Chapter 1 Towards a Culturally Inclusive Model of Care: Quality practice and care through the lens of a practising nurse

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Abstract

When a nurse cares for a patient there is a set of expectations which must be met; not only for the management of health needs, but also to address interpersonal and social needs. Every person is different. Their values and belief systems and the cultural practices they follow, impact on how they like nursing care to be appropriated. The individual nurse varies in how they manage their patient's care. They may not necessarily perceive or accommodate differences within and amongst people for whom they are caring. Locally, Australian indigenous nurses, Aborigines, have been under-represented in the nursing workforce and recognition of Aboriginal patients' cultural needs have been surpassed by dominant Western culture. This is despite national health policy evolving, aimed at raising awareness of traditional owners' beliefs and values. This chapter is a reflection on a practicing nurse's experiences in delivering scientifically-sound care amid patients' needs and best interests.

Key Words

Interculturalism, globalisation, cultural awareness, nursing, education, training

Introduction

The environmental context of nursing has changed significantly over the past twenty years and both multiculturalism and interculturalism have been important concepts for nursing and nurse education. Whilst both concepts have played an important role in the

development of government policies related to health and in approaches to higher education and training in the nursing profession, they cannot be used interchangeably. Sarmento (2014, p.608) comments: '... *the concept of multiculturalism prevails in the Anglo Saxon world, where groups of different cultural matrices are integrated ... in order to ensure social cohesion, but not inclusion'*. 'Interculturalism' on the other hand, is a more inclusive term, defined by Cantle[1] *'… is about changing mindsets by creating new opportunities across cultures to support intercultural activity and it's about thinking, planning and acting interculturally'* (Cantle, 2012). To be inclusive of all, a change in styles of teaching pre-service nurses is necessary to ensure a non-static view of culture. Also, developing a culturally-inclusive model of care, where the formulation of quality care is negotiated and shared between service provider and patient.

Perceived realities of any given situation are not homogenous across cultures and basic responses to realities are subject to social circumstances and social conditioning (Edwards, 2014; Duffy, 2001; Sarmento, 2014; Bloomfield, 1994; Brady, 2010; Broom, Good, Kirby & Lwin, 2013). Edwards (p.87) further explains that a nurse acts: *'... by reference to perception of a mere reality, together with their possession of relevant theoretical knowledge and moral commitment to the health of the patient'*. There is recognition of the need for awareness of cultural differences in Australia since the government announced the 'closing the gap' program in 2008 for Aboriginal people (COAG, 2012; Closing the Gap Clearinghouse, 2013). In addition, globalisation has increased the number of overseas students in universities and the number of international nurses working in Australia (Changfu, Mei & Chen, 2012; Guo, Cockburn-Wootten & Munshi, 2014; Cortés & Pan, 2014; Durey et al, 2008),

[1] See website http://tedcantle.co.uk/publications/about-interculturalism/

ultimately enduring their own cultural backgrounds. That is to say, their own experiences and backgrounds are likely to affect their delivery of 'care' to the patient. A relatively recent television documentary on the Special Broadcasting Service Corporation (Martin, 2014) called 'First Contact', investigated how individuals responded when first exposed to Aboriginal communities in isolated settings. The documentary recorded the response of some individuals which aligned with our own experience of how some nurses respond in similar situations. There are a number of nurses who have never encountered Aboriginal communities and as a consequence, lack insight into some of the problematic circumstances which confront individuals and communities on a daily basis. Service providers may be shocked by living conditions and the lifestyle led within some communities. One may also say there is limited appreciation of the cultural contexts and circumstances of patients and nurses who have moved to Australia from many diverse countries across the globe.

An Australian nurse is more likely to be addressing patient needs through policies and protocols that are aligned with their employing body that may be reactionary to past events and incidents. This nurse will have learnt how to care for people through education which includes studies of human behaviour, culture and scientific expertise, and they may follow an approach which is aligned with the Western model (Lee, Steketee, Rogers & Moran, 2013). The nurse may not have adapted to express their professional care in a manner that suits a multitude of cultures. We contend that the use of the Western model, in its entirety, is not the most effective for the future of nursing. Especially with regard to achieving quality care, given the changing nature of student and patient characteristics. Models of care need to incorporate a broader range of interpretations of what constitutes quality care. There also needs to be more development in a range of pedagogical approaches to assist nurses to gain

cultural awareness, communication skills and clinical approaches to assist themselves, their patients and colleagues in providing optimum individualised care to the patient.

Literature

The literature describes a need for change in nursing education to account for cultural differences (Lee et al, 2013; Duffy, 2001; Long, 2012; Rosenkoetter & Milstead, 2010; Donate-Bartfield & Lausten, 2002; McDonald, 2006; Harding, 2013; AMA, 2014; Australian Indigenous HealthInfoNet, 2014; Closing the Gap Clearinghouse, 2013; ABS, 2008; ANMAC, 2012; Universities Australia, 2011; Alsharif, 2012; Arieli, Mashiach, Hirschfeld & Friedman, 2012; Cuellar, Walsh Brennan, Vito, & de Leon Siantz, 2008; Hoare, 2013; Jones, Bond & Mancini, 1998). There is a concern, however, if approached at a superficial level, it may actually increase the distance between cultures because of its failure to address underlying social conditions and issues of cultural acceptance and integration. Historically, nursing education and practice arose from a sense of duty, where the nurse was considered a quality nurse if she followed rules (Donley, 1985; McCurry, Revell & Roy, 2010). Nursing today is mandated by traditionally established virtues and best practice based on scientific principles (Wake, 2012). Importantly, patients desire the caring compassionate nurse who has the time to listen to them, over the skilled, efficient, and possibly officious one (John, Kawachi, Lathan & Ayanian, 2014). The Western model has been taught to medical professionals for some time (Crowden, 1994; Harding, 2013). However, we now realise in order to address the health needs of people who do not follow Western culture per se, we need to review the very essence of belief systems underlying the provision of quality care (De & Richardson, 2008; Australian Indigenous HealthInfoNet, 2014; McCurry et al, 2010; Harding, 2013; Backof & Martin, 1991; Walsh Brennan & Cotter, 2008). Whilst acknowledging principles of

transformative education, there needs to be further investigation into commonalities in humans, rather than just seeing the differences in cultures (Duffy, 2001; Guo et al, 2014).

Experience from the field

Personal experiences demonstrate how misaligned decisions may develop when nurses (and other members of the health profession) deal with cultures outside of the Western model, as outlined in the following narrative which describes a situation involving an Aboriginal boy from a small rural town in Australia. He had initially presented with a pimple-like wound on his upper inner thigh, which had grown and developed into a large abscess. Attempts at the local hospital to drain the abscess were unsuccessful. It did not heal, the mass continued to grow and swell, and there were concerns regarding development of septicaemia. If the infection spread systemically, the worst scenario for such a case could be fatal. In some cases, this can occur rather rapidly[2]. Medical staff reviewed the wound and deemed surgical cleaning was required to remove the source of infection[3]. However, as the procedure would require a general anaesthetic, it could only be done at a larger hospital, and should be done as soon as possible. Therefore, it was decided the child should be moved to the city immediately. Generally, the child was otherwise well physically. Unfortunately, those caring for him directly had other major life events to deal with and were unable to be with him on the proposed transfer day. He was begging a female Aboriginal volunteer ambulance officer, who was known to him, to come along on the journey, but she refused for her own reasons. He reached out and hung on to her, she struggled to pull herself free from his out-

[2] For a case example see the Coroner's Court of Western Australia Inquest into the Death of Amanda Dana TAUAI http://www.coronerscourt.wa.gov.au/I/inquest_into_the_death_of_amanda_dana_tauai.aspx?uid=1901-1986-3149-8255)

[3] As per protocol for abscess formation, for reference information see - The Royal Children's Hospital Clinical Guidelines : http://www.rch.org.au/clinicalguide/guideline_index/Cellulitis_and_Skin_Infections/

stretched arms. A nurse (Anglo Saxon) stood by holding tightly onto him so that he did not fall from the bed. The information given on clinical handover included that he was violent and aggressive. However, he presented as terrified and distressed. He had been given a large amount of sedatives and still was unsettled and thrashing about. Later he revealed that his bladder was also very full; it was not until he was alone with the transport nurse that he yelled out that he needed to: *'take piss'*. The medical officers who were present decided managing his behaviour was difficult - they thought impossible (as did the other health professionals present), and that he needed to be transported without any complications. In addition, the patient's reported violent behaviour added a further (perceived) dilemma for the attending healthcare staff as there are industry regulations surrounding unruly patients during transport. So, under duty of care (common law principles, case-based, care must be provided to prevent foreseeable injury), the decision was made the boy required transportation to the hospital. However, as he had eaten a few hours earlier, he could not be sedated any further. On deliberation, it was thought if he were intubated, complications of aspiration would be prevented and therefore he could be transported safely. It seemed to be a logical decision at the time, in view of the situation. However, such a proposal was invasive and not without risk. On taking a step back, being mindful of the child's state and allowing for cultural, social and medical dynamics, one wonders if he was not actually as violent and aggressive as he was deemed to be. He had a full bladder, was drowsy from sedatives, had never travelled out of his home town, had never been away from his mother or siblings, had recently lost a close relative and all of his family were organising to attend the funeral. Additionally, his father had not long ago been incarcerated, and he did not like to talk to a large group of strangers (many healthcare professionals were around his bed). He had been in hospital in the town for a few days and had walked out the day before without permission, returning home to his

mother. He wanted to make sure she was okay and check in on his younger siblings (he was the eldest child and in light of his father's absence from home, it would fall to him to be the 'man of the house' and to ensure his family's safety and wellbeing). Fortunately, luck intervened. The tertiary children's hospital communicated they would not take him if he was intubated as there were no beds available for the level of care required. The transport team were happy to travel with him in his current state, and the nurse (I) walked up and talked to him at his bed to further assess him. One of the doctors gave him an intravenous medicine to sedate him. He fell 'asleep' following administration of this. He was loaded for transport and the nurse sat with him alone for a moment, he started to rouse, he was reassured, though at this point he began yelling quite hysterically, this is when he said he needed to urinate (he didn't feel comfortable to say in front of everyone). Again, his behaviour could easily have escalated if his needs were not addressed. Once he had passed urine, he calmed down and talked. He started to cry. He was tied to the bed with restraints, in case he became violent and aggressive. The nurse continued to sit with him and held his hand as he cried more and told of his family's story. He eventually fell asleep. The doctor started to chatter about what he knew of the child's story and inadvertently revealed his mother would have been able to accompany him in one or two days' time as she needed to attend the funeral of a close relative. The question has to be asked; if the child had been transported the following day, would it have adversely impacted on his medical condition? The wound may have caused systemic infection and it may not have. He was on antibiotic treatment, which would have given him some protection. Why were the medics so adamant he travel? Why were his family not with him? How was it that people he knew were unable to help him? Many factors were complicating decisions which were aimed at looking after the child's best interests.

Reasonable care may have just been played out in an overzealous way, the flipside of 'good practice'[4].

A person not so compelled by culture may have declined attending the funeral. However, The Mother still had the care of the remaining siblings to consider. An Anglo Saxon family is generally nuclear. In Aboriginal culture, the child's care is the responsibility of a group of people (Dietsch et al, 2011; Kiraly, James & Humphreys 2014; McConvell, Keen & Hendery, 2013; Schneider & Shapiro, 1989). Often when the child is assessed, their primary caregivers have been asked to tell their story several times and might be tired and frustrated with no answers and may even feel doubted for what they are saying. The family listened to the doctor, but the doctor and the attending team did not consider or interpret the situation culturally. The family were not necessarily negligent of the medical needs of the child. Other coincidental situations held precedence for them. Those situations were not held in as high regard by the attending healthcare professionals. If the doctors had more cultural insight, they would have allowed the mother and other community members to attend the funeral, as it was culturally important for them to do so. The child's medical condition may not have been considered quite so urgent if the situation was viewed as a whole entity.

Sometimes we seek to change the individual or the situation to suit our model of practice. We attempt to align our care with the model we were taught, usually the dominant culture. If we could step away and walk around a situation, applying principles of practice with an adaptive approach, we may see the person in this story, the child (Duffy, 2001; Doris & Plakias, 2008; McGregor, 1996; Government of Western Australia, 2012; Hafferty, 1998).

[4] For further reading see - Samanta & Samanta, 2003; Rogers v Whitaker (1992) 175 CLR 479.; Alexander v Heise [2001] NSWSC 69. S; Roylance v General Medical Council [2000] 1 AC 311; Fitzgerald v The Medical Board of Queensland [2010] QCAT 565.

Rather than rushing into taking the child to definitive care, an Aboriginal response would have been to get the 'mob' together and discuss the situation. The mother was compliant with the care of her child and she had mitigating social circumstances which were impacting on her sound decision making. Her culture is to listen to her 'elders', or in this case, the 'elders' were the medical profession. The child was completely overwhelmed. The community was grieving for a lost member. The healthcare team wanted the child to have good health care. Steps to account for all of the factors need to be considered as cultural block may have severe adverse outcomes in such situations.

Another example is when a health professional approached an adult male Aboriginal to attend to a wound. The man did not like going to hospital as the people there did not understand him. The doctor in this situation did not like Aboriginals as she perceived they were often violent and frightened her (she was from a European background). Both sensed the other's dislike of the situation and it was escalating to a dislike of each other. As the doctor started to put a needle to his wound, the man yelled at her, although her perception was he had agreed for her to proceed. The commonality was they were both frightened. He was loud and vocal, as is common for his culture in the given situation. She was meek and demure (culturally conditioned), lost to his response and beginning to withdraw. He was about to leave yelling and screaming, without being attended. Seeking communication, he was spoken to by another staff member (myself). He was asked why he had attended and the implication was made that perhaps he was frightened. He acknowledged this was the case and dropped his tense shoulders to breathe. The doctor nodded at the change in the situation. The wound was sutured, and the man left laughing.

Duffy (2001, p.489) comments that '…cultural education be redesigned to emphasize equality and inclusiveness ... universities have a social responsibility to prepare students who are learned and caring citizens in multicultural communities ... when culture is viewed through an individual's global lens, stereotypes about cultural groups begin to erode and be replaced by individual identities'. Models and tools have been developed to teach transcultural care (Maier-Lorentz, 2008; Halloran, 2009), it would be of value to undertake further research into the use of some of these. The Aboriginal Cultural Learning Framework 2012 – 2016 (Department of Health, 2012) acknowledges that embedding cultural learning within health is a practical strategy to close the gap in Aboriginal health outcomes.

Higher education for the nursing profession

In response to the need for culturally inclusive patient care, many higher education institutions have introduced cultural awareness and/or competency courses which focus on Australian peoples. Others offer courses which consider cultural diversity more broadly. A model adopted by a number of universities is to include at least one cultural unit in the early years of their undergraduate nursing programs, Australian universities have this information on their websites. There are also short courses available for health professionals to participate in[5]. Such programs and courses assist in developing cultural awareness and competency which can contribute to the continuing professional development of a nurse. However, the preceding narrative provides evidence from the perspective of the field, there has been limited behavioural change to date across the profession. It is important to note that cultural differences are not limited to our own indigenous people; there are many different cultures within Australia, both as patients and as people caring for patients (AIHW,

[5] For example: Services for Australian Rural and Remote Allied Health, SARRAH, see website: http://sarrah.org.au/

2012). This situation is similar to what is being experienced in other countries. Easterby et al (2012, p.84) explains that in the United States *'… nursing students who are prepared to care for culturally diverse populations will help to facilitate access to preventative, primary, health maintenance, and acute/chronic health care services for these individuals and families'*.

Higher education today has evolved from a didactic approach to constructivism. That is, 'knowledge is obtained, and understanding is expanded through active construction and reconstruction of mental frameworks', and that 'learning is not a passive process of simply receiving information – rather it involves deliberate, progressive construction and deepening of meaning' (Killen, 2007, p.4-5, 7). From this perspective, learning and the educative process is a way of making meaning that is socially situated and can only be understood in terms of the specific contexts in which it takes place. Within the constructivist theory of learning even scientific knowledge is not objective or value free. Recognition of the value laden nature of knowledge (Doppelt, 2008) imposes a limitation on teaching scientific knowledge in that it cannot, on its own, provide nurses with all of the information that is relevant to be interpreted and applied in any given individual and unique patient context. The scientific knowledge needs to be understood and applied through a social and interactive process which involves negotiation of meaning, its construction by each party in the scenario, including the patient and their family, and its reconstruction to account for cultural differences.

Currently in many higher education courses, students are expected to do self-directed learning, including on-line tuition and simulated situations with manikins in an effort to manage resources (Richardson, Grose, Doman & Kelsey, 2014; Russell, Gregory, Care & Hultin, 2007). These trends tend to reduce physical contact and exposure to senses such as hearing, seeing and speaking. This introduces a limitation in negotiation of meaning in that being

physically present enables both direct verbal communication and visualisation of non-verbal cues, whereas minimising physical contact means these are not witnessed and is in contrast to the findings of Loue, Wilson-Delfosse & Limbach (2015; also see Sharifian, 2010). Their paper suggests increased contact with diverse patients, along with increased opportunities to practice communication skills may be critical to student awareness and comfort in interacting with diverse populations. By reducing contact, a dilemma is created in how a nurse can follow up on differences in cues that they are not familiar with (based on their cultural learnings), or recognise them if they are not present within their learning environment (active learning). This leads to the question - is the content of courses more important than the teaching? If so, what mix should be sought? Should social and cultural norms be taught? The blending of many cultures globally and locally may well mean that current practices need to be deconstructed to expose deep-seated contradictions. However, any program will be reliant to some extent on a dominant cultural background for teaching styles and format, regardless of intent.

There could be value in a teaching program that provides a number of methods of teaching (Seipold & Pachler, 2011; Kools, Chimwaza & Macha, 2015). Scenario-based training, such as sharing some stories for our Aboriginal counterparts (Carey, 2011; Richardson et al, 2014; Pijl-Zieber & Hagen, 2011; Riley, Howard-Wagner, Mooney & Kutay, 2013; Riley, Howard-Wagner & Mooney, 2015; Kutob et al, 2013; Martin & Kipling, 2006), some rote learning which may be a preferred approach for some Asian cultures (Lund, Berland & Huda, 2013; Changfu et al, 2012; Tan & Pillay, 2008) and in addition, critical thinking for individual democratic learning development (Gainer, 2012; Frost & Regehr, 2013; Bleakley, 2012) could be utilised. Exposure to different cultures is not always possible, so readings which promote cultural learning also need to be further explored and analysed in class discussions (Halloran,

2009). Consider as part of teaching, video recorded interviews with people discussing their culture – what is acceptable, what is offensive and who they feel comfortable being around (male/female, doctor/nurse etc). Recording interviews with candidates, posing the same set of questions to people of different cultures and backgrounds and reviewing the collected responses. Share the interviewees' backgrounds (whether it is their home country and how they have acclimated to Australia or an Australian person with a rural background versus their city counterpart). The notion is to deconstruct idealisms and draw out the essential elements of any given situation, such as in the narratives in this chapter. To do this, one must explore the history of Western ideological theory, thereby discovering its' foundation and bring it into question. Deconstruction (Jacques Derrida, 1930 - 2004) is a rhetorical technique, a pedagogy that challenges the notion of truth and objectivity and seeks to '*…expose the antagonisms within Western philosophy…'* (Newman, 2001; p1). Derrideanism has social value exhibiting a spirit of tolerance and of respect for difference (Rajagopalan, 2007; Direk, 2014; Hunter, 2008; Newman, 2001; Winter, 2007). Value judgements, such as those expressed by the healthcare profession, may be contextualised, rather than seen as truths. The importance of re-empowerment of the oppressed, the non-dominate culture, are described in the works of Michel Foucault (15 October 1926 – 25 June 1984). He examined how power is deployed and how texts contribute to social structure; a suggestion is to redefine the *regime of truth* (Foucault, 1991). Perhaps the works of these philosophers may be the platform for a modern approach to nurse education.

With the above in mind, a teaching plan utilising clinical reasoning practices has been explored for the reader to peruse (see appendix). Cognitive forcing is a strategy which enables a healthcare worker to think beyond the initial interpretation of the presenting patient (Croskerry, 2003).

Reflection and conclusion

The ideology of patient-centred care (Bleakley, 2012), is to approach the patient not the problem. This approach places the cultural identity and needs of the patient at the forefront, and the treatment is therefore a holistic approach to the person and the presenting health problem. The Australian Commission on Safety and Quality in Health Care (2011) explains that a *'… patient-centred approach to health care is an empathy with the patient and an ability to stand in the shoes of the patient … It is an inherent attitude that can instinctively consider how another person will react when addressed in words or by some deed. An attitude which accepts that the patient has a mind as well as a body'* (p.14). This approach does not completely take away the responsibilities of the patient to communicate effectively, as and where they are able. It also does not imply that a nurse will always have an attentive state of being with a busy and hectic case load of patients and (Hollanda, Allena & Coopera, 2013) recognise that burnout is not uncommon. However, it does suggest the concept of transcultural nursing needs to be specifically taught in higher education nursing programs. Such measures will ensure increased awareness and understanding of cultural diversity among caregivers prior to service on the units and wards. Thus, making the process of providing culturally-appropriate care more intuitive, as opposed to a task requiring a high level of mental cognition and efficiency.

The concept of a nursing workforce which is competent in cultural care is being addressed in theory in a range of higher education programs through targeted courses and through embedding of cultural awareness within other theoretical courses. However, from the perspective of a practicing nurse, to date there is limited evidence that such training is reaching the clinical area in the practice of nursing. By addressing further development of

nurse-training programmes and fine-tuning the skill of culturally-competent nursing in a broad range of contexts, some progress will be made in meeting the needs of patients, communities and nurses themselves.

Appendix

Teaching Episode

NAME OF LESSON:

Use of clinical reasoning strategy *Cognitive Forcing* to recognise errors in biopsychosocial interpretation.

AIM OF LESSON:

Anecdotally clinicians from all disciples are subject to cognitive biasing when dealing with Aboriginal people. The problem may be related to lack of exposure to populations that live on the fringe of society and the problems that they face. With the use of active control over the cognitive processes engaged in learning (*metacognition)* and cognitive debiasing (*cognitive forcing)*, I will progress through a teaching session with undergraduate nurses in their final year of study (whilst they attend Royal Flying Doctors Service Western Operations for Critical Care Practicum) initially applying *Pattern Recognition* in a visual case presentation, moving through to *Knowledge–Reasoning Integration* as the case deepens in understanding of the factors involved with using Western Medicine to treat populations from Aboriginal communities in rural and remote Australia.

LEARNING OBJECTIVES:

At the end of this lesson, students will:

1. Understand and demonstrate clinical reasoning skills in Nursing Practice,

2. Communicate health information and health education in the null form (minus psychosocial bias),

3. Communicate with welcoming consideration, to and about, clients/patients and families,

4. Facilitate conversation around Aboriginal Communities and preconceived perceptions of the people who reside in these communities,

5. Documentation of biopsychosocial concerns in the null form (Nursing Charts, Careplans, Clinical Handover).

STUDENTS' INTEGRATION OF PRIOR KNOWLEDGE:

1. Group participation in tutorial class

2. Explanation of key points prior conducting patient admission assessment

LESSON DETAILS:

Type: Discussion group, visual case study

Total duration of the lesson: 3x 30 minutes (consecutive)

No. of students: up to 5 people

Stage of career: Third year undergraduate Registered Nurse; male & female, 23 – 50+ years old

RESOURCES:

Laptop, projector, WiFi, Pointer, extension cord, MS PowerPoint, USB, whiteboard, duster, markers

FORMATIVE ASSESSMENT:

1. Group participation,

2. Direct questioning,

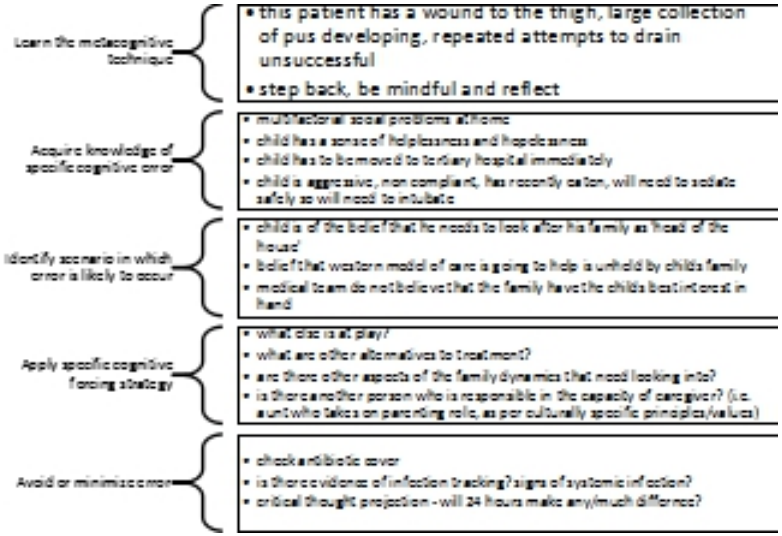
3. Reflective answers in professional journal (approximately 200 words).

LESSON SEQUENCE		Differentiation	Questions
Introduction (Set)	In the tutorial room with whole class: • Outline aim and objectives of the lesson, • Define 'clinical reasoning for decision making on patient care/treatment' – ask class members their thoughts, • Discuss clinical reasoning strategies (metacognition, cognitive bias, and so on): SMALL GROUP DISCUSSION – 'Why is clinical reasoning important in nursing practice? Write down at least three clinical reasoning strategies', share experiences, then discuss with class, • Problems with cognitive bias ACTIVITY: prior to class, watch 'First Contact', Australian television series, Presented by: Ray Martin (available from http://www.sbs.com.au/shop/product/category/DVDs/10973/First-Contact-DVD-Digital-Download-PPSP). • List components of cognitive bias as preconceived ideas (discuss amongst group), • Discuss good communication skills and techniques (listening, engage in conversation at eye level, advocacy, collaboration, use of silence, negotiation, face-to-face talk) as tools to reduce cognitive biasing, • Discuss effective speaking to clients/patients as a practical method to reduce cognitive biasing. • Have student explain to you 'what is therapeutic communication?' (definition, types, results, discuss empathy – may be given as take home assessment prior to class)	Cultural population groups unfamiliar to student: Take time to explain details of social situation of client. Familiarise self with Australian Aboriginal history. Introduction into Australian Healthcare System and availability in remote and rural settings. Small groups.	'Do you engage your client/patient with day-to-day care planning?' 'Are you clients/ patients clear on the care and treatment they receive?' 'Do you have your clients /patients confirm commitment to treatment/care?' 'Explain active listening techniques – paraphrasing, reflecting, clarifying, summarising, empathising, cues'.

Body (Engage)	Simulated clinical setting: • Handover of case example (use photographs of setting to gain visual imagery) and outline case presentation. **Visual Case Study:**  Note, this photo is presented with permission, the actual case study was not photographed for privacy reasons. ***iSoBAR* for Inter-Hospital Transfers:** **Identify** • Nine years old, male aboriginal child, • Speaks a reduced form of English and local Aboriginal dialect • Inter-hospital child patient handover/transfer **Situation** • Principle diagnosis – swollen infected groin abscess • Other diagnoses/problems – nil other medical, has been aggressive, has absconded twice in last two days • Reason for transfer – wound needs to be surgically drained in view of potential sepsis, deep, needs anesthetising, can only be in tertiary centre with anaesthetist and full surgical team on site **Observations** • Airway patent; airway management plan & potential airway compromise relayed to transport provider – recently taken diet, requiring heavy sedation to transport in calm state	One-on-one & small group. Give assessment outline at start of class. Frightened child, perceived difficulty to communicate with health professionals, full bladder, not allowed to walk around to take self to toilet.	'Outline National Clinical Handover Initiative - ISoBAR',

	• Breathing regular, unlaboured, yelling hysterically at times, crying • Circulation perfused peripherally, left leg swollen at thigh - localised, hot, painful, skin colour at site – pink/brown, full range of movement, able to ambulate • Disability, pain in left groin tolerable, patient refused analgesia; behaviour - emotionally distressed; afebrile – on intravenous antibiotics, IV x 2 peripheral **Background** • Relevant past medical history – nil significant • Current episode medications – broad spectrum intravenous antibiotic, paracetamol • Relevant social issues – emotional liable, aggressive at times, mother has two younger children, needs to attend funeral tomorrow, cannot travel today, father is in prison, child local to area, mother has given consent for the child to travel • Alerts – mental health concerns, nil clinical - nil drug allergies **Agreed plan** • Nil specific dietary needs – needs to fast re use of sedation for aeromedical transport, head of bed 45 degrees to maintain clear airway and reduce risk of aspiration, unless has a definitive airway (intubated) • To go to Children's Hospital, reviewing for ventilated bed on ICU – awaiting confirmation of bed • Currently speaking to receiving doctor in the emergency hospital • Can mobilise/ambulate, but is heavily sedated • Mode of transport is fixed wing RFDS aircraft, doctor/nurse flight • Position on stretch with four point restraints to maintain child's safety whilst behaviour is unpredictable and has had sedation • Semi urgent transfer, priority 2		

LESSON SEQUENCE		Differentiation	Questions
	Read back • Interventions – previous attempts to drain wound x2, recollection at site, needs to be surgically cleaned, and is on intravenous antibiotics. Is aggressive and abusive. Has recently taken diet. Needs further sedation to manage behaviour and consideration needs to be given to prevent aspiration during transport References: 1. http://www.safetyandquality.gov.au/our-work/clinical-communications/clinical-handover/national-clinical-handover-initiative-pilot-program/isobar-for-inter-hospital-transfers/ 2. Porteous, J.M., Stewart-Wynne,E.G., Connolly, M. & Crommelin, P. F. (2009). iSoBAR — a concept and handover checklist: the National Clinical Handover Initiative. MJA ,190 (11), s151 – s156.		

Skill Building	Clinical Reasoning skill building: **Clinical reasoning – *Pattern Recognition:*** Poor compliance, little social support systems, likely to abscond again, concerns re development of septicaemia, if he leaves may exacerbate. **Clinical reasoning - *Knowledge–Reasoning Integration:*** At the scene is a local Saint John Ambulance Officer who the child knows personally, he is begging her to come on the journey with him. She is refusing. An Anglo-Saxon nurse is holding his arm as he leans dangerously over the rails, he has physical restraints insitu.  Reference:		

LESSON SEQUENCE		Differentiation	Questions
	Croskerry, P. (2003). Cognitive forcing strategies in clinical decisionmaking. *Annals of Emergency Medicine, 41*(1), 110-120. doi:10.1067/mem.2003.22		
Closure (Rest)	Afterwards have the student report back on how they felt they went, feedback your assessment: • Review: Ask for any questions; name and frame problems - consider the patients choices, review process and outcome, and how to be interactive and engage with patients from 'foreign' cultures • Eyes: Maintain eye contact • Summary: Ask students to give a short concise summary of what was learned (match to learning objectives - assess for construction of meaning in clinical reasoning, negotiation of common goals and management decisions that may have been made) • Termination: Remember to continue to apply cognitive forcing in clinical settings.		Do you think you achieved the outcome you were hoping for? What else could you do?' 'Outline any adjustments you may make when next presented with a cultural different client/patient?

REFLECTION/EVALUATION:

All students will fill out an evaluation of clinical supervision form

Repeat exercise on the student and assess for variations and improvement on skills

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