sensitive and responsive end of life care. Staff need to be mindful of the influence of religion, culture, family dynamics and family structures in decision making for the resident regarding end of life care planning.



CASE STUDY 3: WORKING WITH THE FAMILY IN END OF LIFE CARE FOR A RESIDENT FROM ISLAMIC FAITH

Jaladar, a 90 year old Turkish woman, was admitted to the residential care home 3 months ago with end-stage cardiac failure. Her condition has deteriorated in recent days evidenced by breathlessness, inability to eat and drink, and for most of the time, she is unconscious. Her GP did not expect her to live beyond a couple of weeks. Although the family has been informed of Jaladar's severe condition and been offered a palliative care approach, the care plan stated that she was still for resuscitation.

The care plan also stated that she migrated to Australia with her daughter's family from Turkey in 2010 and the family are practising Islamism. Jaladar's daughter Asli was her principal family carer prior to entering residential care. Asli visited her mother in the care home on a daily basis and spoke simple English. Her son, Dadas (Jaladar's grandson) is the contact person and representative of the family for Jaladar's treatment and care.

On a morning shift, two personal care assistants, Jan (Australian-born without religion) and Asha (Indian-born Catholic) were allocated to Jaladar's care. Asli was holding her mother's hand and was in tears and asked about her mother's condition. She also said that she would like staff to do everything they could to keep her mother alive.

In the handover, Jan reported Asli's reaction to her mother's condition and her request to keep her mother alive. Most staff in the handover said that Asli's demands might add distress to her mother.

What should the care team do to provide end of life care for Jaladar and support her family?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. Staff should ignore Asli's demand, stop providing active treatment for Jaladar's heart failure and provide palliative care for Jaladar.
- ☐ b. The care team needs to identify the family relationships with Jaladar and organise a family conference to discuss treatment options and end of life care planning for Jaladar.
- ☐ c. It is OK for staff to tell the truth to Asli that Jaladar is dying in the presence of Jaladar.
- ☐ d. It is OK for staff to blame the family demands for active treatment for Jaladar adding unnecessary distress on her.
- ☐ e. The care team need to enable the family to practice religious activities regardless of their decision to pursue or withdraw from active treatment.
- ☐ f. The management team should organise an education session for staff to support them understand the influence of religions and cultures in end of life care.

PART 2

AN UNFOLDING CASE ON GRIEF, LOSS AND BEREAVEMENT

INTRODUCTION TO MADAM LI

The Facilitator will organise the online video for staff in order to participate in this unfolding case study.



VIDEO 1: MADAM LI

Watch the video via the web link

www.caresearch.com.au/caresearch/tabid/3920/Default.aspx

Please note, the source of the video is from Brisbane South Palliative Care Collaborative (2016a). The transcript for the video is available via the web link below: Video Transcript of Cultural Considerations: Some Tips for Careworkers in Residential Aged Care: <https://www.caresearch.com.au/caresearch/tabid/3924/Default.aspx>



ACTIVITY 5: THE DIFFERENT VIEWS OF A GOOD DEATH

1. Work in small groups, analyse the different views on good death (meaningful death) held by Madam Li, her family and Pat, a personal care assistant.
2. Summarise your analysis in Table 9.
3. Share your findings with other groups.

Table 9: The different views of meaningful death held by Madam Li, her family and by Pat

DOMAINS OF GOOD DEATH	MADAM LI	MADAM LI'S FAMILY	PAT
Decision on end of life care.			
Physical comfort.			
Psychosocial care needs .			
Spiritual and religious care needs.			

*Note: ACP= Advance Care Planning * please use a pseudonymous name*

SUPPORTING THE FAMILY TO COPE WITH GRIEF, LOSS AND BEREAVEMENT

The residents' family and close friends will experience grief, loss and bereavement before and after a residents' death. In order to support the family, staff need to understand the terms of grief, loss and bereavement as listed in the following (Commonwealth of Australia 2006, p. 173):

Loss is the severing or breaking of an attachment to someone or something, resulting in a changed relationship.

Grief is the normal response to loss. It may involve a range of reactions: physical, mental, emotional and spiritual. Responses to grief sometimes include unhappiness, anger, guilt, pain and longing for the lost person or thing. Feelings of numbness, emptiness, relief and isolation may also be related to grief.

Bereavement is the total reaction to a loss and includes the process of healing or 'recovery' from the loss. We all grieve and recover in our own way.

It is recommended for end of life care best practice, that the care team will need to assess family members' needs for bereavement support using the 'Modified Risk Bereavement Risk Index' (Brisbane South Palliative Care Collaborative 2012). This assessment tool is available from the online Palliative Approach Tool-kit Module 2 (Brisbane South Palliative Care Collaborative 2012).



ACTIVITY 6: SUPPORTING MADAM LI'S FAMILY

The team identify that Madam Li's sister is at high risk of experiencing extreme loss, grief and bereavement as she has a very close relationship with Madam Li; they depended on each other to survive the Cambodian Khmer Rouge regime; and they have cared for each other since they migrated to Australia. She visits Madam Li in the home on a daily basis, feeds her and reads books and the newspaper in Chinese to her. The team also notice that Madam Li's sister speaks very little English.

What should the team do to support Madam Li's sister? What kinds of culturally and linguistically appropriate bereavement support does the team need to provide for her?

Please use ✓ to indicate a good response and X to indicate a poor response in the box for each statement. Please also discuss the reason why you think it is a good or a poor response.

- ☐ a. Give a copy of an English version of the booklet - 'Now What? Understanding Grief' to Madam Li's sister so she can read and seek resources to cope with bereavement.
- ☐ b. The team appoints an RN FenFang, who is Chinese and bilingual to undertake a bereavement risk assessment for Madam Li's sister using the Modified Risk Bereavement Risk Index.
- ☐ c. FenFang reports to the team that Madam Li's sister has a score of 10 in the bereavement risk assessment. The team appoints Mei-Ling to discuss with Madam Li's sister a culturally and linguistically appropriate bereavement counselling service that is available in her local area. After gaining her permission, FenFang has arranged the service for her.

PEER SUPPORT AND SELF-CARE

Working in a care home with supportive team members to deliver high-quality care for residents has enormous rewards for staff. However, it is also widely recognised that staff will experience different levels of loss, grief and bereavement when residents they care for die. Seeking peer support as Pat, the personal care worker did in the video and providing peer support as showed by Mei-Ling enable staff to manage their reactions to loss, grief and bereavement in a positive way.

Staff will need to refer to the 'Bereavement Support Booklet for Residential Aged Care Staff' (Brisbane South Palliative Care Collaborative 2013) from time to time to learn how to cope with loss, grief and bereavement (available online).



ACTIVITY 7: IDENTIFY PAT'S REACTIONS TO LOSS AND GRIEF REGARDING MADAM LI'S DEATH

1. Based on the video, please analyse Pat's reactions to Madam Li's death.
2. Using arrows from the list of common reactions to death and dying (Brisbane South Palliative Care Collaborative 2013) indicate Pat's reactions to Madam Li's death (see the example).

THE LIST OF COMMON REACTION TO DEATH AND DYING	PAT'S REACTIONS TO MADAM LI'S DEATH
Feelings of confusion, sadness and stress.	
Challenges to your religious or spiritual beliefs	
A sense of not being 'in control' of your own thoughts, feelings or behaviour.	
Loss of confidence in your ability to function well at work or in your personal life.	
Physical and mental exhaustion.	
Not eating or sleeping properly.	



ACTIVITY 8: PEER SUPPORT FOR PAT

Based on the video, please analyse what kind of peer supports Mei-Ling provided for Pat.

Using arrows from the list to cope with bereavement (Brisbane South Palliative Care Collaborative 2013) indicate Mei-Ling's support for Pat (see the example).

THE LIST OF PEER SUPPORT TO COPE WITH BEREAVEMENT	MEI-LING'S SUPPORT FOR PAT
Recognising and acknowledging the loss and grief that a peer may be experiencing.	
Encouraging peers to share their concerns and feelings following the death of a resident.	
Listening and responding in a 'non-judgemental' way to peers' experiences and needs.	
Sharing cross-cultural end of life care knowledge with peers.	
Refer peers to bereavement support in-formation or services.	



ACTIVITY 9: SELF-CARE STRATEGIES

Table 10 lists evidence-based self-care strategies to cope with loss, grief and bereavement for staff working in care homes (Brisbane South Palliative Care Collaborative 2013).

1. Reflect on your recent experience in caring for a resident from another culture.
2. Identify self-care strategies you have or have not used but plan to use.
3. Identify other strategies that may help you cope with loss, grief and bereavement regarding residents' death in your care homes.
4. Summarise your self reflection in Table 10.

Table 10: Self-care strategies in cross-cultural end of life care

SELF-CARE STRATEGIES	NOTES OF USING THESE STRATEGIES
Acknowledge your grief and recognise that it is a normal reaction to the experience of loss.	
Talk to your supervisor and colleagues about what you are experiencing and request their help.	
Seek support from a professional counsellor.	
Develop self-care strategies that promote your physical and emotional well-being - e.g. healthy diet, regular exercise, find activities that help you to relax and make time to do them.	
Have fun with your family and friends.	
Think positively and be proactive in raising and addressing concerns.	
Other strategies you identified:	

RESOURCES

Aboriginal wills handbook: a practical guide to making culturally appropriate wills for Aboriginal people

http://www.tag.nsw.gov.au/verve/_resources/Aboriginal_Wills_Handbook.pdf

Advance Care Planning Australia website

<http://advancecareplanning.org.au/>

Advance care yarning

http://www.pallcare.asn.au/upload/info-resources/aboriginal-palliative-care-resources/Advance_Care_Yarning_ATSI_SA.pdf

Calvary Health Care - Bereavement Support Across Cultures website

https://www.caresearch.com.au/caresearch/Portals/0/Documents/PROFESSIONAL-GROUPS/Calvary_A5_real.pdf

CareSearch of Palliative Care Knowledge Network website

<https://www.caresearch.com.au/Caresearch/Default.aspx>

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Decision Assist website

<https://www.caresearch.com.au/Caresearch/tabid/2583/Default.aspx>

Guidelines for a Palliative Approach in Residential Aged Care website

<https://www.nhmrc.gov.au/guidelines-publications/ac15>

Multilingual Brochures website

<http://palliativecare.org.au/what-is-palliative-care/>

National Palliative Care Service Directory website

<http://palliativecare.org.au/directory-of-services/>

palliAGEDnurse website

<http://apps.caresearch.com.au/palliAGEDNurse/Home>

Palliative Care Australia website

<http://palliativecare.org.au/>

Palliative Care Nurses Australia website

<http://www.pcna.org.au/>

Residential Aged Care Palliative Approach Tool-kit - CareSearch

<http://www.caresearch.com.au/caresearch/tabid/3629/Default.aspx>

Respecting Patient Choices - Australia's leading educational program & guidelines on Advance Care Planning

<http://www.respectingpatientchoices.org.au/>

Taking care of business: Planning ahead for Aboriginal people in New South Wales

http://www.tag.nsw.gov.au/verve/_resources/NSWTG_Taking_Care_Business_v2.pdf

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CROSS-CULTURAL CARE TOOL KIT



CROSS-CULTURAL CARE TOOL KIT

This section includes these tools:

- Cross-cultural Care - Staff Self-reflection Tool.
- Cross-cultural Care - Leaders Self-reflection Tool.
- Cross-cultural Care Service Audit Tool.
- Multicultural Workforce Management Audit Tool.
- Organisational Support for Cross-cultural Care Services Audit Tool.

CROSS-CULTURAL CARE STAFF SELF-REFLECTION TOOL

The 'Staff Cross-cultural Care Self-Reflection Tool' has been developed to assist staff to reflect on their own attitudes and practice as you provide cross-cultural care and services to older people. The tool is suitable for all staff including (1) direct care staff, (2) non-direct care staff and (3) those staff who have management and supervisory roles. This tool is informed by 'Cultural Humility' described as developing a reciprocal and equal partnership when engaging in cross-cultural interactions (Foronda, Baptiste, Reinholdt, & Ousman, 2016; Hook, Davis, Owen, Worthington, & Utsey, 2013). When you undertake self-reflection using this tool, please take notes to help you recognise your strengths and areas that need to be further developed. You do not need to submit your notes to the Facilitator or your supervisor, but keep them as a resource for yourself as part of your own personal and professional development.

This tool is suitable for all staff to perform self-reflection

CULTURAL HUMILITY AND ITS ATTRIBUTES		SELF-REFLECTION CUES	NOTES
Respect for differences in values. Capacity for reflection on cultural values and beliefs. Demonstrates self-awareness around cultural values and beliefs. Ability to understand different values and beliefs Exploring, tolerating, reconciling and respecting others values and beliefs.		How would I describe my values to another person?	
		How might someone else's values differ to my own?	
		How do I engage with someone else who has different values to my own?	
		What do I do to ensure I don't impose my values on others?	
		How do I tolerate my co-workers' cultural values?	
		How do I encourage others to maintain their cultural and ethnic needs?	

CULTURAL HUMILITY AND ITS ATTRIBUTES	SELF-REFLECTION CUES	NOTES
<i>Continued...</i>	How do I accommodate residents' values and beliefs and foster their health and well-being?	
	How do I actively seek out information about cross-cultural care?	
	How do I participate in cross-cultural activities and events?	
	How do I embrace working in a multicultural team as something to broaden my learning?	

CULTURAL HUMILITY AND ITS ATTRIBUTES	SELF-REFLECTION CUES	NOTES
<p>Effective communication with residents and staff in cross-cultural interactions.</p> <p>Ability to use a range of means to communicate with residents and staff from CALD backgrounds.</p> <p>Able to engage with residents, their families and staff in English.</p> <p>Actively seeks knowledge and skills in cross-cultural communication.</p>	<p>Am I aware that I need to speak English in a clear way to minimise communication errors in cross-cultural interactions?</p>	
	<p>Should I use slang? Which slang? Why should I not use slang?</p>	
	<p>Do I use appropriate eye contact, body language, sign language and cue cards to assist with communication?</p>	
	<p>Is there a time when it is appropriate to use a language other than English in the workplace?</p>	

CULTURAL HUMILITY AND ITS ATTRIBUTES	SELF-REFLECTION CUES	NOTES
Continued...	Am I aware that my accent might make it difficult for others?	
	Do I encourage the understanding of my own and other cultural norms, beliefs and common terms?	
	Do I seek confirmation that others have understood the conversation and how do I do show this aspect?	
	Do I practice or encourage others to practice English to improve communication?	
	Do I have patience to listen to residents and staff from CALD backgrounds without interruption?	
	Am I willing to learn a few words from residents from CALD backgrounds and communicate with them?	

CULTURAL HUMILITY AND ITS ATTRIBUTES	SELF-REFLECTION CUES	NOTES
<p>Positive attitudes and actions in cross-cultural interactions with residents, families and staff.</p> <p>Fosters high-quality cross-cultural care and services by working in partnership with residents and families.</p> <p>Contributes to an inclusive, cohesive workforce by supporting peers.</p>	<p>Do I actively seek and provide support for residents to preserve their cultures and beliefs that have positive outcomes for their well-being?</p>	
	<p>Could my interactions ever be interpreted as arrogant, or humiliating?</p>	
	<p>Do I actively seek to understand diverse cultures and beliefs of the residents and staff?</p>	
	<p>How can I include family members in care decisions to ensure I meet residents' cultural needs?</p>	
	<p>Where appropriate, how do I engage with visitors of residents from CALD backgrounds to support their and the residents' needs?</p>	

CULTURAL HUMILITY AND ITS ATTRIBUTES	SELF-REFLECTION CUES	NOTES
Continued..	How do I ensure resident's decision making is respected without imposing my values?	
	Do I contribute to resolve cross-cultural issues or cultural clashes in the workplace that have positive outcomes for residents' care and for workforce cohesion?	
	Do I know the process required to report and investigate a 'cultural' issue in the workplace?	
	Am I aware of workplace policies, legislation and standards that support cultural inclusion, equal opportunity, anti-discrimination and zero tolerance of racism?	
	Are there any continuous improvement opportunities related to high-quality cross-cultural care services	
	Are there any continuous improvement opportunities related to workforce cohesion in the multi-cultural workplace?	

CROSS-CULTURAL CARE LEADERS SELF-REFLECTION TOOL

This tool has been designed for use by staff who are in management, supervisory and team leader roles. It has been developed using the 'Australian Health Leadership Framework'. When you use self-reflection tools, please take notes to help you recognise your strengths and areas that need further development.

AUSTRALIAN HEALTH LEADERSHIP FRAMEWORK AND ITS ATTRIBUTES	SELF-REFLECTION CUES	NOTES
Leads self	Am I aware of my own cultural values and beliefs and how these may impact on my practice in leading the team?	
	Do I understand and manage the impact of my cultural background, assumptions, values and attitudes on myself and others?	
	Do I promote understanding, respect and trust between different cultural individuals and groups?	

Engages others	Do I engage with others and act in accordance with values, beliefs and skills that facilitate cross-cultural communication?	
	Am I approachable and do I listen to differing cultural needs of both staff and residents?	
	Do I listen, inspire and enable staff and others to share ideas in improving cross-cultural care and services?	

Achieves outcomes	Do I work in collaboration with residents, their families and staff to set goals for cross-cultural care and services?	
	Do I motivate self and others to provide culturally appropriate care that contributes to continuous quality improvement?	
	Do I monitor and evaluate progress and am I accountable for culturally sensitive care?	

Drives innovation and improvement	Do I champion the need for innovation and improvement in cross-cultural care and services?	
	Do I build support for change, encourage diverse voices and consumer involvement in providing culturally appropriate care?	
	Do I communicate system awareness and negotiate within and across health care teams in providing culturally appropriate care?	

Shapes systems	Do I explore, implement and disseminate new care practices in regard to cross-cultural care and services?	
	Do I systematically maximise the potential benefit of change while minimising unintended consequences in providing culturally appropriate care?	

Reference: Health Workforce Australia. (2013). Health LEADS Australia: the Australian health leadership framework. Retrieved (Accessed 28 March 2016), from Available at: <https://www.aims.org.au/documents/item/352>

CROSS-CULTURAL CARE SERVICE AUDIT TOOL

The cross-cultural care service audit tool is designed to assist staff to collect data to inform quality improvement activities. This audit tool is informed by the Availability, Accessibility, Acceptability and Quality (AAAQ) framework developed to address access and equity for consumers in government subsidised health and social care systems (World Health Organization 2015).

The project team adapted the framework and have defined the AAAQ as follows:

Availability: The residential aged care home has a sufficient quantity of effective cross-cultural care services to meet the specific care and service needs of residents from culturally and linguistically diverse (CALD) backgrounds.

Accessibility: The accessibility of cross-cultural care services for residents has four sub-dimensions: non-discrimination, physical accessibility, economic accessibility (or affordability) and accessibility of information.

Acceptability: Cross-cultural care services (CCCS) are respectful and acceptable to residents, family and friends.

Quality: Cross-cultural care services provided by staff demonstrate high-quality, continuous improvement against criteria/standards and is monitored in the aged care system.

The auditor needs to randomly select 5-10 residents from CALD backgrounds. The auditor needs to check care plans, progress notes, incident reports and interview residents/proxies to gather evidence. Besides these data collection methods, it is strongly recommended that the auditor observes the home for two hours on at least two consecutive days, to clarify evidence from other sources.

Name of residential aged care home:.....

Audit period:.....Auditor:.....

REQUIRED CROSS-CULTURAL CARE SERVICE FOR RESIDENTS	CCCS NEEDS ASSESSED & RECORDED AT ADMISSION & VIA REGULAR CARE PLAN REVIEW	SERVICES ARE AVAILABLE FOR RESIDENTS TO MEET THEIR NEEDS*	SERVICES ARE ACCESSIBLE AS NEEDED*	SERVICES ARE RESPECTFUL/ ACCEPTABLE*	SERVICES HAVE MET HIGH-QUALITY STANDARDS*	FURTHER ACTIONS ARE REQUIRED
SCORE	1 Not identified 2 Partially identified 3 Identified NA Not applicable	1 Not identified 2 Partially available 3 Identified NA Not applicable	1 Not identified 2 Partially accessible 3 Identified NA Not applicable	1 Not respectful or acceptable 2 Partially acceptable 3 Respectful/ acceptable NA Not applicable	1 Met standards 2 Continuous improvement 3 Using robust evidence NA Not applicable	Yes/No If yes, action plan needs to be developed
1. Diet, drinking and dining activities that require special considerations in cross-cultural care services.						

REQUIRED CROSS-CULTURAL CARE SERVICE FOR RESIDENTS	CCCS NEEDS ASSESSED & RECORDED AT ADMISSION & VIA REGULAR CARE PLAN REVIEW	SERVICES ARE AVAILABLE FOR RESIDENTS TO MEET THEIR NEEDS*	SERVICES ARE ACCESSIBLE AS NEEDED*	SERVICES ARE RESPECTFUL/ ACCEPTABLE*	SERVICES HAVE MET HIGH-QUALITY STANDARDS*	FURTHER ACTIONS ARE REQUIRED
2. Needs associated with culturally appropriate dressing/make-up.						
3. Ability to speak, read and write English and special considerations in cross-cultural communication.						

REQUIRED CROSS-CULTURAL CARE SERVICE FOR RESIDENTS	CCCS NEEDS ASSESSED & RECORDED AT ADMISSION & VIA REGULAR CARE PLAN REVIEW	SERVICES ARE AVAILABLE FOR RESIDENTS TO MEET THEIR NEEDS*	SERVICES ARE ACCESSIBLE AS NEEDED*	SERVICES ARE RESPECTFUL/ ACCEPTABLE*	SERVICES HAVE MET HIGH-QUALITY STANDARDS*	FURTHER ACTIONS ARE REQUIRED
4. Interpreter services needs and/or the need for working with family members as communication resources.						
5. Sensory impairments that require special considerations in cross-cultural communication.						

REQUIRED CROSS-CULTURAL CARE SERVICE FOR RESIDENTS	CCCS NEEDS ASSESSED & RECORDED AT ADMISSION & VIA REGULAR CARE PLAN REVIEW	SERVICES ARE AVAILABLE FOR RESIDENTS TO MEET THEIR NEEDS*	SERVICES ARE ACCESSIBLE AS NEEDED*	SERVICES ARE RESPECTFUL/ ACCEPTABLE*	SERVICES HAVE MET HIGH-QUALITY STANDARDS*	FURTHER ACTIONS ARE REQUIRED
6. Cognitive impairment that requires special considerations in cross-cultural communication.						
7. Religion/spirituality needs that require special considerations in cross-cultural care services.						

REQUIRED CROSS-CULTURAL CARE SERVICE FOR RESIDENTS	CCCS NEEDS ASSESSED & RECORDED AT ADMISSION & VIA REGULAR CARE PLAN REVIEW	SERVICES ARE AVAILABLE FOR RESIDENTS TO MEET THEIR NEEDS*	SERVICES ARE ACCESSIBLE AS NEEDED*	SERVICES ARE RESPECTFUL/ ACCEPTABLE*	SERVICES HAVE MET HIGH-QUALITY STANDARDS*	FURTHER ACTIONS ARE REQUIRED
8. Needs associated with cultural occasions/ special dates of significance.						
9. The need for regular activities/ visits organised by CALD communities or interest groups.						

REQUIRED CROSS-CULTURAL CARE SERVICE FOR RESIDENTS	CCCS NEEDS ASSESSED & RECORDED AT ADMISSION & VIA REGULAR CARE PLAN REVIEW	SERVICES ARE AVAILABLE FOR RESIDENTS TO MEET THEIR NEEDS*	SERVICES ARE ACCESSIBLE AS NEEDED*	SERVICES ARE RESPECTFUL/ ACCEPTABLE*	SERVICES HAVE MET HIGH-QUALITY STANDARDS*	FURTHER ACTIONS ARE REQUIRED
10. Needs associated with Complementary and Alternative Medicine.						
11. Needs associated with culturally/ linguistically appropriate lifestyle.						

REQUIRED CROSS-CULTURAL CARE SERVICE FOR RESIDENTS	CCCS NEEDS ASSESSED & RECORDED AT ADMISSION & VIA REGULAR CARE PLAN REVIEW	SERVICES ARE AVAILABLE FOR RESIDENTS TO MEET THEIR NEEDS*	SERVICES ARE ACCESSIBLE AS NEEDED*	SERVICES ARE RESPECTFUL/ ACCEPTABLE*	SERVICES HAVE MET HIGH- QUALITY STANDARDS*	FURTHER ACTIONS ARE REQUIRED
12. Need to avoid cultural taboos, culturally unacceptable behaviours and language.						
13. Need to avoid triggers that lead to difficult behaviours in cross-cultural interactions.						

REQUIRED CROSS-CULTURAL CARE SERVICE FOR RESIDENTS	CCCS NEEDS ASSESSED & RECORDED AT ADMISSION & VIA REGULAR CARE PLAN REVIEW	SERVICES ARE AVAILABLE FOR RESIDENTS TO MEET THEIR NEEDS*	SERVICES ARE ACCESSIBLE AS NEEDED*	SERVICES ARE RESPECTFUL/ ACCEPTABLE*	SERVICES HAVE MET HIGH-QUALITY STANDARDS*	FURTHER ACTIONS ARE REQUIRED
14. Needs arising from behavioural patterns related to cultural factors (i.e. sitting on the floor, not a chair).						
15. The need to use culturally and linguistically appropriate social worker and counselling services.						

REQUIRED CROSS-CULTURAL CARE SERVICE FOR RESIDENTS	CCCS NEEDS ASSESSED & RECORDED AT ADMISSION & VIA REGULAR CARE PLAN REVIEW	SERVICES ARE AVAILABLE FOR RESIDENTS TO MEET THEIR NEEDS*	SERVICES ARE ACCESSIBLE AS NEEDED*	SERVICES ARE RESPECTFUL/ ACCEPTABLE*	SERVICES HAVE MET HIGH-QUALITY STANDARDS*	FURTHER ACTIONS ARE REQUIRED
16. Others (add more rows if needed):						
SCORE	Mean Total =	Mean Total =	Mean Total =	Mean Total =	Mean Total =	Mean Total =

ITEMS AS DESCRIBED IN TABLE ABOVE	KEY POINTS

MULTICULTURAL WORKFORCE MANAGEMENT AUDIT TOOL

The Multicultural Workforce Management Audit Tool has been designed to assist staff who are in management, education and training roles to collect evidence to inform staff development activities. The auditor needs to check relevant documents, staff meeting agendas, minutes, incident reports and interview staff to gather evidence.

Besides these data collection methods, it is strongly recommended that the auditor observes the home for two hours on at least two consecutive days, to gather evidence from other sources.

Periodic audits are needed to provide evidence of the improvement of the multicultural workforce management.

Name of residential aged care home:.....

Audit period:..... Auditor:.....

SUPPORT/RESOURCES FOR THE MULTICULTURAL WORKFORCE	SCORE 1 = Not met. 2 = Partially met. 3 = Met. NA= Not applicable	FURTHER EXPLANATIONS & ACTIONS
1. Updated summary information on cultural diversity of the workforce are available for the public to access.		
2. Culturally acceptable behaviours/ languages have been identified and presented in writing for staff to access.		
3. Buddy support for new staff from culturally and linguistically diverse (CALD) groups are available and tailored to their needs.		
4. Mentoring support for new staff on effective cross-cultural care services are available and tailored to their needs.		
5. Resources on enhanced cross-cultural care services are available for staff to access.		

SUPPORT/RESOURCES FOR THE MULTICULTURAL WORKFORCE	SCORE 1 = Not met. 2 = Partially met. 3 = Met. NA= Not applicable	FURTHER EXPLANATIONS & ACTIONS
6. Resources on enhanced cross-cultural communication with residents/their family and friends are available for staff to access.		
7. Resources on enhanced cross-cultural communication in the multicultural care team are available for staff to access.		
8. In-service education sessions on cross-cultural care services are available for staff.		
9. Cultural exchange activities between staff and residents to enhance cross-cultural understanding are available.		
10. Cultural exchange activities for the care team to enhance cross-cultural understanding of team members are available.		

SUPPORT/RESOURCES FOR THE MULTICULTURAL WORKFORCE	SCORE 1 = Not met. 2 = Partially met. 3 = Met. NA= Not applicable	FURTHER EXPLANATIONS & ACTIONS
11. Cultural occasions/special dates for staff and the impact on rostering have been identified and managed.		
12. Policies which address dress/make-up/body markings for staff from diverse backgrounds are in place.		
13. Policies are in place to meet the specific needs of staff associated with their culture and religious beliefs.		
14. Culturally and linguistically appropriate counselling services for staff are available and accessible when needed.	.	

SUPPORT/RESOURCES FOR THE MULTICULTURAL WORKFORCE	SCORE 1 = Not met. 2 = Partially met. 3 = Met. NA = Not applicable	FURTHER EXPLANATIONS & ACTIONS
15. Incidents of cross-cultural communication, conflict in a team and racially negative attitudes/behaviours have been identified, investigated and resolved in a timely manner.		
16. Residents/family complaints on cross-cultural communication issues have been investigated and resolved in a timely manner.		
17. Other incidents and resolutions (please specify):		
18. Others (please add more rows if needed):		
SCORES	Mean Total =	

ORGANISATIONAL SUPPORT FOR CROSS-CULTURAL CARE SERVICES AUDIT TOOL

This audit tool is designed to assist aged care organisations to collect evidence to inform cross-cultural care services for residents and to effectively manage human resources. The auditor needs to check relevant documents and interview key people in the organisation to gain evidence.

Besides these data collection methods, it is strongly recommended that the auditor observes the home for two hours on at least two consecutive days, to gather evidence from other sources.

Periodic audits are needed to provide evidence of improvements in the organisational attributes that support cross-cultural care services and the development of the multicultural workforce.

Name of residential aged care home:.....

Audit period:.....Auditor:.....

DEMOGRAPHIC INFORMATION OF RESIDENTS AND STAFF

	NON-CALD	CALD	TOTAL (%)	COUNTRY OF BIRTH IF BORN OVERSEAS	LANGUAGE SPOKEN AT HOME IF SPEAKING A LANGUAGE OTHER THAN ENGLISH
Residents					
Staff					

ORGANISATIONAL ATTRIBUTES	SCORE 1 = Not met. 2 = Partially met. 3 = Met. NA = Not applicable	FURTHER EXPLANATIONS & ACTIONS
1. The organisation has updated data on the diversity of residents and staff.		
2. The organisation uses the updated data on the diversity of residents to inform CCCS development.		
3. The organisation's recruitment policies/guidelines/staff development/skill testing consider the requirement for culturally and linguistically appropriate care for residents.		
4. The organisation's recruitment policies/guidelines/staff development/skill testing considers the requirements for an inclusive and culturally competent workforce.		

ORGANISATIONAL ATTRIBUTES	SCORE 1 = Not met. 2 = Partially met. 3 = Met. NA = Not applicable	FURTHER EXPLANATIONS & ACTIONS
5. The organisation has policies/ guidelines/resources and supporting mechanisms to enable culturally and linguistically diverse (CALD) staff to adapt their practice in the organisation environment if needed.		
6. The organisation has resources and supporting mechanisms to enable culturally and linguistically diverse (CALD) staff to improve their English communication in the workplace.		
7. The organisation has education/ training resources for staff to engage in continuing staff development to advance cultural diversity for residents.		

ORGANISATIONAL ATTRIBUTES	SCORE 1 = Not met. 2 = Partially met. 3 = Met. NA = Not applicable	FURTHER EXPLANATIONS & ACTIONS
8. The organisation has personnel to manage issues arising from the diversity of the workplace.		
9. The organisation has systems and processes in place to ensure all staff know it is their responsibility to facilitate and advance CCCS for residents.		
10. The organisation has policies/ guidelines/procedures/resources for identifying and resolving racially negative attitudes/behaviours in the workplace.		
11. The organisation has culturally and linguistically appropriate counselling support for residents and staff when needed.		

ORGANISATIONAL ATTRIBUTES	SCORE 1 = Not met. 2 = Partially met. 3 = Met. NA = Not applicable	FURTHER EXPLANATIONS & ACTIONS
12. Job descriptions for different levels and categories of staff /volunteers consider the performance of effective resident-staff and staff-staff cross-cultural interactions.		
13. Competency assessment for different levels and categories of staff / volunteers considers the performance of effective resident-staff and staff-staff cross-cultural interactions.		
14. Appraisals for different levels and categories of staff considers the performance of effective resident-staff and staff-staff cross-cultural interactions.		
15. Promotion policies /guidelines consider the performance of effective resident-staff and staff-staff cross-cultural interactions.		

ORGANISATIONAL ATTRIBUTES	SCORE 1 = Not met. 2 = Partially met. 3 = Met. NA = Not applicable	FURTHER EXPLANATIONS & ACTIONS
16. Induction and orientation has an introduction to effective resident-staff and staff-staff cross-cultural interactions.		
17. Updated summary information on the multicultural workforce is available for residents, family/friends and potential service users to access.		
18. Others (please add more rows if needed):		
SCORES	<i>Mean Total =</i>	

APPENDICES



APPENDIX 1

INSTRUCTIONS FOR ACCESSING THE ONLINE CROSS-CULTURAL CARE PROGRAM FOR AGED CARE STAFF

STEP	HOW TO DO THIS
1. Accessing the program	Go to: www.flinders.edu.au/cross-cultural-care
<i>If you are not already registered with Open Learning, you will need to create a username and password before you start. Please follow these steps:</i>	
2. Create a username	<p>A username is a personal ID for you to use online. It is also a way for you to remain anonymous when you are online. Some people use their initials and a favourite number, for example 'LBD2000'.</p> <p>You may have to try a few combinations if someone else is already using the username you are trying.</p>
3. Creating a password	<p>Usually, a password must be 8 characters in length and have a mixture of letters and numbers, for example 'Banana25'.</p> <p>You may also like to add a capital letter.</p>
4. Find the course	Search for 'Cross-cultural Care Program for Aged Care Staff' or use the link above

5. Get help with module navigation	On the Welcome page, there is information about how to move around within the modules and within the program.
6. Start the program	You will be able to view to the whole program but only have to review modules that are relevant to your work.
7. Our survey	<p>Your feedback is very important to us.</p> <p>Please complete our Survey for the modules you undertake. The survey will take under five minutes to complete.</p> <p>A link to the survey can be found in the Summary section.</p>
8. Need Help ?	Please contact your team leader or supervisor.

APPENDIX 2

THE AUSTRALIAN AGED CARE SYSTEM

Aged care in Australia is provided through the Australian Government's Department of Health. This Department is responsible for the regulation of the aged care industry in every Australian state. The Government works with aged care organisations and families to provide affordable and accessible aged care and carer support services by providing subsidies and grants, industry assistance and training.

The care provided includes support for people to enable them to keep living in their own homes as long as possible (community care), after-hospital (transition) care, respite care for carers, and residential Residential aged care homes where care is provided 24 hours a day. There are also multi-purpose services for small rural and remote communities.

To access aged care services provided with government funding, older people need to be assessed to meet eligibility requirements. Some of these requirements can be a minimum age and a decreased ability to perform basic daily living tasks without some extra help. These services are provided to older people with diverse backgrounds across the Australian community.

Although the Australian government subsidises aged care services, older people receiving these services may have to pay a basic fee or an income-tested fee. The fees vary across different types of services and different income levels. Older people who are eligible for a full aged care pension pay less than people who are part-pensioners or self-funded retirees. There are also provisions for people experiencing financial hardship.

ADDITIONAL RESOURCES:

Ageing and aged care

<https://agedcare.health.gov.au/>

My aged care

<http://www.myagedcare.gov.au/>

APPENDIX 3

RESIDENTIAL AGED CARE HOMES

Residential aged care homes are required to have government approval to receive aged care funding and must meet the Australian Government's Accreditation Standards. They provide 24-hour care to older people who may be admitted because of an illness, a disability, an emergency, or because of the needs of their family or carer. Older people may live in a Residential aged care home on a permanent basis or for a short stay called 'residential respite'.

Before an older person can live in a Residential aged care home subsidised by the Australian Government, they must have a free assessment by an Aged Care Assessment Team (ACAT). Once in a Residential aged care home, residents contribute to the cost of their accommodation depending on what they can afford to pay. The Australian government sets the maximum fees that can be charged for care and daily living expenses and there are rules about how much an aged care provider can charge residents for accommodation.

Residents are provided with care services such as activities of daily living and allied health services, such as physiotherapy and occupational therapy. Care also includes accommodation, laundry services, some toiletries, meals and refreshments, and buildings and grounds maintenance.

Residential aged care homes are different from 'retirement villages'. People living in retirement villages can receive community care assistance that is the same as people living in their own homes.

ADDITIONAL RESOURCES:

Aged care homes

<http://www.myagedcare.gov.au/aged-care-homes>

APPENDIX 4

CROSS-CULTURAL COMMUNICATION TIPS

The following tips are guide for good cross-cultural communication by staff. One of the activities you are asked to undertake is to look at each tip and try and find an example of how you can use this to help better communication between yourself and culturally and linguistically diverse (CALD) residents and staff.

GENERAL TIPS IN CROSS-CULTURAL COMMUNICATION:

1. **Smile and be friendly.** This does not take any extra time and a smile and being friendly will generally be returned.
2. **Make eye contact.** It is OK and expected in Australian culture that people make eye contact when communicating unless you are an Indigenous person relating to certain people.
3. **Listen.** Take time to listen. If you don't understand, or you are not being understood, take the time to find out why. Explain or ask questions. For example, 'Would you help me understand?' Give the person plenty of time in which to communicate. Having to hurry creates tension, which affects the way people listen and speak.
4. **Be self-aware.** Develop self-awareness and do some reflection on what you say and do. Look at your own biases and prejudices, and become aware of and respect different cultural norms, attitudes and beliefs to your own.
5. **Value difference.** Value diversity and focus on the positive aspects of difference.
6. **Do not judge.** Do not allow cultural differences (preferences) to become the basis for criticism and judgements. Differences are neither good nor bad - it is what we do with them that makes a difference.
7. **Be polite.** Australians generally say 'please' if they want someone to do something and 'thank you' if something is done for them.
8. **Make a friend from another culture.** Build friendships of mutual respect and a desire for shared understanding.
9. **Ask questions.** Show an interest and ask questions about the culture and ethnic background of a person that is different to your own - both residents and staff.
10. **Encourage intercultural relationships.** Encourage relationships between CALD staff and residents from the same culture or ethnic background.

11. **Be yourself and show you care.** Show that you care about the person from a different culture and that you honestly want to help or understand them.
12. **Seek cultural knowledge.** Acquire knowledge about other cultures by attending classes or seminars, reading books or watching movies about other cultures, and attending cultural events/festivals.
13. **Quiet environment.** Make the environment conducive to communication and free from distraction and excessive noise levels. Avoid places with too much background noise, distractions and where interruptions are likely.
14. **Speak slowly, clearly and distinctly.** Adapt the pace of the conversation to fit the person's ability to comprehend. Give instructions in clear, logical sentences and present one topic at a time. Write it down if you are unsure whether something has been understood. This is particularly useful for numbers.
15. **Repeat and simplify.** Repeat when you have not been understood or ask the person to tell you what has been said to check their understanding. Put it in simpler terms. Gauge how much people are likely to remember. Seek feedback from residents and staff to confirm their understanding.
16. **Use common words.** Use words your listener is likely to know. Avoid jargon and popular idioms or slang. Explain any words not understood.
17. **Avoid jokes.** Avoid jokes, as these may not be understood by your listener. Irony, satire and sarcasm should be avoided for the same reasons.
18. **Consider the individual.** Have consideration for the individuality and personality of the person, as well as their life history.
19. **Be Supportive** and give encouragement to those with English as a second language as this gives them confidence, support and a trust in you.
20. **Do not raise your voice.** Speaking loudly will not necessarily ensure that you will be understood and it can be demeaning.

TIPS FOR COMMUNICATING WITH RESIDENTS

1. **Your body language and the resident's body language** can provide important clues for increased understanding for the carer and the resident. It can also be misinterpreted so make sure your body language is one of being there for the resident. Sign language is also valuable.
2. **Use a calm voice and caring facial expressions** to help alleviate the resident's fear.
3. **Use empathy** to show you know what the resident is expressing or feeling.
4. **State you know what the resident is expressing.** Validate the person's thoughts and feelings to show your understanding of any issue.
5. **Use touch** if appropriate and acceptable as it can be comforting and it shows residents you care. However, be aware that some residents do not like being touched.
6. **Do not exclude the resident** from discussions when other staff or relatives are present. It may be easier to talk to relatives and staff, but it is important that the resident is aware, included and heard.
7. **Learn key words** in the resident's own language to improve communication during routine care and other simple interventions.
8. **Use visual aids, gestures and physical prompts such as communication cards and signage** in other languages.
9. **Use qualified language interpreters** during assessment, meetings or other events for communication with residents and their carers in cases that require a level of assistance that if not understood, could be critical, or dangerous to the well-being of the resident. Ask the interpreter to translate the message, not just the individual words.
10. **Utilise bilingual staff and relatives** for communication with residents from the same culture if available and appropriate when there are day to day problems with activities.
11. **Use translation** as necessary. All information relating to key service delivery contexts (e.g. care plans and service agreements) should be provided to the client and their advocate in their own language.
12. **Repeat the message in different ways**, if necessary and maybe state something in a different or simpler way. Keep messages simple and repeat them frequently.
13. **Be alert to words the patient seems to understand and use them frequently.** Also communicate these words to other staff. Use an appropriate language dictionary.
14. **Avoid jargon or slang** or using medical terms and abbreviations that the resident may not understand.

TIPS FOR EFFECTIVE CROSS-CULTURAL COMMUNICATION BETWEEN STAFF

1. **Build relationships and friendships** between culturally and linguistically diverse (CALD) and Australian staff through sharing, inclusion and understanding.
2. **Talk in English** at work with other staff as the common language, even if staff may have a common language other than English. It can be viewed as rude for staff to talk together in another language not understood by others.
3. **Practice English.** Staff from a non-English speaking background need to practice their English language and their pronunciation, as well as writing, reading and documenting in the English language.
4. **Learn Australian Culture.** Encourage those staff from CALD backgrounds to increase their understanding of the Australian culture through Australian staff giving explanations, and CALD staff practicing the English language and documentation.
5. **Make allowances.** Be willing to modify your own communication style or make allowances in order to reach common understanding.
6. Establish standard procedures and formats in phone communication, handover and written reporting.
7. Use a report-back strategy or obtain feedback to confirm that a staff member has comprehended the message from colleagues.

Source: (Giger 2013, Multicultural Communities Council of SA Inc and Multicultural Aged Care Inc 2005, Ziaian and Xiao 2014)



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