Making connections: Communication with culturally and linguistically diverse undergraduate nursing students on clinical placement

MAKING CONNECTIONS:

Communication with culturally and linguistically diverse undergraduate nursing students on clinical placement

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What this booklet is for …

Facilitating culturally and linguistically diverse (CALD) undergraduate nursing students on clinical placement can be challenging, but also rewarding. This booklet outlines strategies for supporting CALD students at key points during the clinical learning experience, based on *cultural interaction analysis* approaches. The aim of this booklet is to improve clinical learning outcomes for CALD students by providing:

- ✦ A background for understanding the needs of CALD students
- ✦ A basis for understanding and clarifying cultural boundaries between the student, the teacher and the clinical environment
- ✦ Strategies for improving communication and problem-solving with students and agency clinicians
- ✦ Strategies for providing culturally appropriate, relevant support for CALD students while they are on clinical placement, based on sound theoretical principles
- ✦ Strategies for engaging with CALD students at key points during the clinical learning experience

Clear communication is critical for clinical supervision, problem solving, providing support and competent nursing practice. Clinical facilitators play an instrumental role in socialising students into the culture of the clinical environment. They can provide an environment that supports students, reduces culture shock (Kilstoff & Baker, 2006) and enables students to achieve clinical competence. With clear communication and understanding, clinical teachers can offer CALD students support and guidance, enabling them to develop.

The materials and ideas in this book are based on a study carried out by the authors in 2007 to investigate the issues related to assisting CALD students on clinical placement, including a literature review and focus groups with Griffith University clinical facilitators. Results from this study have informed development of these materials. Ideas and verbatim quotes from this study are used throughout.

Cultural diversity in nursing

In recent years, with increasing general migration and to ease workforce shortages, there has been a steady migration of overseas qualified nurses coming to work in Australia. These trends have resulted in cultural and ethnic diversity in the nursing workforce in

wards where students are placed (Hawthorne, 2001, Sommer, 2001), and also among their academic and clinical teachers.

There is also cultural and ethnic diversity in our student population. Throughout the world, Australia is recognised as providing opportunities for high quality education in health care for international students (Kilstoff & Baker, 2006; Shakya & Horsfall, 2000). More recently, Australian universities have become a popular choice for many overseas students who wish to study nursing (Kilstoff & Baker, 2006). Teaching and learning needs for CALD students may differ from main-stream students and clinical facilitators need to expand their knowledge about their issues and experiences during clinical placement. Traditional teaching and learning methods may need modification to ensure they are appropriate, and that there are sufficient learning opportunities to assist these students to reach their goals (Shakya & Horsfall, 2000; Griffith University, 2006) and attain clinical competence.

Clinical facilitators play an important role in helping CALD students achieve success in nursing programs by providing appropriate support during clinical placement. Amaro, Abriam-Yago and Yoder (2006) identified that clinical teachers can play a role in providing emotional and motivational support by being patient and open for questions, making themselves available, providing encouragement and giving “permission to not know everything”.

Cultural difference

> *You know I'm from [United Kingdom] and so I supposedly speak English. But when I first came here I had to learn a whole new set of rules and [laughs] and colloquialisms, you know, nurses were using words that I'd never heard of and so … it's much bigger. It's about how we communicate generally.*
>
> *I think especially the first year [student], … they really are very tense and you have to give [them] time and to tell them, … to have a balance. I think they need to know about what the lifestyle is like here. … It's difficult to change from their own country [culture] to [the] Australian culture.*

At Universities around Australia, undergraduate nursing students spend many weeks in supervised clinical placements as part of their education program. Differences in culture and language arise from professional, ethnic and social backgrounds and can create particular challenges in the clinical environment, particularly for CALD students. CALD students bring experiences, cultural values and understandings, which provide a basis for activities, behaviours, ways of relating to others and communication patterns. Some CALD students come to the clinical setting with a wealth of previous nursing experiences in either Australia or their home countries, whereas others may come from a non-nursing background with unique experiences that will enrich their nursing practice. In addition to individual differences, there is also a professional culture in nursing, which has its own language and values. Nursing students are usually unfamiliar with the organisational and professional culture of clinical environments and clinical facilitators can assist them to socialise into these new cultures (Koskinen & Tossavainen, 2003).

On clinical placement at least four different cultures come together – those of the student, clinical facilitator, ward preceptor and the clinical environment.

CALD students can have difficulty negotiating the expectations of the clinical environment. Clinical facilitators may discover that even students who are very experienced clinicians in their own country can find it difficult to negotiate the different expectations and culture of the Australian health care system. Bringing together the different cultural values of the student, teacher, ward preceptor and clinical

environment can lead to misinterpretation and misunderstandings related to:

- ✦ Activities
- ✦ Behaviours
- ✦ Ways of relating to others
- ✦ Communication patterns.

(Milnes, 2007; Sommer, 2001)

For example, a student from a culture in which leaders are not questioned may be considered unassertive and lacking in initiative by an Australian clinical teacher. On the other hand, an Australian student who questions and critiques may be considered to be rude and to have a 'poor attitude' by a teacher from a culture that values respect for seniors. These value differences can become magnified in the stress of an unfamiliar clinical learning environment.

While all nursing students will benefit from support to understand the culture of the clinical workplace, Lee and Carrasquillo (2006) pointed out that students with linguistically diverse backgrounds may need extra assistance to understand their role in the clinical environment.

Although CALD students share some common difficulties with local students in clinical placement, they require specific support from their clinical facilitators.

Understanding cultural safety

Cultural Safety addresses issues of power, prejudice and attitude amongst nurses and with their patients. Risks to Cultural Safety exist whenever people from different cultures come together. Cultural differences are not just about ethnic origins, they include differences in age, position, gender, religion and social group.

People from different cultures can have different ways of relating, language, words, meanings, and ideas about what is important.

People from cultures other than our own can seem "different". Cultural differences are not only ethnically-based, but include differences in age, social position, gender, politics, religious beliefs, and a person's socio-economic status. Cultural Safety is a concept that has developed in nursing as a framework for interaction with others from different cultures and for providing care that that addresses cultural differences (Ramsden, 2002).

When differences in ways of relating, use of language, words, meanings and ideas about what is important are not understood (particularly by a dominant culture) there can be social and emotional risks. Cultural Safety has a particular emphasis on power, prejudice and attitudes. Power differences exist when one person has more knowledge or authority than another, which is the case in the student-facilitator or health professional-patient relationship. Prejudice and attitudinal differences exist when we do not share similar values and beliefs.

Cultural Safety encourages each of us to explore *our own* cultural beliefs, perspectives and values and to identify where our own personal biases and prejudices about another culture might originate. Kilstoff and Baker (2006) point out that reflecting on our own biases and prejudices can be confronting, and that the realisation that one's culture is not the only way to view the world may be a shock. By questioning our own cultural beliefs we can learn where our actions could create an unsafe environment for those from other cultures, take a learning attitude to interact respectfully, and make changes to our own behaviours to create a culturally safe environment for inter-cultural interaction. Cultural Safety recognises that each of us will interact and provide care for another by respecting individual differences and through the establishment of mutual trust (Ramsden, 2002). To be deemed culturally safe, each person in a relationship is responsible for *establishing a trusting relationship*, for *determining when trust has been established* and *deciding that the relationship can be deemed culturally safe*. Thus, an understanding of the principles of Cultural Safety will lead a clinical facilitator to carefully reflect on their own beliefs and values and beliefs about teaching, learning and excellence in clinical practice, particularly where these may differ from those of their students. Understanding where practices may be culturally unsafe for their students will enable them to make changes to create a culturally safe and trusting relationship.

Cultural interaction analysis

We base our judgements on our own perspectives and values, so without questioning these we could be unwittingly contributing to poor communication. Misunderstandings can occur when there are cultural differences in values. However, it would be impossible to know and understand every culture fully: what is important, what is valued, the nuances of communication and how people relate to each other. There are also individual differences within cultural groups – not everyone in a particular social or cultural group is the same. Consequently it is important that we take care not to make

generalisations and assumptions. Diversity and difference requires us to engage with others respectfully with an open mind: to take interest, to listen, to learn and reflect on and question our own values and beliefs – so that our actions are culturally appropriate.

Understanding and exploring differences in foundational values provides a basis for intercultural communication across cultural boundaries – at the communication 'meeting place'. Cultural interaction analysis (Milnes, 2007) provides a structure for understanding differences in values based on Hofestede's theory of *dimensions of cultural difference*. Although simple, Hofestede's (1980, 2005) theory provides deep insight into the perspectives of other cultures, but more importantly - our own. Hofestede divides cultural differences into five dimensions:

High power-distance *versus* Low power-distance attributes

Power distance refers to the way in which cultural groups deal with power inequalities in society. In a high power-distance society, there is a clear social status hierarchy and clear symbols of power and status. In low power-distance societies, equality is valued and people minimise symbols of power and status.

Collectivist *versus* Individualist attributes

Individualism and collectivism refer to the cohesiveness and independence exhibited by members in a cultural group. In an individualistic society, people are expected to look after themselves and their immediate family. It is considered healthy to pursue your own goals. Collectivist societies integrate people into strong protective and cohesive social groups, in return for loyalty.

Competitive (masculine) *versus* Caring (feminine) attributes

These attributes refer to gender role assignment within cultural groups. Cultures have differing expectations about what is appropriate for men and women's behaviour, dress, ways of relating, roles, professions, and so on. For example, masculine societies have traditional male/female roles of competitor and carer.

Strong Uncertainty Avoidance *versus* Weak Uncertainty Avoidance

Uncertainty avoidance refers to the way members of a culture feel when threatened with uncertainty or unknown situations. For example, many traditional cultures have stable belief systems, finding it difficult to understand how Western cultures can be comfortable with multiple approaches to belief, religion and ethics. On the other hand many people in Western cultures can become

very stressed in the face of uncertainty in relation to medical care and environmental disaster.

Short-term Economic "time" *versus* Long-term Social "time"

Time orientation refers to the way people view time. For example, Western cultures tend to view time in economic terms – time can be lost, spent, gained and used for the future. A social perspective on time sees social obligations and connections as more important.

Understanding these different dimensions in foundational values provides a basis for communication across cultural boundaries, including teaching and learning.

Appendix 1 outlines these five dimensions of cultural difference related to teaching and learning.

These dimensions can be used to facilitate non-judgemental understanding and clarification of differences in values, fears, expectations, actions and attitudes in the clinical learning environment. Teachers can use the dimensions of cultural difference to:

- ✦ Reflect on their own perspectives and values
- ✦ Clarify students' perspectives on their own learning
- ✦ Identify teachers' and students' expectations of activities, behaviours in the clinical learning environment
- ✦ Provide a basis for discussion of the professional and organisational values of the clinical agency
- ✦ Provide a safe and non-judgemental environment within which to explore different values and clarify expectations
- ✦ Determine if a relationship can be deemed culturally safe.

Communication

> *They [the student] may agree with their buddy nurse [preceptor] that yes, they will do 'X,Y & Z", but whether or not they've understood what they have been asked to do is not clear. It may not be within their culture to disagree [question] someone [who is] more qualified than they are.*

The English language and culture

Language is the most important medium of human communication. Foundational English language skills are required before students can enter a nursing course and are also required for registration with State and National registration bodies. For example, the Queensland Nursing Council (2008) requires applicants who have qualified outside the United Kingdom, Ireland, New Zealand and the United States of America to demonstrate English language competence as follows:

1. Occupational English Test - minimum requirement is 'B' Pass in all components
2. IELTS - minimum of 6.5 in the reading and listening components and a minimum of 7 in writing and speaking.

Universities must ensure students meet these requirements, so all CALD students undertake English language testing before commencing their studies, to demonstrate a requisite competence in the English language.

While students may have demonstrated appropriate levels in their language skills in a test such as an IELTS test, they may still experience difficulties. Language is a direct reflection of a given culture and its belief system. Malcolm (1995, p. 19) argued that the English language is often incapable of capturing all the cultural imperatives, values and context of other languages. In some languages there may not be any words to substitute for English words, or conversely a student's first language may have words for which English is inadequate. Further, clinical placement offers unique language challenges for CALD students (Julian, Keane & Davidson, 1999), as the technical language of the health care in Australia may be unfamiliar (Shakaya & Horsfall, 2000) or different from their previous experiences.

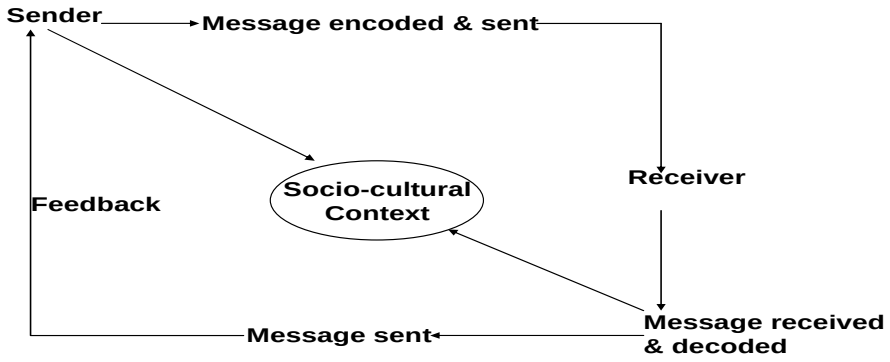
> *Medical terminology is a problem for them…*

Communication is complex and socially constructed, requiring language, culture, context and interaction to be considered.

Communication competency

Overall, communication competency is an essential requirement for the nursing profession, with language skills critical to competent nursing practice (Xu & Davidson, 2005). Nurses communicate verbally and in writing with clients, families, and other health professionals to assess clients; and negotiate, organise, provide, document, report on and evaluate care.

Communication involves a two-way pathway that unfolds as a purposive conversation that is bi-directional rather than uni-directional. Communication is the medium through which messages are sent and received between people. There are many ways a message can be sent. For instance, people communicate through speech, written materials, use of body language, by the way people wear their clothes, the possessions they own, and by their behaviour. Powell (2000) argued that communication may be considered effective when a message sender considers that the message recipient has understood what is being communicated. To do this, a sender encodes the message and sends it to the receiver, who then decodes the message in order to make sense of it. Both the sender and receiver encode and decode the message from the standpoint of their socio-cultural context. Thus, communication involves deep and complex thought processes and occurs within a socio-cultural context. The diagram below is an example of communication between people.



Henderson, 2005

When words hold different meanings for people from other cultural backgrounds miscommunications can easily result (Powell, 2000). The potential for miscommunication is relatively high when fundamental differences exist with respect to language and culture. For example, in some cultures it may be considered rude to ask a person a direct question.

> *… students … are reluctant to ask questions because they believe that it is telling the teacher they are not doing a good job…*

As well, the medium the sender has selected as appropriate to send the message may not be appropriate for the receiver. For example, a written medium may not be well received by someone who predominantly engages in oral culture, as is the case with Aboriginal people (Powell, 2000). It is also important for clinical teachers to note that while most CALD students will use English well at a conversational level, they may have difficulties with one or more aspects of communication that includes listening, reading, writing and speaking. Non-verbal cues and behaviours can also be misunderstood. Furthermore, many CALD students and most clinical facilitators are not bi-culturally competent, which can lead to a high risk of miss-communication.

> *Once a CALD student explained [to me] why it took so long to answer my questions. When asked a question in English [the student] had to translate to [their] own language, decide on an answer and then work it out in English. She got behind because of the time it took to do this and appeared to not understand.*

The clinical teaching and learning environment presents its own challenges. CALD students may have difficulty understanding or decoding what is being said to them or understanding meanings in the clinical teaching and learning environment. For example, social differences may mean that CALD nursing students may not be as accustomed as Australian nursing students to question-answer discourses with a teacher. Hence they may be reticent to ask direct questions of their clinical teacher. Instead, these students may wait to be asked a question by the clinical teacher, which may be interpreted by the clinical teacher as a disinterest in learning (Eades, 1992).

> *Passive learner role in some cultures… teachers have the answers.*

CALD students can become sheltered and frightened. They say they feel 'attacked' when we have eye contact with them, they perceive our direct explanations as aggressive.

Many CALD students come from cultural orientations that have different power distances from Australians, which influences how CALD students interact with clinical teachers and agency staff during clinical placement.

There can be different cultural expectations about what is polite and appropriate, and meanings attached to student performance, including reflection, review and critique of clinical performance.

They are wanting to please and they don't want to offend and that does mask how much they are learning with us.

They sometimes cover up what they don't understand in fear of failing the subject.

Clinical teachers need to be aware of the culture and language use of non English-speaking students, so that they can work to optimise CALD students' learning needs in the clinical environment.

Improving communication

Australians speak quickly and things may be unclear. This can cause fear and fluster for CALD students.

Clinical staff could be encouraged to give CALD students more time to answer their questions, like the bumper sticker on driving school cars [that] read, "Just give me 10 seconds". This will provide the CALD student with the time they need to form the answer.

Communication does not simply include language, because relationships and the context in which communication occurs affect meanings and messages. To improve communication it is important to:

- ✦ Build a trusting relationship
- ✦ Use cultural interaction analysis to clarify values and communication
- ✦ Use relevant and culturally apt examples in teaching sessions
- ✦ Use instructional strategies that allow students to learn using their own communication and cognitive styles and aptitudes

- ✦ Clearly articulate expectations at the outset of the teaching session. Expectations can be communicated both verbally and in writing.
- ✦ Provide relevant and timely constructive feedback
- ✦ Speak clearly, ask students to let you know when they have not understood a word or idea so that you can explain
- ✦ Give students 'permission' to ask questions and clarify expectations
- ✦ Give students more time to answer questions
- ✦ Clarify student and clinical facilitator roles.

Ideas for clinical facilitation

1. If you think the student is having trouble with verbal instructions, find other ways to provide them with information, eg. print material off for them to read, show them where to read things in agency documentation.
2. Provide students with actual examples of how to ask for things assertively. For example, role play how to say "Excuse me, if anyone has antibiotics to give, can I do them?"
3. Give each student a list of recognised abbreviations and acronyms before each placement.
4. Provide students with the encouragement and tools to engage in the Australian context, which has a lower power distance. Provide suggestions and opportunities to practice new skills. For example:
   - Asking their preceptor what they would like to be called. This is seen as respectful behaviour in Australia
   - Asking for assistance if they do not understand what a patient wants. The patient will then trust the student and trust is important in clinical relationships.
5. Identify differences in clinical languages.
6. Acknowledge that communication on clinical placement can be difficult.

   Some of them say 'I feel bad when you ask me this question'. I say 'I don't mean to make you feel bad, but I just want you to understand, because it's really very difficult'.

7. Make it easier for CALD students to ask about and discuss Australian and health care social practices, nursing culture, colloquial speech and customs.

8. Don't use abbreviations, slang or colloquialisms when speaking with students without explaining. These are unlikely to be understood without further explanation.

Student activities to explore differences in cultural values

1. Ask CALD students to share or explain something from their country or culture, or teach the group some words and meanings from their language.

   Get students to do a role reversal with each other.

   How about you go and be [Jane] and you come and be [Mary] 'and so what's it like?' When you hear people chatting away in another language too it serves to broaden students' experience of each other and they just learn something different about themselves then as well.

3. Discuss ways different cultures show respect. For example:

   - Ask students to explain how respect is shown in their country
   - Discuss how respect is shown in Australian society
   - Explore ways that these behaviours could be misunderstood.

3. Ask the group to identify and explain the thinking and values behind the way people behave in Australia. For example:

   - That eye contact is perceived as 'honest' in Australia and that honesty is valued in Australia
   - Discuss how this could be misunderstood in different cultures.

ORIENTATION

By identifying their knowledge base you can start them in a 'safe place' with their scope of practice. So when they go to the ward you are not starting out in a negative way. Any negative attitudes can be hard to break in the 2-3 weeks of their placement. It is a lot of hard work to start with. Taking steps to ascertain each individual's knowledge can prevent problems.

Orientation provides an important opportunity to create an inclusive climate, clarify expectations, and provide parameters for students while they are on clinical placement. In addition to outlining the goals of a placement, housekeeping and assessment processes, an orientation is important for clarifying communication issues.

Preparation and goal setting at the beginning of placement is essential for successful learning.

To develop a relationship and establish a climate in which clear and respectful communication can occur, there is a range of issues that should be addressed:

- ✦ Self assessment of learned knowledge and gaps: What is already known? What needs to be learned? What are my knowledge strengths and weaknesses?
- ✦ Goal setting for achievement on placement: Clinical assessment tool analysis and how to make plans to achieve goals. What are their expectations of facilitators and preceptors?
- ✦ Clarify expectations and differences in foundational values – students, clinical teacher, preceptor and agency staff
- ✦ Introduce reflection, critical thinking, problem-solving
- ✦ Build trust
- ✦ Clear communication with agency staff about students' objectives and expectations about students level of practice.

Ideas for clinical facilitation

1. Spend time with students to observe how they interact with patients and other staff.
2. Suggest that at handover they could let their preceptor know what areas of experience they are seeking, and tell other clinical staff as well.
3. Exposure to procedures/skills is important, so discuss how to arrange to watch or do less common procedures. Gather a list of the procedures that are happening in the ward / agency each day.
4. Work with preceptors to keep them informed of students' strengths, weaknesses and their plans to achieve goals.
5. Build trust:

- Give students 'permission' to ask questions: "I would like you to ask me questions". "Please do not take unanswered questions home." This is especially important for students who come from societies that have larger power distances.
    - Give reassurance: "It is not an embarrassment if you get it wrong. That's how we learn". "You are not alone… local students can have similar problems too".
    - Talk to the students first to see if they are having any problems. Do not make assumptions.
    - Encourage students to speak up and ask for opportunities or let you know if they need help accessing learning opportunities in the clinical environment: "Please let me know if you would like the opportunity to do or watch a clinical activity".

Student activities to clarify cultural differences in the clinical teaching/learning environment

1. Ask students to identify the things that are valued in this ward or agency. Use the *dimensions of cultural difference* to discuss the values they have identified. Revisit this list at different times throughout the placement and at the end of the placement. Ask students to reflect on any changes to their perceptions, and why these changes have occurred.
2. Have students assess strengths and gaps in their own knowledge (see Orientation Checklist in Appendix 2). Ask

students to make a list of things they would like to achieve during this placement.

3. Discuss expectations of: clinical facilitator, student and agency staff (Appendix 3).

   Discuss the differences in expectations between clinicians, teachers and learners. For example, students in Australia and this University are responsible for their own learning, so they must ask questions if something is unclear. Reassure students that asking questions is valued and not seen as a challenge or an insult to the clinical facilitator / preceptor.

4. Identify and discuss the thinking and values that provide a basis for the way staff in this agency behave:

   - What is considered important?
   - What routines are there in this ward/agency, and what is their purpose?
   - What are the characteristics of someone who is considered a 'good' nurse on this ward / in this agency? Why?

5. Below are some statements that represent expectations of students undertaking clinical placement.

   There is an expectation that the student will let you know [have initiative] if they don't know something. Ward staff and patients also expect this.

   [The students] need the ability to identify what they need to know and be proactive themselves.

   Ask students to identify what would make it difficult for them [ie. barriers] to meet these expectations and how they would overcome them. [Use cultural dimensions to assist analysis and discussion with students].

PROVIDING LEARNING OPPORTUNITIES: ENCOURAGING REFLECTION, CRITICAL THINKING AND PROBLEM-SOLVING

> *Ask deep probing questions and rationales [as to] why they are doing what they are doing ……to clarify.*

Clinical learning environments span basic health promotion through to managing complex clinical conditions. It is crucial that nurses think critically in order to use the appropriate knowledge and skilled judgments in delivering patient care (Ford & Profetto-McGrath, 1994; Khosravani, Manoochehri, & Memarian, 2005; Krammer, 1993; Miller & Malcolm, 1990).

Providing a learning environment that encourages critical thinking will enhance CALD students' learning

Clinical teachers facilitate the use of critical thinking, decision making and problem-solving by nursing students by using questioning as a technique to develop those skills (Sellappah, Hussey, Blackmore & McMurray, 1998). These researchers identified that the types of questions asked were important, starting with 'low level' questions about 'what' they would do, to high level questions about 'how' and 'why'. This logical format allows a chain of reasoning to build students' knowledge.

Many CALD students are from cultural orientations that have large power distances. This may pose a challenge, because students from large power distance orientations tend to take a more passive role in learning (Milnes, 2007). Thus, the challenge is to create a comfortable learning environment that supports and encourages critical thinking, and to overcome power distance issues. Alternatively, students may come from a culture that takes a bargaining, oppositional stance in social interactions. These students may need assistance to frame questions, requests and social interactions in ways that will be more successful in a clinical environment and organisation.

It is fair to say that both Australian and CALD students may have difficulty with the notion of critique, seeing it as criticism. The issue of critical thinking is difficult in societies where it is considered rude or impolite to point out where others are wrong, and highly embarrassing to have your own mistakes identified in front of others. While those from an individualistic society will be more comfortable

with critique, those from collectivist societies may find critical approaches particularly difficult. Difficulty in learning to think critically can be compounded when a student's culture deems it disrespectful to question a respected teacher or senior colleague. Further, some students' previous experience of education may not have included the type of critique and analysis that is expected of students in Australia. For these students, it may be the first time they have been expected to provide critique, debate, ask and answer questions, challenge other people's ideas, or have their own ideas challenged. To have this occur in a group is difficult, requiring students to change and learn new skills.

To create a stimulating learning environment the following should be addressed:

- ✦ Encourage reflection, critical thinking and problem-solving
- ✦ Encourage information-seeking
- ✦ Provide learning opportunities
- ✦ Use the power of positive feedback: students perform better when they know they are doing well.

Ideas for clinical facilitation

1. Ask CALD students to reflect on their experiences in debriefing sessions – in the same way as other students:
   - "Everyone has to say something"
   - If they cannot reflect on anything for the first session, reassure them that "it is ok today, but you may have to say something tomorrow"
   - Cast issues in a positive way "how could this be improved?"
2. Provide strategies for information seeking:
   - "Ask other people"
   - "Search for the information on the internet"
   - "Look in texts, the library or journals"
   - "Look for agency documentation, policies, manuals, texts"
   - "Have a small note book to record the questions you need answered".
3. If you are not sure of a students' level of understanding, 'dig deeper' by asking questions.

4. Look for learning opportunities such as exposure to procedures, a chance to practise skills.

5. Present students with a scenario, and don't accept 'yes' and 'no' answers.

   I try to get them thinking so they will look for more information. "What does this mean for your patient, what will you see? Who will you ask, where will you go?" Don't ask questions like "Did you understand that?" You need to ask questions that require more of an answer.

Student activities to encourage critical thinking

1. Getting the most out of handover

   This exercise will help students' ability to assimilate handover information. While applicable for all students, this exercise will be particularly useful for CALD students. You may need to speak slower and give student extra time to respond before you move on to the next exercise.

   a. Use the following proforma to guide students' assimilation of information, problem-solving and planning. You may have to take the students through the proforma a couple of times with examples. Students can join agency staff for handover and take notes on an allocated patient. After handover, have the students access the patient's notes and answer the following questions:

      i) Why, when and how did the patient come to the hospital?

      ii) What is the diagnosis and how was this confirmed?

      iii) Are there any abnormal tests? If yes, what do they mean?

      iv) What is the patient's prognosis?

      v) What nursing assessments have been done? What do they show?

      vi) What treatment/tests/nursing care has been given since admission?

      vii) What treatment/tests/nursing care may the patient now need?

      viii) What is likely to be happening today?

ix) What needs to be planned for today?

b. Ask students to write a summary of the information about their patient (like a handover).

c. Ask students to give a ‘handover’ of their patient to the student group during debriefing.

d. Ask the rest of the group to take notes, as though receiving handover.

e. Get the students taking notes to compare their notes with those of the student presenting, and to clarify anything they have not understood.

f. Discuss what has been learned in this process.

Repeating this process throughout the placement will provide opportunity for development, positive feedback, and enable students to identify the ways in which they are progressing.

2. Self-evaluation:

Ask students to identify goals and plans to achieve goals at the beginning of the semester using Appendix 2, or a similar proforma. Work with students to identify strategies and plans to achieve their goals. Encourage self-evaluation periodically to monitor and review progress against their plan and make modifications.

Provide feedback for students: include discussions of the concept of critique, processes for review and grading students, and explain clinical practice competencies. Making sure students understand these concepts and processes will helps to clarifying expectations about clinical performance, behaviours, actions and attitudes.

> *… then the student stands back and doesn't initiate, then they look like they are lazy. They're not, they're non-communicative...*
>
> *So I think -we have to be careful as facilitators that we don't automatically think the problem is the language there's maybe something else cooking for that student..... when we are under stress[that] affects their ability to communicate.*

The quality of a program preparing nurses is dependent on supporting students' ability to successfully apply nursing knowledge in a clinical setting. Students must demonstrate clinical competence and a high level of communication skill in a clinical setting in order to be successful in a nursing program. It is easier to undertake a student's performance review if clear goals have been set and communicated with the student from the beginning of placement (see orientation section above).

Understanding clinical competency

According to Benner (1994), there are five levels of competence ranging from Novice (Beginner), Advanced Beginner, Competent, Proficient, to Expert. Each of these has a minimum acceptable level or standard. Beginners are obviously not experts, but they can be competent at their level (note: Here, competent does not mean the "competent level" in Benner's categories). A beginner may be slow, but will develop further skills and improve their speed of action in time. They may ask many questions, but they are safe to practice because they know what questions to ask and seek help when needed. One purpose of clinical education for undergraduate nursing students is to help them learn the skills they need in order to be life-long learners. Life-long learners are able to continue to develop clinical competencies to keep up with changes and advances in clinical nursing.

To ensure student review is constructive, the following should be addressed:

- ✦ Provide positive feedback.
- ✦ Identify problems and deal with a need to improve.
- ✦ Use dimensional analysis (such as power distance, collectivist and individualist attributes) when dealing with students from CALD backgrounds and differences.

✦ Clarify expectations:

- What competencies are required to successfully meet the requirements of a clinical assessment; how to realise them
- Your (facilitator) expectations of the students
- Students' expectations for this placement
- Analyse these expectations and identify gaps
- Work with the students on how to close the gaps.

Ideas for clinical facilitation

1. Use case examples that demonstrate how to apply knowledge in practice.
2. Encourage students to ask questions.
3. Encourage students to observe their preceptors' practice.
4. Provide positive feedback on successful performance during placement.
5. Suggest that students keep a reflective journal: this will help them to reflect on their own as well as other people's practice
6. Use debriefing sessions in groups.
7. Use debriefing sessions with individuals.
8. During the clinical experience (School of Nursing and Midwifery, Griffith University, 2008):
   - Undertake an interim assessment of the student's performance
   - Ask the student to complete the clinical assessment tool and assess themselves
   - Identify and justify areas in which you feel the student needs further practice and development
   - This helps the student have some idea of your perspective of their strengths and areas for improvement and may give them a chance to improve their performance
   - Each indicator is to have comments and examples documented, to justify the mark given, these include incidents and activities that the student may have undertaken.

Reflective activities

1. Scenario One

Laura is an international student from a South-East Asian country studying a Bachelor of Nursing program and this is her second year. She came to Australia to study nursing and is on a student visa. She has just commenced her first clinical placement in a local public hospital three days ago. Her first year clinical placement was in a nursing home, which was a totally different environment from this placement. This hospital is a considerably larger hospital and it is very busy. The students are in groups of 5-6, with each group managed by one clinical facilitator who is employed by the hospital. Each student has a designated preceptor in their allocated wards. The clinical facilitator moves between wards to support the students and also receives feedback from the ward preceptors. Laura's university Course Convener received a call from the clinical facilitator this morning regarding her performance. She said that Laura's preceptor is complaining that Laura has showed no initiative. Although the facilitator has reminded Laura twice already, she has not made any changes to the way she is working. The clinical facilitator has requested a meeting with the university Course Convener, the preceptor and Laura. The facilitator requested help to deal with the issue just in case there were culturally sensitive issues.

The following is the dialogue in the meeting:

Course Convenor: *Could you tell me your experiences in the first four days of your clinical placement?*

Laura: *It's been OK. I have seen heaps of stuff… done a lot of procedures too. The preceptor has been very nice to me.*

Course Convenor: *Thank you. Laura, we organized this meeting because there were some 'initiative' issues with you. Do you think there is a problem?*

Laura: *This is where I am very confused. I was told (by the clinical facilitator) that I need to show more initiative. What more do I need to do? ... I mean, I have always done what I was told and completed those tasks well…*

Clinical facilitator: *That's the problem. You shouldn't just wait for your preceptor to tell you what to do. You should work to develop a plan and care for your patients according to your plan. Your preceptor will supervise you, but you can't expect her to tell you what to do all the time…*

Laura: *I do have a plan. Have a look at this… (shows a hand-written plan she carried in her pocket. The plan seemed very logical and reasonable). But I didn't want to intrude while the preceptor was working. I am just a student. I don't want to be annoying.*

Questions

1. Power distance analysis: using the information provided in Appendix 1, analyse why Laura and the clinical facilitators/preceptors may have different understandings about 'taking initiative'. Think about who drives the learning process in a high power distance culture and vice versa.
2. Think about cultural safety: read the "understanding cultural safety" section of this booklet. If you were in this situation, how would make sure your communication with this student is culturally safe (think about the "meeting place" in cultural interaction).

A plan of action

An agreement was reached between Laura, the ward preceptor, the clinical facilitator and the Course Convener as follows: At the beginning of the shift Laura will draft a care plan for each of the patients she cares for under the supervision of her preceptor. The preceptor will go through the plan with her and let her know what things she can do without her supervision, and what things will need to be supervised. They will have another quick similar session half way into the shift to review progress and make plans for the rest of the shift.

Outcome

The plan is carried out. The Course Convener rang the clinical facilitator four days later. Laura was doing great. Although she was still very cautious with everything she did - checking and getting permission for little things - she was able to manage

independently. She had made significant progress since the initial meeting.

2. Scenario Two

John, an international student, is experiencing difficulties. The ward staff, preceptor and the clinical teacher are concerned about an aspect of his practice. When discussing the issue with John, he is reluctant to admit that he has a problem, or that he has made errors. The clinical teacher is worried that John does not understand the things that he needs to improve.

Questions

1. What cultural dimensions could make it difficult for John to admit that he has made mistakes? (Hint: think about collectivism and individualism).
2. How might a clinical teacher work with John to address the problem?

A plan of action

Ask John to list ideas about how he might address a problem - and try them.

The ward staff does worry about the CALD students and medication safety.

…we have to play mediator between the staff, the patients and the student.

Interactions occurring on clinical placement between international students, the clinical facilitator and agency staff may result in conflict and culturally unsafe practices. Clinical placement brings together the aims, needs, issues and cultures of the ward, the profession, the patient, the student and the clinical teacher. Agency issues can include increased workloads due to the presence of students, poor skill mix within the agency, and the sense of having to manage students without support. Student issues can include language difficulties, misunderstandings of cultural behaviours and personal student issues. Clinical issues can involve concern about client safety and care. Educational issues can include a need to assess a student's knowledge and clinical competence. These problems and issues can be magnified and escalate into conflict if there is racism or misunderstandings about the values systems of the patients, ward staff or student, and the culture of the workplace itself. At times, important needs can conflict with each other. Normal student stresses can be exacerbated by social and cultural isolation. Difficulties experienced by ward staff can be magnified if there are differences between workplace culture and educational perspectives, merged with the perceived burden of managing an international student.

Understanding conflict

Interpersonal conflicts will emerge whenever an action by one person prevents, obstructs, or interferes with the actions of another person. For example, a preceptor may have unrealistic expectations regarding the desired behaviours of second year nursing student on their first clinical placement. Further, two equally important issues may conflict with each other. For example, the clinical needs of the patient and the learning needs of the student.

Conflict itself is neither good nor bad. Rather, it is the manner in which conflict is managed that determines whether a conflict situation is constructive or destructive.

Processes for problem-solving and defusing potential conflict

It is difficult to deal with ward nursing staff complaints about a student you are supervising, particularly when complaints are being made in front of the student. These processes are provided as a guide to dealing with a problem, addressing ward nursing staffs' needs, student needs and ensuring that outcomes are appropriate and safe.

1) Request to meet the ward nurse privately after you have had a quick word to organise the student.

   Rationale: Removing discussion to another place and time will:

   - Reduce the 'spectator' effect that can happen in a ward environment
   - Give the ward nurse time for reflection, rather than immediately reacting
   - Provide time to reassure the student about the process.

2) Briefly, speak privately to the student. Explain that the ward nurse has some concerns and that as a team (ward nurse, student and clinical facilitator) you will work together to find a suitable outcome. Explain the process you will take in dealing with the issue.

3) Meet with the ward nurse to get an overview of the problem. Questions to ask include:

   - What is the main concern?
   - Are there any patient safety concerns?
   - What suggestions do you have to improve the situation?

   Ask the ward nurse to describe specific incidents they have experienced. It is important that the ward nurse discusses only her own concerns and not those of other staff – as this is hearsay. Involving the ward nurse in discussion of possible solutions ensures ownership of addressing issues, which is essential for a collegial work environment. It also provides a way of generating solutions.

4) Meet with the student. Obtain the student's perspective on the problem. Some questions to ask are:

   - What do you believe is the main concern?
   - How are you feeling about this?

- Do you have any suggestions on how we can improve the situation?

Identify and clarify any underlying dimensions of cultural difference that may be contributing to the problem.

5) Let the student know that you will be organising a meeting with the ward nurse together to work out a solution.

Rationale: This allows the student to explain their perspective on the problem, stimulates reflection, and provides an opportunity to voice other concerns. Discussing possible solutions empowers the student and provides a sense of teamwork.

6) During the meeting between the student, ward nurse and clinical facilitator, the following process will contribute to problem-solving:

- Define the conflict as a mutual problem to be solved not as a lose/win situation.
- Each should describe their perspective on the situation and actions that have caused the conflict (without labelling or insulting each other).
- Each should have an opportunity to describe their feelings and how it has affected them.
- Each should have an opportunity to describe the actions that helped create and continue the conflict.
- Define the conflict in the most specific way possible.
- Identify and clarify any underlying dimensions of cultural difference that may be contributing to the problem.
- Each person should have an opportunity to present ideas and solutions.

Reflective activities

1. Scenario

A third year international nursing student has been working on a busy orthopaedic ward during the last three days. As the clinical facilitator you have been called to the ward by one of the ward nurses. On arrival you see a very solemn student standing in the nurses' station as she confronts you with these comments. "All she does is stand there; I have to tell her to do everything." "She does not understand anything

I am saying to her." "She is a danger to the patients and I don't know what to do with her." "We are a really busy ward and I need you to spend more time with her."

Verbal indicators:

All she does is stand there; I have to tell her to do everything.

A common reaction when we are frustrated with an issue is to generalize behaviours, implying that "all" and "everything" is a problem.

She does not understanding anything I am saying to her.

As this comment was spoken in full earshot of the student, it is likely that the student understands what the ward nurse has said to you, but doesn't know how to behave.

She is a danger to the patients and I don't know what to do with her.

The ward nurse is feeling concerned that care delivered to the patient will be compromised. Her conflict may not only be with the student, but also with her own work ethics.

We are a really busy ward and I need you to spend more time with her.

The ward nurse is indicating that she is under pressure and is trying to find solutions to the problem.

Questions

What are the needs and values of the student?

What are the needs and values of the ward nurse?

What differences in cultural attributes may have contributed to this situation?

What actions may overcome them?

2. Reflect on a time when have you been confronted by a cultural difference that resulted in conflict.

   What was your immediate response?

   On reflection, did you think you managed the situation in a culturally safe way?

   Was the conflict resolved and the outcome favourable?

   What are other possible ways that this situation could have been handled?

Resources and Readings

http://www.ruralhealth.utas.edu.au/indigenous-health/RevisedCulturalSafetyPaper-pha.pdf

A paper discussing the implications of Cultural Safety for work practices.

http://www.naho.ca/english/documents/Culturalsafetyfactsheet.pdf

A fact sheet on Cultural Safety from the National Aboriginal Health Organisation (NAHO).

http://culturalsafety.massey.ac.nz/thesis.htm

A link to Ramsden's PhD thesis: Ramsden, I.M. (2002). *Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu.* Unpublished PhD. Victoria University of Wellington.

http://www.csupomona.edu/~tassi/gestures.htm

An interesting collection of information about the meanings of gestures in Asia and the USA.

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Appendix 1: Dimensions of cultural difference in teaching and learning

Attributes	
High power-distance attributes	**Low power-distance attributes**
Inequalities among people are both expected and desired; prevailing religions and philosophical systems stress hierarchy and stratification Students/subordinates expect to be told what to do; are expected to do as they are told and not ask questions Teachers are expected to take the initiative The ideal teacher or manager is a benevolent autocrat Privilege and status symbols for teachers and managers are both expected and popular; powerful people try to look as impressive as possible Power is based on family or friends, charisma, and ability to use force The way to change a political system is by changing the people at the top (revolution)	Inequalities among people should be minimised; prevailing religions and philosophical systems stress equality Teachers treat students as equals; students/subordinates expect to be consulted Teachers expect initiative from students The ideal teacher or manager is a resourceful democrat Privilege and status symbols are frowned upon; powerful people try to look less powerful than they are Power is based on formal position, expertise and an ability to give rewards As system is changed by changing the rules (evolution)

Collectivist attributes	**Individualist attributes**
People are born into extended families or other in-groups that continue to protect them in exchange for loyalty Identity is based in the social network to which one belongs Students think in terms of 'we' Harmony should always be maintained and direct confrontations avoided People are expected to defer to the interests of the group and powerful others Private life/opinions are invaded by group/s Opinions are predetermined by group membership Harmony and consensus are ultimate goals	Everyone grows up to look after him/herself and his/her immediate (nuclear) family only Identity is based in the individual Students think in terms of 'I' Speaking one's mind is a characteristic of an honest person People are expected to act on their own behalf Everyone has a right to privacy Everyone is expected to have a private opinion Self-actualisation by every individual is an ultimate goal
Competitive (masculine) attributes	**Caring (feminine) attributes**
Dominant societal values are material success and progress Men are supposed to be assertive, ambitious, and tough Women are supposed to be tender and to take care of relationships Girls cry, boys don't; boys should fight back when attacked, girls shouldn't fight Teachers / managers are expected to be decisive and assertive Equity, competition among colleagues, and performance are stressed Conflicts are resolved by fighting them out	Dominant societal values are caring for others and preservation Everybody is supposed to be modest Both men and women are allowed to be tender and concerned with relationships Both boys and girls are allowed to cry, but neither should fight Teachers / managers use intuition and strive for consensus Equality, solidarity, and quality of work life are stressed Conflicts are resolved by compromise and negotiation

Strong Uncertainty Avoidance	**Weak Uncertainty Avoidance**
Rules Many and precise laws and rules Emotional need for rules, even if these will never work ***Technology*** Time is important as a commodity and precision and punctuality are valued Emotional need to be busy; inner urge to work hard Lots of time, expense and effort put in to creating controlled environments and people believe that the accumulation of material is important to guard against the unknown. ***Religion*** There is only one Truth and we have it What is different, is dangerous Suppression of deviant ideas and behaviour; resistance to innovation Nationalism, xenophobia, repression of minorities	***Rules*** Few and general laws and rules There should not be any more rules than is strictly necessary ***Technology*** Time is a general framework for orientation and precision and punctuality have to be learned The laissez faire approach to environment results in less emphasis on work Lots of time is spent in uncontrolled environments and people are content with less material. ***Religion*** One group's truth should not be imposed on others What is different, is curious Tolerance of deviant and innovative ideas and behaviour Regionalism, internationalism, attempts at integration of minorities
Short-term Economic "time"	**Long-term Social "time"**
Do one thing at a time Concentrate on the job Adhere religiously to plans Are concerned about not disturbing others; follow rules of privacy and consideration	Do many things at once Are highly distractible and subject to interruptions Change plans often and easily Are committed to people and human relationships

(Adapted from Hofstede, 1991; Hall, 1990; Hall & Reed-Hall, 1987)

Appendix 2: Orientation checklist

Setting Expectations with Students

At the beginning of clinical placement, set a context for communication that is inclusive. Use the Dimensions of Difference as a basis for discussing differences in expectations, based on an exploration of the issues below:

- ✦ Background, what placements have you done previously?
- ✦ Information about this ward / placement
  - Senior staff
  - Nursing duties
  - Overview of equipment / general experiences at this placement / types of patient care delivered (eg. wound dressings for vascular ulcers)
  - Learning opportunities
  - List of what is available / resources
- ✦ Students' strengths, gaps in knowledge
  - What things are you worried about?
  - What do you think you do well?
- ✦ What would you like to work on while you are here? Is there something you would like to practice while you are on this placement?
- ✦ Goals for this placement? What would you like to achieve while you are on this placement?
- ✦ What would help you reach your goals?
- ✦ Lines of communication, how to contact me
- ✦ Your expectations and my expectations about communication and learning while you are on clinical placement (Appendix 3)

Use Cultural Boundary Clarification to explore differences in values and expectations.

Discuss.

Appendix 3: Expectations about communication and learning while you are on clinical

MY EXPECTATIONS

You are here to learn.

(You are responsible for your own learning.)

You need to seek out learning opportunities.

(It is your responsibility to make the most of learning opportunities in this clinical environment. Learning opportunities include: practising skills, accessing helpful ward resources, practising with equipment, talking with patients and staff, observing procedures and participating in ward activities and so on.)

I am here to facilitate your learning.

(My job is to support opportunities for you to learn.)

If you don't know something - you need to ask me.

(I don't know when you don't know something. I am happy to answer your questions. We all have things we don't know.)

If you don't understand what I have told you, please ask me to tell you again, slow down or explain.

(I don't mind. That is what I am here for – to explain things.)

If you have a problem you need to let me know.

(I am not a mind reader. The sooner I know, the sooner we can work on finding a solution.)

If you do make a mistake you need to let me know.

(There are usually ways we can address things if we get onto it quickly. Putting things off does not solve problems.)

I will ask you and all the other students lots of questions about what you are doing.

(This is to help you think about what you already know, how it can be applied in clinical practice and to identify things you still need to learn.)

You should always make sure you are adequately prepared and have adequate supervision from either the nurse you are assigned to or from me

(Being adequately prepared means you have learned about this topic at university, have looked it up to make sure you understand, and you have practiced skills in the nursing laboratory.)

It is important that you show interest. Ask your preceptor questions and for a chance to do things.

(Ward and agency nurses love students who are interested, want to learn, and listen to what they know. For example, you should ask questions, initiate discussion on patient care. Don't wait for someone to talk to you or tell you what to do.)

What are your expectations for this placement?

_____

_____

_____

_____

_____

_____

_____

What do you think the Ward staffs' expectations of you are?

_____

_____

_____

_____

_____

_____

_____

_____

What do you think your course convenor's expectations are for you while you are on placement?

_____

_____

_____

_____

_____

_____

_____

Use *Cultural Boundary Clarification* to explore differences in values and expectations. Discuss ways that these differences could be addressed. Discuss the differences between expectation related to the workplace and educational purposes of the placement eg. requirements for success using the clinical assessment tool.