

Communicating Safety and Care in the Context of Linguistic and Cultural Diversity in Aged Care

An Intercultural Approach to Training

January 2017

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Research Centre for
Languages
and Cultures



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Executive summary

Increasing linguistic and cultural diversity among nurses and care workers, combined with growing complexity in health profiles (e.g. the challenging behaviours or unmet needs associated with dementia), are increasing the complexity of communicating safety and care. This complexity poses an increasing challenge among staff and those they care for, and is especially acute where communication takes place across languages and cultures.

The aim of this project was to develop professional learning resources and practical strategies to enhance the capacity of supervisory and direct care staff to manage this communication complexity. Of particular concern in contexts of linguistic and cultural diversity is communicating care and safety around challenging behaviours or unmet needs. Building on a previous study (Scarino, O’Keeffe, Crichton, O’Neill & Dollard, 2014), the project took an intercultural approach to the development and design of the resources.

The outcome of the project is a set of five professional learning modules that reflect principles of intercultural learning. The project team collaborated closely at all stages with management and staff at Helping Hand and South Cross Care and the project Advisory Group. The modules, which incorporate video clips and a guide for facilitators, were developed in four stages. The first stage comprised analysis of critical incident reports; focus groups comprising nursing, care and training staff; and video interviews with staff and residents. The second stage, designing the modules, drew on the data and findings of this project and the data and recommendations of the original study. The third stage involved trialling, evaluation and revision, and the fourth stage, finalisation and dissemination.

The modules cover five key, interrelated themes around accomplishing safety and care in the workplace in the context of increasing linguistic and cultural diversity:

1. The ways in which behaviours / needs are understood, with a clinical focus on conditions associated with challenging behaviours / unmet needs and their implications
2. The layer of complexity added to communication by linguistic, cultural and faith-based diversity
3. Attentiveness to language / how we communicate
4. The value placed on knowing the person, their personal history, life journey and memories
5. Risk management: tension between notions of ‘being at home’ and the accomplishment of care within the efficiency model.

Each module builds on the other, focusing on a particular aspect of practice while maintaining a common orientation relevant to workers at all levels of the organisation: carers, enrolled nurses, registered nurses, trainers and managers. The modules are designed for flexible delivery, on- or off-line, and incorporate a four-segment structure that can be adapted to the needs and interests of participants and the professional development time available.

Part One: Report

Introduction

The communication of care and safety in aged care has become complex because of a significant growth in linguistic and cultural diversity, due to both an ageing migrant population and the presence of migrant nurses and care workers in this sector. Caring for the elderly in this context is known to be physically and psychologically demanding. Compounding this complexity is that aged care workers must manage residents with complex health profiles, including dementia. Dementia is associated with challenging behaviours or unmet needs that can complicate communication, care and safety. Staff need professional development in order to be able to understand and manage these behaviours in contexts of linguistic and cultural diversity, specifically, how to communicate and enact care and safety. Professional development must address the fact that all workers frequently experience perceptions of a language barrier and culture clashes, and that migrant workers experience a lack of understanding about what it means to adapt to new ways of communicating care and safety.

This project has taken as the basis for development, the findings and recommendations of a previous study undertaken by members of the research team in conjunction with colleagues from the Asia Pacific Centre for Work Health and Safety. That study explored the communication of safety in aged care in contexts of linguistic and cultural diversity (Scarino, O'Keefe, Crichton, O'Neill & Dollard, 2014). It revealed how staff and residents are situated linguistically and culturally and that communication of care and safety necessarily involves an intercultural process of moving between different knowledge, understandings, perceptions, expectations and values in communicating safety and care. This process requires a reconsideration of the term CALD (culturally and linguistically diverse), which has become a convenient tag but needs to be understood not as a trait restricted to particular minority groups, but as a characteristic of all people. It requires the recognition that all people are situated linguistically and culturally in the language and culture of their primary socialisation; that they will see the world through their particular cultural lenses. In the communication of safety and care, the knowledge, understandings, experiences, perceptions and values that individuals bring to communication become the framework through which they understand what is going on. The process is all the more complex when communication takes place *across languages and cultures*. This fundamental understanding provided the foundation for the present project.

The present project focused on: (a) supervisory staff training and (b) direct care staff training. It was developed collaboratively and implemented with staff in two industry sites. The professional learning was designed to equip them with practical strategies to communicate care and safety more effectively, particularly when faced with challenging behaviours or unmet needs. The intercultural orientation adopted foregrounds on-the-job action, critical thinking and reflective practice. This means stepping outside of routine ways of interpreting what is going on in care and safety interactions, considering the diverse perspectives in play, mediating understandings and reflexively changing practices.

Background research

Increasingly, people from migrant backgrounds are being employed to meet the demand for aged care workers in Australia (Productivity Commission, 2011; Fine & Mitchell, 2007; Hugo, 2007, 2009; King et al., 2012) and many aged care recipients are themselves from migrant backgrounds. This interplay of diverse languages and cultures in both staff and clients creates complexity, which can lead to perceptions of a language barrier and culture clash (Nichols, Horner, & Fyfe, 2015; Tayab & Narushima, 2014), loss of trust (Beheri, 2009; Candlin & Crichton, 2013) and experiences of marginalisation and discrimination for workers (Acker, Pletz, Katz, & Hagopian, 2014; Nichols et al., 2015; Tayab & Narushima, 2014; Tuttas, 2014). The consequences for communication of care and safety are poorly understood (Diallo, 2004; Federation of Ethnic Communities' Councils of Australia, 2015; Fine & Mitchell, 2007; Hugo, 2009; Martin & King, 2008), but the impact is known to be

compounded when residents have dementia and associated aggressive or challenging behaviours (Federation of Ethnic Communities' Councils of Australia, 2015; Jones, Moyle, & Stockwell-Smith, 2013; King et al., 2012). In one of the participating sites for the proposed project, 65% of incidents in the last 12 months involved residents who had what is sometimes called 'resistive behaviours'. Despite the acknowledged importance of work, health and safety in aged care, and the provision of mandatory training for workers in a physically and psychologically demanding workplace (Department of Health and Aged Care, 2000; Yeung & Chan, 2012), little is known of the extent of work-related injuries in this context of increasing diversity and the effectiveness of current training (King et al., 2012).

Nurses and carers from migrant backgrounds are often learning to adapt to new ways of communicating and caring on the job, and further research is needed to understand what professional learning they need to equip them to work in this demanding environment (Bosher & Smalkoski, 2002; Gandhi & French, 2004; He, 2012; O'Neill, 2011; Olson, 2012). In developing ways to support such people more effectively, there are challenges that extend beyond simply learning another language or learning about one another's cultural differences (Deegan & Simkin, 2010; Dreachslin, Hunt, & Sprainer, 2000; He, 2012; Johnstone & Kanitsaki, 2007; Lum, Dowedoff, Bradley, Kerekes, & Valeo, 2014; O'Neill, 2011; Pearson et al., 2007; Scarino, O'Keefe, Crichton, O'Neill, & Dollard, 2014). An emphasis on migrant workers' need to adapt to mainstream practices may overlook that local staff also have a part to play. This can have a negative impact on how teams work together in their diversity, despite policies that support cohesiveness (Acker et al., 2014; Davis & Smith, 2013; Nichols et al., 2015; Tayab & Narushima, 2014), and it is argued that team leaders and management could more effectively model attitudes and behaviours that promote communication and teamwork in diversity (Colón-Emeric et al., 2006; Tyler & Parker, 2011; Williamson, 2007).

The original study (Scarino et al., 2014) explored the complexity of communicating care and safety in the context of linguistic and cultural diversity in aged care from multiple perspectives and in many sites of communication. It included a training intervention that supported management, nurses and carers in creating greater awareness of the relational, interactional and *intercultural* aspects of communication. The findings highlighted the challenges for management, nurses, carers and clients in making sense of (a) the interplay of diverse languages and cultures, and (b) how perceptions of one another and assumptions about roles and responsibilities greatly influence communication and the accomplishment of care and safety.

Following the recommendations of the original study, the current project brought the innovation of an intercultural approach to professional learning for supervisory and direct care staff. The professional learning resources and practical strategies were developed collaboratively with management and staff in two industry sites to enable them to communicate care and safety more effectively, particularly about behaviours in residents with dementia. The intercultural approach has foregrounded processes of critical thinking and reflective practice. The result is a set of practical strategies to equip staff for noticing normative practices; stepping outside of routine ways of interpreting what is going on in an interaction; considering the multiple perspectives in play; mediating understandings; and reflexively changing practices (Arakelian, 2009; Byram, 2009; Garneau & Pepin, 2014; Liddicoat & Scarino, 2013; Scarino et al., 2014; Schön, 1983).

Methodology

The research took a qualitative approach (Cresswell, 2007) to data gathering and analysis in two residential aged care sites, as identified by Helping Hand and Southern Cross Care. It involved the following four stages.

Stage 1: Analysis of safety in relation to challenging behaviour and unmet needs in the context of linguistic and cultural diversity

Part One: Report

This stage involved undertaking an analysis of incident reports and conducting a range of focus group discussions that would provide a foundation for the design and content of the professional development resources. There were five steps:

1. Collation and analysis of incident reports relating to challenging behaviours or unmet needs in the context of linguistic and cultural diversity, and evaluation of the nature and scope of the information provided. The findings of this analysis informed focus group discussions in steps 2 and 3
2. Conducting focus group discussions to examine experiences of managing safety in relation to challenging behaviours or unmet needs, especially in the contexts involving linguistically and culturally diverse staff and residents. There were three focus groups:
 - care workers
 - enrolled nurses (ENs)
 - supervisors and registered nurses (RNs)
3. Conducting a focus group discussion with training staff to identify needs for professional learning practices
4. Analysis of focus group data in 2 and 3 to identify content and design specifications for the modules
5. Review of the content and design specifications with the Advisory Group.

Stage 2: Development of professional learning modules

Originally, it was intended that one module would be developed for supervisors and another for care workers; however, as a result of the analyses undertaken and discussions with the Advisory Group and with staff responsible for training, it was decided to develop a single resource that could be used by both groups. This shift in thinking was significant, as the analyses highlighted the need for supervisors and those responsible for direct care to work together in communicating safety and care. There were four steps:

1. The development of five online modules, drawing upon:
 - the rich data and recommendations of the original study (Scarino et al. 2014)
 - the data and findings of the analysis in Stage 1 of the present project.
2. Discussion of the modules by the Advisory Group and staff responsible for training
3. Recording and developing digital resources (film clips) illustrating supervisors' and care workers' perspectives and strategies on managing safety in relation to challenging behaviours in diversity
4. Review of the modules and digital resources with the Advisory Group and staff responsible for training.

Stage 3: Implementation and evaluation

This stage involved the trialling, evaluation and revision of the professional learning modules. There were three steps:

1. Trialling the modules at the two sites, with supervisors and carers (see Stage 4 for further details of the trialling process)
2. Analysis of evaluative data, including the experiences of all participants
3. Review of project evaluation with the Advisory Group.

Stage 4: Finalisation and dissemination

This stage involved the finalisation of the professional learning modules based on the trialling process, and planning the dissemination. There were five components:

1. Revision and finalisation of modules and digital resources
2. Preparation of a brief report on the project
3. Website expansion to include all project materials
4. Planning of a workshop open to state-wide attendance from the sector
5. Review of project outcomes with the Advisory Group.

Throughout the process of development, several issues arose that became themes for ongoing discussion among the research team and in dialogue with the Advisory Group:

- The naming of the behaviours
- The use of the label 'CALD'
- The nature of the professional learning resource

The naming of the behaviours

The project began with an interest in dementia and the use of the term 'resistive behaviours'. After much discussion it was agreed that the term to be used would be 'challenging behaviours or unmet needs'.

The use of the label 'CALD'

As indicated above, although recognised as a convenient term to use when referring to minority migrant groups, the term was abandoned in recognition that all people are linguistically and culturally situated, not only those who have recently arrived from various countries of the world. The problem with the label arises from an appreciation that all people are situated within the linguistic and cultural world of their primary socialisation and therefore see their own experiences, knowledge, know-how, understandings, and values through the lenses of the language and culture into which they were first socialised. When interacting in diversity, different ways of understanding the world come together and can be a source of understanding or misunderstanding, of appreciation or not – of the diverse knowledge, know-how, experiences and values that people contribute.

The nature of the professional learning resource

Much discussion centred on the best approach to take to the development of the professional learning resource, noting as required by the project that workers are (a) diverse, (b) time poor and (c) will necessarily engage differently with professional learning. Further, in environments that are highly regulated, especially with respect to safety, there is always a tension between learning (in order) to ensure compliance and learning (in order) to expand workers' repertoires of practice.

The development of the professional learning modules

The original intention was to develop two online professional learning modules, one for supervisors and one for care workers. It was also understood that the development would draw upon the recommendations of the original study (Scarino et al. 2014) and the Stage 1 data and analysis (i.e. the incident reports and focus group discussions with carers, ENs, RNs and training staff).

Analysis of incident report documentation

A total of 54 incident reports from both sites were analysed, with a focus on the following questions:

What do we learn about residents' 'behaviours' or 'needs' from this documentation? The kinds of resident behaviours documented included verbal abuse, throwing objects, and hitting, punching, grabbing, squeezing, kicking, scratching and biting staff. The analysis of the documentation highlighted staff understandings of these behaviours as associated primarily with a resident's impaired cognitive state, a 'diagnosis' of dementia or 'aggressive' disposition, rather than being triggered by unmet needs (e.g. needing pain relief or trying to go to the

toilet). Other documented explanations included residents' responses to staff gender, insufficient staff, new or inexperienced staff or an 'unknown trigger'. The majority of incidents occurred while providing care. In five cases the documentation indicated that an incident resulted from the resident's refusal of care from a staff member. This raised the question of how staff communicated their intentions to residents when initiating or providing care.

What is the role of languages, cultures and communication in safety and care?

The analysis highlighted that linguistic and cultural factors could contribute to incidents, including as a result of residents' language or loss of language and staff communication with residents. However, the linguistic and cultural profiles of staff and residents are not clear from the documentation and the exact nature of these 'barriers' to communication are not documented. The analysis also highlighted that non-verbal staff actions (e.g. placing hands on residents to encourage them to do something) could contribute to incidents. The analysis shows that staff and residents may have different understandings of what is going on in an interaction involving care, and it is not clear from the documentation whether this was followed up and explored.

How does documentation contribute to educating staff?

The analysis revealed that supervisors used the process of documenting incidents as an opportunity to direct care workers to dementia training resources and resident care plans, and in their supervision of new, inexperienced staff. However, it was also clear that staff had often used these resources before, and yet there had been no change in practices.

Analysis of focus group discussion data

The following five themes emerged from the analysis of the focus group discussion data:

1. How behaviours / needs are understood informs how people act in the workplace; there is a clinical focus on conditions associated with challenging behaviours / unmet needs and implications for safety and care.
2. The ways in which linguistic, cultural and faith-based diversity add another layer of complexity to accomplishing safety and care needs to be explored and understood.
3. Attentiveness to language / how we communicate is important in accomplishing safety and care.
4. The value of knowing the person and their personal histories, life journeys and memories in accomplishing safety and care.
5. When managing risk within the efficiency model, there is a tension between notions of 'being at home' and the accomplishment of care.

Five professional learning modules were developed around these major themes.

The modules bring together a clinical and a narrative focus, and are designed for both a supervisor (EN and RN) and direct care worker target audience. This results from a key finding in the analysis and discussion with the industry partners that 'working together' needs to be emphasised in communicating and accomplishing safety and care in relation to challenging behaviours or unmet needs in contexts of linguistic, cultural and faith-based diversity. This means that in each of the five modules, supervisors and care workers are presented with content relevant to developing shared understandings and opportunities to share their perspectives and strategies for ways of working together.

All contributors to the project, and especially the trainers, highlighted that workers benefit most from short scenario-based interactive resources that help participants to step outside their common understandings. They wanted a set of resources that did not just involve 'talking to staff' but that would stimulate conversations around managing challenging behaviours or unmet needs, invoke reflection and ultimately, lead to changes in practice.

An expert was engaged to film diverse workers from Helping Hand and Southern Cross Care talking about their practices. Several segments were filmed and subsequently edited and integrated into the professional learning modules.

The research team drafted the five modules, with substantive feedback from the staff of the two organisations and members of the industry partners represented on the project's Advisory Group. Each module explores one of the themes that emerged from the research. Each module includes four segments that present different facets of the focal theme. The resource is designed to be used flexibly with a focus on any one segment or combination of segments from the modules as appropriate to the desired professional learning. Each module takes the participants (as individuals or groups) through some key questions and concepts related to the theme, towards practical strategies for accomplishing safety and care. The module tasks incorporate quotations from interviews with staff and video clips in which staff relate their experiences and reflections on caring for people with challenging behaviours or unmet needs in contexts of linguistic, cultural and faith-based diversity. A total of 19 video clips have been produced. These video clips have been catalogued and loaded on USB sticks for the industry partners to maximise ease of use. The videos are also available on the RCLC website/Funded Research Projects: <http://www.unisa.edu.au/Research/Research-Centre-for-Languages-and-Cultures/Research-Consultancy-Projects/>

An intercultural orientation

The five modules incorporate *an intercultural orientation*, which we describe through four interrelated principles of learning. Each of these principles is described in **Table 1**, along with implications for the design of the modules.

The learning process itself, as embedded in all five modules, can be seen as *intercultural*. It recognises the *relational* nature of communicating and 'doing' safety and care in contexts of linguistic, cultural and faith-based diversity.

Table 1. The four inter-related principles of learning and their implications for the design of the modules.

Principle	Implications
<p>1. Learning as situated and personalised</p> <p>This principle recognises that all people are situated or 'at home' in their own language, culture and history of experiences. Their framework of knowledge, understandings and values originates in their situatedness. They use this framework to interpret and act upon what it is that is going on.</p>	<ul style="list-style-type: none"> • The professional learning begins with the recognition of each participant and his/her framework of knowledge, understandings and values. • All participants are encouraged to recognise themselves as participants in diversity and are invited to share their distinctive experiences. • The diversity of knowledge, understandings and values that participants bring needs to be elicited, shared and valued as diverse ways of 'doing'. • The professional learning activities need to be meaningful, authentic and relevant the participants themselves and add value to their practices.

Principle	Implications
<p>2. Learning as interactive and experiential</p> <p>Learning involves interaction focused on the exchange not only of information but of meanings and understandings. This exchange is mediated both <i>within</i> and <i>across</i> languages and cultures and therefore requires an attentiveness to languages and cultures in the exchange of meanings. Language is fundamental to all learning.</p>	<ul style="list-style-type: none"> • The professional learning includes activities that incorporate personal experience and existing knowledge. • The participants are positioned not as passive receivers of information but as active participants in a network of fellow workers. • The activities are not just about receiving information, but about learning to do – differently – and to strengthen/enrich their judgment and decision-making, which guides practice. • The activities invite consideration of diverse perspectives and ways of doing. • The professional learning includes filmed, narrative accounts of experience that invite discussion. • The discussions encourage observation, description, analyses and interpretations of knowledge/phenomena, and also active engagement in interpreting self (intra-culturally) and other (inter-culturally).
<p>3. Learning as reflective and reflexive</p> <p>This principle highlights that through reflection people re-consider their own/ others' interpretations – their knowledge, assumptions, perspectives, positions, expectations and judgments. This builds understanding of communication, exchange and learning.</p> <p>Reflexivity turns people's own experience into an object of critical examination, so that they recognise how influential their own learned behaviours and understandings have become, and through this process develop self-understanding, identity and belonging.</p>	<ul style="list-style-type: none"> • All activities invite reflection on participants' own experiences, responses and reactions in interacting in diversity. They encourage <ul style="list-style-type: none"> ○ consideration about influences that inform their understandings, choices, decisions ○ taking into account <i>multiple</i> perspectives ○ consideration of self as contributor. • All activities acknowledge that the work is emotionally charged at every point.
<p>4. Learning as inter-interpretive</p> <p>This principle highlights that</p> <ul style="list-style-type: none"> • learning in diversity involves not only introspection (consideration of self) and one's own knowledge, know-how experiences and values, but also the assumptions that sit behind those things • this process of coming to understand is the same for others and as such it involves a <i>reciprocal</i> process of interpreting others and self in relation to others. 	<ul style="list-style-type: none"> • All activities invite <ul style="list-style-type: none"> ○ exploration and comparison of diverse interpretations and alternative choices, leading to an understanding the role of language/s and culture/s and diverse linguistic and cultural worlds ○ developing self-awareness in work ○ respect for the participants themselves and a culture of ongoing experimentation, learning and change.

Trialling and evaluating the modules

The trialling and evaluation of the modules was planned and conducted in collaboration with the Advisory Group and industry partners. The purpose of the trialling process was to pilot the draft modules to (1) obtain feedback on the processes of engaging the participants – *the learning experience*, and (2) collect evidence associated with shifts in understandings and associated changes in practice, particularly in relation to safety and linguistic, cultural and faith-based diversity – *the learning in practice*. In evaluating the extent to which the modules met the brief, the evaluators considered the content of the modules, contribution of activities and learning transfer. The trialling and evaluation process involved two phases to evaluate the usefulness for trainers and the overall value of the professional learning resource and experience. In Phase One, segments of the modules were trialled in two sessions led by the project team and observed by managers and educators from the industry partners. In Phase Two, an industry partner educator trialled the modules in collaboration with a member of the project team.

Trialling and evaluation of different modules and segments took place in both industry sites with supervisors (ENs and RNs), care workers, educators and managers. Participating staff reflected the linguistic and cultural diversity of the partner organisations. At Helping Hand, one half day and one whole day session were conducted. The first trial with 11 staff was facilitated by the project team, and the second trial with ten staff was co-facilitated by an educator from Helping Hand and a member of the project team. At Southern Cross Care, ten staff participated in a half-day trial of the modules, facilitated by the project team. Written evaluation from all participants was collected and a debriefing session was held with the educators.

The overarching theme highlighted by the analysis of data collected during the trials of the modules was the need to rethink safety and care in relation to ‘challenging behaviours’ and ‘unmet needs’ in ways that:

- go beyond the ‘usual dementia training’
- go beyond a focus on the clinical or manual handling alone
- take into account the personal experience and expertise of staff and facilitate the sharing of that experience and expertise with all staff
- engage staff from *all* linguistic, cultural and faith backgrounds.

The following are examples of the feedback:

‘Very useful for my workplace.’

‘Through this segment I understood how we understand, recognise and identify the behaviour which poses risk to safety and care for them and also how we can manage the risks in relation to challenging behaviours and unmet needs.’

‘Good emphasis on language being inseparable from care, this information is critical.’

‘Solutions came from within the group and then drawn by facilitator in wrap up.’

‘A good strategy to move people to a new understanding of "CALD", which underpins future modules.’

‘Videos good – breaks it up – and focus on individual care needs rather than "CALD" needs.’

‘I think that I’ve never seen staff as connected with behaviour intervention – especially staff from linguistic diversity (sorry for language). I can’t help but think this could be a critical strategy in encouraging relationship-centred care which will in itself encourage better care, which will reduce “triggers”. I’d like to see this across the organisation.’

The modelling of 'working together', the rethinking of the term 'CALD' and a focus on everyone's language, culture and communication as being part of everyone's roles and responsibilities when communicating safety and care was evaluated positively as a means of fostering inclusivity and conscious awareness, and facilitating an ongoing project of 'culture change'.

Conclusion

The growing complexity of communicating care and safety brought about by increasing linguistic and cultural diversity presents both challenges and opportunities for those receiving and providing aged care. This communication becomes even more complex when those being cared for are losing their communication capabilities as a result of dementia or other conditions associated with ageing. The challenge for the sector will continue to grow as Australia's population continues to experience the 'ageing of the aged' and the 'diversification of diversity'. This project has sought to challenge some of the understandings and assumptions that have long underpinned work, education and training in aged care, and the health sector more broadly. With the aged care sector in transition from institutionalised models of care to 'person-centred' care, the focus has been on people and the relational nature of communication. It is significant that at every phase of the project and development of the professional learning resource, the researchers have worked in close collaboration with people who understand the importance of communicating safety and care and the consequences for all involved. From the outset, the project has sought to model an intercultural orientation to communicating in complex diversity and working together, by drawing on the collective expertise available in the workplace across the diverse organisational roles and responsibilities, and the diverse languages and cultures in play.

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Part Two: The professional learning modules

Introduction: Using the modules

The aim of the project Communicating Safety and Care in the Context of Linguistic and Cultural Diversity in Aged Care: An Intercultural Approach to Training is to improve safety and care through an intercultural orientation that recognises the role of communication in the provision of safety and care.

The resources include:

- a set of five professional learning modules for use in training in diverse aged care environments
- a series of 19 video clips that are integrated into the five professional learning modules and which invite discussion and reflection on the experiences of practitioners.

All resources developed in the project will be available online on the Research Centre for Languages and Cultures/Research and Consultancy Projects/Funded Research Projects website at <http://www.unisa.edu.au/Research/Research-Centre-for-Languages-and-Cultures/>

The modules cover five key themes that emerged from research undertaken through the project. They are best seen as an interrelated set, each module building on the previous and each focusing on a particular aspect of practice while maintaining a common orientation. The five modules are:

Module 1: *Challenging behaviours or unmet needs: A clinical perspective*

Module 2: Understanding linguistic, cultural and faith-based diversity in relation to *challenging behaviours or unmet needs*

Module 3: Communicating in relation to *challenging behaviours or unmet needs*

Module 4: Relating to the person with *challenging behaviours or unmet needs: Personal histories, life journeys and memories*

Module 5: Managing risk in relation to *challenging behaviours or unmet needs*

Each module is relevant to workers at all levels of the organisation: carers, enrolled nurses, registered nurses, trainers and managers.

For each module we provide:

- a general introduction to the module
- the objectives of the module
- the outline of the module through the four segments that approach different facets of the theme
- a set of PowerPoint slides, including notes for facilitators
- video clips and related activities that invite participants to discuss, compare and reflect on their own/others' practices
- suggested activities that invite participants to experiment with the learning captured in the module.

The presentation of four segments in each module is intended to provide flexibility so that depending on needs, interests and time, participants can work through one or more segments related to a particular module, or indeed combine different segments from more than one module. Each segment and each module can be run as a brief 15-minute on-the-job segment or as a dedicated session of two or more hours.

The inclusion of notes for facilitators is deliberate. Facilitators will wish to see what the developers had in mind in the creation of the modules, particularly in adopting an intercultural orientation to professional learning that might be different from regular practice in the sector. We hope that they find this feature of value. The notes are also included for those participants who might wish to work through the materials independently. For them, the notes may provide a way of understanding safety and care in the context of linguistic, cultural and faith-based diversity in aged care that resonates with or stands in contrast to their own understanding. Although an individual journey through the modules and segments is possible, experience through trialling has highlighted the important role of discussion and reflection *with* others. Thus opportunities for working together on professional learning should be made available as much as and whenever possible.

Module 1:
***Challenging behaviours or unmet needs: A
clinical perspective***

Module 1: Challenging behaviours or unmet needs: A clinical perspective

Objectives

In this module, participants will:

- explore clinical perspectives on behaviours and unmet needs
- consider how a person's behaviours and needs will vary immensely according to their individual clinical profiles, and will also be constantly changing in individuals themselves over time
- consider how a better understanding of a person's clinical profile can contribute to safety, communication and care
- develop strategies for communicating and 'doing' safety and care through knowing a person's clinical profile.

Outline

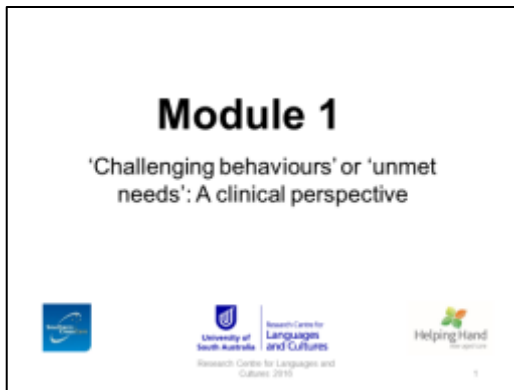
1. Exploring clinical perspectives behind behaviours and needs
2. Understanding the clinical variation between individuals and within individuals over time
3. Understanding the role of my behaviour: triggers and needs
4. Strategies for communicating and doing safety and care

About this module

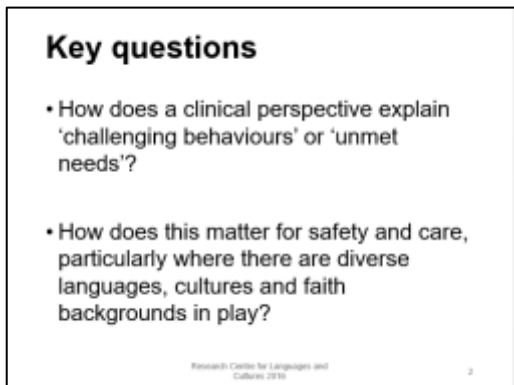
The aim of this module is to explore clinical perspectives on challenging behaviours or unmet needs and to highlight principles for safe practice and practical strategies for providing care.

A good starting point is to consider how we understand dementia, behaviour and communication. In a series of activities we will explore what it means to be a person who has a clinical condition that affects how they think, act, speak, understand and respond to others. What is the significance of the different clinical profiles we see in the people that we care for, and how does this change over time?

PRESENTER'S NOTES

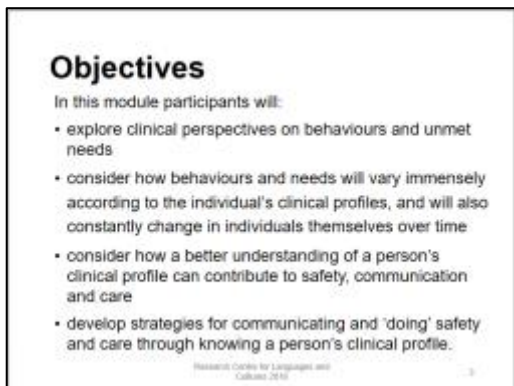


Briefly present the topic.

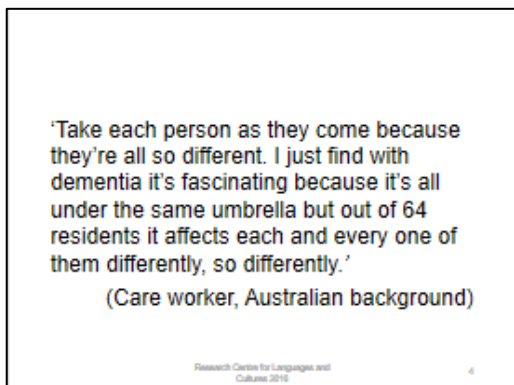


Introduce key questions to be considered. Participants will reflect on and respond to these questions when they complete the module to evaluate their learning.

Emphasise the importance/focus that will be given to safety and care in this training.



Outline objectives for this module.



Use this slide to contextualise the focus of the module – each person has a different clinical profile. This means their care, behaviour and needs will be different.

Outline

1. Exploring clinical perspectives behind 'behaviours' and 'needs'
2. Understanding the clinical variation between individuals and within individuals over time
3. Understanding the role of my behaviour: triggers and needs
4. Strategies for communicating and doing safety and care

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This module is made up of four segments. (The segments may be completed individually or together.)

Segment 1

Exploring clinical perspectives behind behaviours and needs

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About dementia

Together, consider that dementia is:

- not just a normal part of ageing.
- not one disease, but an umbrella term for more than 100 types of changes in the brain that affect cognition, memory, emotion, behaviour and more.

What are some of the causes/forms of dementia that you know of?

Adapted from: <https://www.healthline.com/health/dementia>

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Ask participants to share some of the different types of dementia (from a clinical perspective).

Possible answers:

- Alzheimer's disease
- vascular dementia
- Parkinson's disease
- dementia with Lewy bodies, fronto temporal lobar degeneration (FTLD)
- Huntington's disease
- alcohol-related dementia (Korsakoff's syndrome)
- Creutzfeldt-Jacob disease

About dementia (contd)

Some people with dementia may experience changes in:

- mood +/- anxiety, depression, highs/lows
- behaviour +/- restlessness, wandering, agitation, aggression
- memory loss +/- language difficulties, perceptual changes, intentional movement, executive function

DSMU (2013)

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'Confusion. Not knowing where they are a lot of the time and just wandering, trying to get out, find somebody in familiar surroundings. They want to go home, see their children, find their partner who's died 20 years ago, they forget. Refusal of ADLs, showers, washing, getting clean clothes on. Refusing to eat. Everything.'

(Care worker, Australian background)

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Consider the word 'Everything' used by this care worker and ask participants to consider what this means for them in terms of safety and care.

Causes and perspectives

Video 1.1.

Consider a trainer's account of how some perspectives on dementia and behaviours are not always clinically based.

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Ask participants to consider the perspectives expressed in the video.

Play video 1.1

'I'd say it's a challenge sometimes. I've been doing this for five years. I've studied nursing as well which helps me to understand their behaviour. It's not something they're doing on purpose.'

(Care worker, African background)

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Small group activity

Discuss together

- what you know about the many types of conditions (often lumped together as one condition, dementia)
- the ways in which the quotes on the previous slides highlight the need to understand the clinical profile of each person you care for
- why it is important for safety and care to understand that dementia will be different in different people.

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Organise participants into groups of 3 or 4 to discuss the points on these slides.

Bringing it together

What key ideas have emerged about:

- the huge variation in types of dementia?
- how this variation may affect different people in different ways (behaviour, communication)?
- how understanding these differences is crucial for managing safety and care?

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In bringing the discussion together, emphasise how lumping people together under one clinical label could compromise safety and care, because it is important to:

- consider the individual clinical profile and how this impacts on a person's thought processes, communication, emotions and behaviours
- anticipate a person's needs
- tailor individual safety and care strategies.

Segment 2

Understanding the clinical variation between individuals and within individuals over time

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Changing clinical profiles

- Think of a person you currently care for. What do you know about their clinical profile? What don't you know?
- How has it changed over time?
- How do you think their clinical profile may affect their needs and their behaviour?

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^Yeah, and I guess there is that, seeing the increased confusion that a person might experience and then that resulting in some changed behaviours, that may be interpreted as "it's just the dementia" as opposed to, "there's an unmet need behind this", or "there's a change in health status" or something along those lines ...

(contd over)

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(contd)

'... We may be seeing then that "Oh, they've got these changed behaviours" is probably the worst words that are used around that and "We should expect that because it's their disease" ...

'As opposed to "It might be the by-product of not being able to communicate appropriately", therefore those needs that you and I can express really easily which prevent us from having that behaviour, these clients don't have that capacity to do that.'

(Trainer, Australian background)

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'I guess "unmet needs" would be if they're in pain. Their medications might not be correct. If they're losing weight. There could be, obviously dietary concerns. Are they on the right diet? You'd look into that. Have they got dental issues? Things like that ... (contd over)

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(contd)

'We delve a bit deeper into everything really... say if they weren't eating or suddenly became agitated for no reason, unexplained reason, they might have a urinary tract infection ... You do a urinalysis. If they were different from what they usually are, you'd go further, depending.'

(Enrolled nurse, Australian background)

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Small group activity

Consider a time when you noticed a change in a person's condition or behaviour. Discuss in small groups:

- What did you do? What happened next?
- How do you think this variation between different individuals and within different individuals might affect how you 'do' safety and care? What options do you consider?
- How do you explain some of the challenges?
- How do you confirm your own understanding?

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Bringing it together

What key ideas have emerged about

- knowing a person's individual clinical profile and how this impacts on their needs?
- noticing changes in their condition, needs and behaviours?
- how such variation influences *communicating* and *doing* safety and care?

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In bringing the discussion together, highlight how:

- knowing something of the individual clinical profiles of people we care for is important when it comes to understanding their needs and noticing a deterioration in their condition
- these people may be less able to express their needs due to cognitive and non-cognitive changes, and therefore
- this makes it everyone's responsibility to know as much as possible about the person's clinical profile for safety and care.

Segment 3

Understanding the role of my behaviour: triggers and needs

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'Now if you're coming in to someone in aged care whose hearing and sight is down a bit anyway and they have other issues. They're scared of falling, they've got painful areas, and if they've got people rushing in and they do not understand what is required of them, they feel that these people just rush in, pulling or pushing them around, and that can actually trigger that behaviour because they're scared, or whoever is doing it is causing them pain. Both of those things, there's survival instincts they go to, and so that actually triggers the behaviour.'

(Trainer, European background)

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Use this slide to shift the focus from people with dementia to how we ourselves may contribute to behaviours.

Individual or pair activity

- Consider the kinds of things you do in caring for people that could be potential triggers (e.g. in your behaviour or in the environment).
- In what ways can you do things differently to minimise these triggers?
- Exchange examples of times when you noticed something that was a trigger, and then communicated it to someone else. (contd over)

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Ask participants to compare their responses to these questions in pairs or small groups.

Individual or pair activity (contd)

- What do you do when you cannot identify a trigger?
- Exchange examples of times when you noticed a need that a person was unable to express, and then communicated it to others.
- How did you communicate these triggers or unmet needs to your colleagues?
- How does this matter for care and safety?

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Bringing it together

What key ideas have emerged about how:

- our own behaviour or environmental factors could create triggers?
- we might change what we do to minimise such triggers?
- we might be more aware of needs a person is unable to express?
- we communicate to others information about triggers and needs we have noticed?
- this influences *communicating* and *doing* safety and care together when we communicate (or don't communicate) this with others?

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In bringing the discussion together, highlight how:

- our own behaviour and/or environmental factors may be contributing factors
- it is crucial to communicate with one another about potential triggers
- it is necessary to keep communicating, as people's conditions are always changing.

Segment 4

Strategies for doing safety and care

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'You've just told me that they're cognitively impaired and you're going to remind them to use the call bell. Yes, that's part of a strategy, because it's not to say you shouldn't do that, but it's thinking again about the individual.'

'Why were they getting up? Were they trying to get to the toilet? Do we need to put in toileting strategies? They were bored in their room. Well, we need to give them options of activities. Again, it's thinking of that person and beyond 'It's their fault.'

(Trainer, Australian background)

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Video 1.2. Consider the perspectives of five care workers, an enrolled nurse, a registered nurse and a manager in the video.

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Ask participants to consider the perspectives expressed in the video.

Play video 1.2

'Sundowning' in dementia is very common, so there is a particular time when they start their behaviours, especially with him, like he starts around 3.00, so we need to pick up, like looking, observing for signs of his agitation. There can be any triggers, like for example for him, you cannot tell him what to do.

'Those sorts of things you have to, like we have figured them out. So we have to ask him really passive questions, instead of saying 'Do this', 'Can we ...?', 'Would you like ...?', instead of asking directly, something like that. Giving him the leave to do it. He was in that kind of role before. So that worked out with him. (contd over)

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(contd)

'So what we do, when we find out all the strategies, we put them in his care plan. And we've got behaviour assessment as well. What we do is we keep updating, and then communicating with the staff, "How is it working?"

'And then if some of the things are still not working, then we have to think ahead, out of the square, and think of something else as an alternative. This is the way I think it works.'

(Registered nurse, Indian background)

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Group activity

Consider together the different ways you do safety and care based on how you know a person you care for according to their clinical profile. How does this influence:

- the ways you behave towards them?
- how you identify and minimise triggers?
- how you try to understand and anticipate their needs?
- how you communicate these things with your colleagues?

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Bringing it together

What key ideas have emerged about:

- the importance of understanding that your behaviour is a potential trigger?
- how knowing a person's clinical profile can help you anticipate needs that they are less able to express themselves?
- the importance of sharing this information with others you work with?

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In bringing the discussion together, highlight how, in pooling our diverse understandings of a person's clinical profile:

- we can work together to develop new ways of caring that minimise triggers
- we can enhance our anticipation of their individual needs
- we can notice triggers and behaviours and adapt our care appropriately
- this is crucial for safety.

Reflection and application

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'They're "aggressive" or "they swear", "they spit", all of those things are handed over to new staff or other staff, so already you've got people going in with preconceived ideas about how it's going to work, so their body language is different, the resident can pick up on the body language, so there's a cycle.'

(Trainer, Australian background)

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Bringing it all together

- What have you learnt from this module?
- How do you see the role of knowing the clinical profile, the potential triggers, and unmet needs of a person, for how you care for yourself and others safely?

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In bringing the whole module together, ask participants to discuss how they can break the cycle of misunderstanding people's behaviours and needs by taking a clinical perspective and communicating with one another.

What next?

On your next shift:

- Find out something new about the clinical profile of a person you care for by asking a staff member or reading their case notes.
- Do your own research on types of dementia.

The following sources may be helpful:

- <https://www.fightdementia.org.au/about-dementia/health-professionals/the-essentials>
- <http://www.nhs.uk/Conditions/dementia-guide/Pages/symptoms-of-dementia.aspx>

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Emphasise the ongoing nature of *reflecting* and *acting* on emerging understandings of:

- how the person's condition is changing over time
- roles and responsibilities – working together
- sharing what works
- working together on new ways of communicating and doing safety and care.

Over the next week

Person of the week

Working together (i.e. nurses and care workers), focus on one person you care for at a weekly meeting or handover.

- What knowledge about the person's clinical profile/type of dementia could be shared to better understand them and their needs?
- What triggers have been identified?

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Again, emphasise the ongoing nature of *reflecting* and *acting* on emerging understandings of:

- how the person's condition is changing over time
- roles and responsibilities – working together
- sharing what works
- working together on new ways of communicating and doing safety and care.

Over the next week

Person of the week (contd)

- How do different staff members anticipate the needs the person is unable to express?
- What successful strategies do different staff members use in caring for this person?
- How is this communicated clearly and consistently to all staff, including agency staff.

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Over the next week

Person of the week (contd)

At the end of the week:

- What have we learned/noticed?
- What could be done differently?
- How does this matter for safety and care?

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Further resources

My Aged Care

<http://www.myagedcare.gov.au/health-conditions/dementia>

Health Direct

<http://www.healthdirect.gov.au/dementia>

Alzheimer's Australia

<https://www.fightdementia.org.au/>

DBMAS

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

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Further resources

My Aged Care

<http://www.myagedcare.gov.au/health-conditions/dementia>

Health Direct

<http://www.healthdirect.gov.au/dementia>

Alzheimer's Australia

<https://www.fightdementia.org.au/>

DBMAS

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

Evaluating learning after this module: Key questions for reflection

Reflecting on what you have learned in this module, consider the following questions and write a brief response for each one:

1. How does a clinical perspective explain *challenging behaviours* or *unmet needs*?

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-

2. How does this matter for safety and care, particularly where there are diverse languages, cultures and faith backgrounds in play?

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3. What will I now do on my next shift?

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Module 2:
**Understanding linguistic, cultural
and faith-based diversity in relation to
*challenging behaviours or unmet needs***

Module 2: **Understanding linguistic, cultural and faith-based diversity in relation to *challenging behaviours or unmet needs***

Objectives

In this module, participants will consider:

- the label CALD (culturally and linguistically diverse) and the linguistic, cultural and faith-based diversity in their own environment
- how they and others are at home in their own language, culture and faith
- how linguistic, cultural and faith-based diversity influences perceptions of relationships, communication and practices
- the risks and opportunities that diversity brings in providing for safety and care.

They will also develop:

- strategies for intercultural interaction and communication in providing for safety and care.

Outline

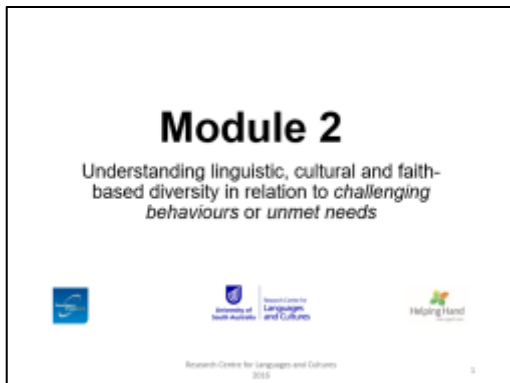
1. Reconsidering the CALD label
2. Considering the influence of diversity on perceptions
3. Understanding risks and opportunities in diversity
4. Developing strategies for doing safety and care in diversity

About this module

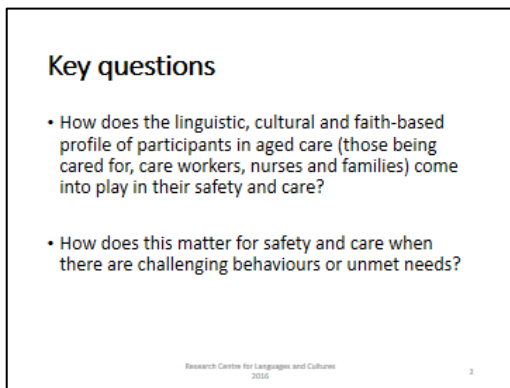
The aim of this module is to consider the impact of increasing linguistic, cultural and faith-based diversity in aged care environments and why and how it matters for safety and care, particularly in the context of challenging behaviours or unmet needs. It raises questions about the label 'culturally and linguistically diverse' (or CALD), which is used extensively in policy and practice to refer to people who come from non-English-speaking backgrounds. This module suggests an alternative way of understanding such diversity and offers some practical strategies for providing safety and care involving nurses, care workers, families and the people being cared for.

This module consists of a series of activities/segments relating to the ways in which nurses and care workers, together with those being cared for and their families, understand how diversity in languages, cultures, and faith comes into play in accomplishing safety and care. This module questions the CALD label. It considers how language, culture and faith influence perceptions of relationships, interactions and practices that are central to providing safety and care. It highlights the fact that on the one hand, the reality of diversity can intensify risks to safety and care, and on the other hand, it can also be a rich resource for achieving workplace safety and care. It also suggests some strategies for providing safety and care.

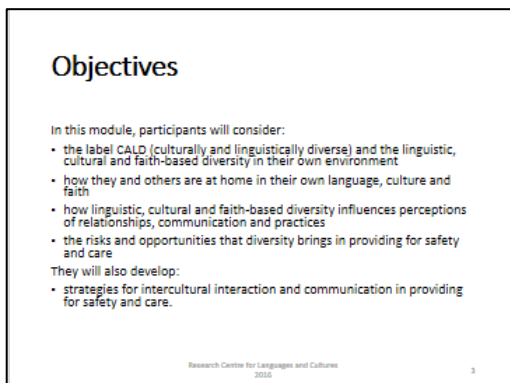
PRESENTER'S NOTES



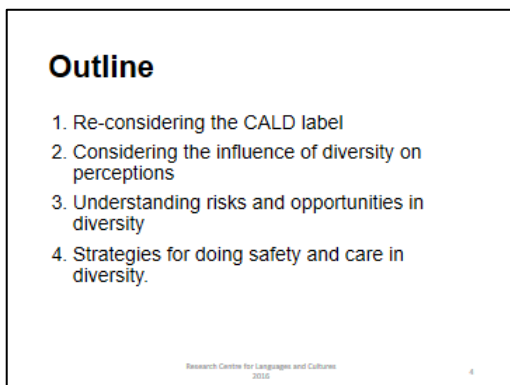
Briefly present the topic.



Introduce key questions to be considered. Emphasise the importance/focus that will be given to safety and care in this training.



Outline objectives for this module.



This module is made up of four segments. (The segments may be completed individually or together.)

Segment 1

**Re-considering the CALD label
(culturally and linguistically diverse)**

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2016

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Small group or individual activity

Think about a recent experience when you had to interact with a person/s from another language, culture and faith – at work or in your social life.

Write down some notes about the experience.

- Did you understand them?
- How did they understand you?
- What did you notice was different / the same in your interaction?
- What did you do to try to share understanding? What did they do?
- How did you react, respond, feel? How did they?
- How did you explain the experience to yourself?

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2016

6

Small group activity

Share your strategies for trying to understand people of different cultures, languages and faiths.

Compile a list of the reactions, responses, feelings of the group, and the explanations you gave to the experience.

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2016

7

'We have a gentleman here at the moment, an Indian man, and he is of the Sikh religion. Now, I don't know anything about that. In his culture, the elderly stay at home and the family looks after them. I know there is a lot of resentment there, towards his daughter who can't look after him at home. He has to be in here. But in his mind, because he is of that age and background, he believes that she should be looking after him and she is not. So that then causes problems for us because he does not want to be here, so he won't always communicate as effectively as he can. He can, but he just doesn't want to because he doesn't want to be here ...

'They have rituals and we don't know what those rituals are and the last thing you want to do is offend anyone at that time, but it's very hard ... you don't know what those rituals are and you can't find out what those rituals are.'

(Enrolled nurse)

Research Centre for Languages and Cultures
2016

8

Use this slide to contextualise the focus of the module – each person has a different linguistic, cultural and faith profile. This means their care, behaviour and needs will be different.

Pairs or small group activity

Consider the account of the Sikh gentleman given by a nurse in the previous slide and in pairs discuss:

- What do you notice about how the nurse describes the gentleman?
- What observations does she make about his culture? How does she interpret his culture? Do you both/all agree?
- How does she see the consequences for the gentleman?
- What observations does she make about the rituals? Do you both/all agree?

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2016

9

Video 2.1 Consider the perspectives of five care workers and a registered nurse in understanding the linguistic, cultural and faith-based profile of participants in aged care in the following video.

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2016

10

Ask participants to consider the perspectives expressed in the video.

Play video 2.1

Small group activity

In groups of four, ask one another:

Have you encountered the phrase 'culturally and linguistically diverse' – the label 'CALD'? Where? When? How do you understand this term?

We tend to take labels for granted.

Pause for a minute to consider what CALD means. To whom does the label refer? Have you noted any problems with the label?

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2016

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Reconsidering the CALD label

It identifies a particular group of people, when in reality all participants (those being cared for, carers, nurses, family) are 'at home' in their own language and culture. All people see their way of behaving, their own world view as normal.

It is imposed by the dominant group in a way that positions non-dominant groups as different.

It is normative – it suggests that the dominant group's behaviour is considered 'normal' and that the non-dominant group will behave *in contrast* to the dominant group. It defines the non-dominant group as a problem or as different.

It is attributed to persons rather than contexts or situations.

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2016

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CALD is a convenient label and it is used a lot in policies and guidelines BUT ...

It can hinder understanding in providing for safety and care if communication is not recognised as:

- *intercultural* – i.e. that understanding requires bridging one's own language and culture in relation to the languages and cultures of others
- *everyone's responsibility* – because being 'at home' in one's own language and culture is a characteristic of all of us.

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2016

Bringing it together

What key ideas have emerged about linguistic, cultural and faith-based diversity, and the way they come into play in providing safety and care?

Have you experienced linguistic, cultural and faith-based diversity in your work context? How do you understand this diversity?

Research Centre for Languages and Cultures
2016

In bringing the discussion together, recognise that:

- interacting across languages, cultures and faiths can be challenging and effortful
- strategies might have included repeating, asking questions, rephrasing/rewording, using gestures, giving up
- reactions might have included frustration at misunderstanding, joy at some success, giving up, reaching positive or negative conclusions about the person and their language and culture
- explanations might have been: 'we're just so different, worlds apart, it is impossible to bridge the differences'; 'there are as many similarities as there are differences between us'; 'we're really all the same'.

The facilitator might conclude the discussion by saying that identifying similarities and differences is a normal reaction in thinking about how we behave in interactions in linguistic, cultural and faith-based diversity. But it can also be unhelpful. If we highlight similarities too much, we risk putting aside the very real differences; if we highlight the differences too much, we risk creating too much distance. Fundamentally, we need to come to *understand* others, better and better.

Segment 2

Considering the influence of diversity on perceptions

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2016

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'Cultural factors determine the ways in which workers interpret information, the meanings they attribute to messages and the conditions under which information will be noticed, interpreted and given importance.'

(Trajkovski & Loosemore, 2006)

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2016

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The effect of culture and language

- How people perceive and understand information and each other or in fact misunderstand information and each other
- How people perceive and understand the world around them and what it is that's going on – and what they see as the 'normal' way of doing things
- People's beliefs

The quotation goes a bit too far, suggesting that culture 'determines' how people interpret information. It does not 'determine' as such, but it certainly influences how people understand what's going on.

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2016

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Small group or individual activity

Some aspects of culture are directly visible (food, dress) but a lot are not (how people see the world, their values, attitudes, beliefs). Bearing in mind there are both visible and invisible aspects of culture, consider a person that you care for.

Make some notes to build a linguistic, cultural and faith-based profile of the person.

(contd over)

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2016

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Ask the participants to write down some notes about the linguistic, cultural and faith-based profile of a person they care for, then get them to consider what they have/have not included.

(contd)

Look at your notes.

- What details have you included?
- What aspects have you not yet captured?
- How might you find out more about the person's linguistic, cultural and faith-based profile?
- How will you use the profile that you have created?

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2016

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'I would probably say it's a cultural thing, you know, and they've all got different religious backgrounds and rules and regulations that aren't the same as ours ... well, even the basic showering, they do it a lot different than we would, you know, totally different ... we do them normal, you know, what is normal, you know what I mean, the washing and that, you know, they do it totally different, but that's what they know.'

(Care worker, Australian background,
reflecting on differences in cultural practices)

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2016

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Small group activity

In small groups, ask each other to comment on the reflection of the Australian care worker in the previous slide.

- How does she understand cultural differences?
- How does she understand what is 'normal'?
- How does this compare with your understanding?

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2016

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'The kind of caring that comes from my background ... thinking about my culture, we're very respectful, Right? ... So it was a challenge for me when I came to Australia. It was a challenge for me to maintain eye contact with older people, because it's considered rude in my country. So, now, talking to you, I'm looking you straight in the eye. I can't do that in my home country. So the thing I had to understand when I came to Australia is if you don't maintain eye contact, they think you're lying. So that's changed my perspective about things. So working with older people, calling them by name, it's so rude. So it took me a while to fit in here because we don't do it. We don't.'

(Care worker, reflecting on his African background)

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2016

22

Small group activity (contd)

Now discuss the perspective of the second care worker.

- How does he explain differences in cultural practices (e.g. looking at someone in the eye)?
- Why did he change his behaviour?
- Reflect on the process of change from his point of view ... how easy/difficult is it to make these changes? What is actually involved in making these changes?

(contd over)

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2016

23

What do the two quotations reveal?

The Australian care worker highlights that it is about what different people understand to be 'normal'.

The African care worker reflects on how he has had to adjust his understanding of how to show respect in different cultures.

- Reflect on who it is that needs to change ... the process of change from his point of view ... how easy/difficult is it to make these changes?
- What is actually involved in making these changes?

(contd)

The focus of the discussion so far has been on different perceptions of *regular cultural practices*.

Now consider the impact on *relationships*. How do you think the differences influence relationships among those being cared for and carers, carers and carers, carers and nurses?

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2016

24

Ask participants to consider the perspectives expressed in the video.

Play video 2.2.

Video 2.2 Consider the perspectives of a carer, a relative and a trainer on the influence of linguistic, cultural and faith-based diversity on how we understand one another in the following video.

How does this matter for the safety and care of one another?

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2016

25

Bringing it together

Language/s, culture/s and faith/s are not just about artefacts, rituals and practices. They are *frameworks* through which people *interpret, create, and exchange meanings* and create the world in which they live.

These frameworks affect how people act, interact, react, respond in receiving or providing for safety and care. It is a part of *interpreting and understanding* 'where they are coming from', in other words, the way they are 'at home' in their language and culture.

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2016

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The focus of the discussion so far has been on different perceptions of *regular cultural practices*. Now consider the impact on *relationships*.

In bringing the discussion together, highlight how these differences influence relationships among those being cared for and carers, among carers and carers, and among carers and nurses.

But remember, 'we' are all 'at home' in our own language and culture in the same way, so we need to understand our own actions, interactions, reactions and responses are 'normal'.

When a person takes the norms from their first language and culture (English into another language or another language into English), misunderstandings can result. These misunderstandings can lead to negative perceptions of the speaker and this may be interpreted as rudeness or being inappropriate and cause stress, tension and a sense of mistrust for all parties involved.

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2020 17

Bring together key ideas that have emerged about how culture and language affect provision of care and safety:

- When working in contexts of linguistic, cultural and faith-based diversity we all need to participate in understanding our own and others' actions, interactions, reactions and responses.
- We need to change our mindsets about how we interpret our own and others' actions, interactions, reactions and responses. (We tend to think of our own as 'normal' and others' as 'abnormal'.)

Communicating safety and care is not simply about others, or particular characteristics of other people. It relates to all involved.

There is a need to change our mindsets about how we interpret people and their interactions, reactions, responses.

Communicating safety and care is not an individual matter that relates to a particular characteristic of an individual. Instead, it relates to *all* participants who are involved.

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2020 18

Segment 3

Understanding risks and opportunities in diversity

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2020 19

'I've been here nearly six years now. I think I really like working here. We have a lot of cultures involved, and we do respect each other's feelings. Everyone brings, everyone's welcome to bring their new ideas in. Everyone has their new thoughts to develop new strategies, and people give them and they're welcome and we try them, and they've worked as well. So I think that is what makes it interesting as well.

'Like, for example, some residents, they don't speak English, and they also have dementia, that's the difficulty as well. We have one resident who does not really speak one word of English. We tried to arrange a volunteer from his nation, but when that person came in, when the resident spoke, it didn't make any sense.

Research Centre for Languages and Cultures
2020 (contd over)

(contd)

'So this is the difficult part, we feel. This is like when we feel: 'How are we going to provide the care?' How are we going to understand when he's in pain? There's more pressure we're going through, but we don't get any verbal response, which is very important to know the feelings of the resident as well.'

(Registered Nurse, Indian background)

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2016 22

Small group or individual activity

Consider the perspective of the registered nurse of Indian background on working in diversity in aged care. In two columns, list:

1. What she sees as the difficulties or risks
2. What she sees as possibilities.

From your own experience, add your own thoughts on difficulties/risks that arise because of complex diversity and the possibilities that diversity brings. Bring together the two lists that others have made. What do you notice?

Returning to the perspective of the registered nurse of Indian background, whose perspective/s did she take into account?

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2016 23

Bringing it together

Understanding risks and opportunities

In all *interactions* in providing safety and care, in both acting (talking, handing over, documenting etc.) and managing (supervising, training), there are risks and opportunities for all:

- those who are being cared for and care workers – and families
- care workers and co-care workers
- care workers and supervisors
- care workers and trainers.

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2016 24

After participants have written their lists, ask them to compare their lists of risks and possibilities with a partner.

In bringing the discussion together, highlight key ideas that have emerged about risks and opportunities:

Risks, e.g.

- complexity of diversity and needs
- time-pressured, regulated environment
- physical and psychosocial safety
- professional isolation
- different perceptions/expectations of practices, roles and responsibilities
- fear of negative evaluation
- discrimination

Care is physically and emotionally demanding.

Care easily becomes a *transaction* rather than an *interaction*.

Diversity provides opportunities, e.g.

- additional sources of knowledge and strategies
- increased cultural sensitivity
- multiple perspectives

Safety and care depend on shared perceptions of health, safety, care and a willingness to share, through communication, how people *reciprocally interpret* actions, interactions, reactions, responses in accomplishing diverse tasks.

Segment 4

Strategies for doing safety and care in diversity

'You also have to get to know their culture, simple things. Like if they don't like to shake hands; in some cultures, the gender equality is an issue, still evident. So women tend to be looked down on for certain male residents. Sometimes we've had to change the therapist, so if they prefer a male therapist, we change. Again, the other way round, if they prefer, a female prefers a female physiotherapist, we also try to meet their needs if it's possible. So really in tune with who they are.
'Dementia – they do have the long-term memory stored, so they remember, and that's what we actually go on.'

(Trainer, European background)

Small group or individual activity

Consider the trainer's perspective:

- What strategies does she suggest?
- Have you tried any of these strategies?
- Add some more strategies that you have tried or that you would like to try out.

'In our country we respect our parents and older people and when they come to our home it is respectful to offer tea, coffee. There is a different culture here. You know the plumber, the electrician, they come to your home here in Australia, but that's my culture. You ask, 'would you like a cup of tea?' ... because I just think about how he's come here, maybe he's thirsty. But no, they say, 'No, I'm fine thank you, it's nice of you to ask'. And I say, 'That's our culture'. To make sure everyone is comfortable in our home. Hospitality. So we respect them and I just learn these things, culture from my parents. My parents told me when I was a child. We just learn, how to respect elders, and we do those things.

'Same thing I did in that nursing home, and maybe that's why I got that job, because I was lovely to them, the residents, and very friendly with them. With new ones, I just go and hold her hands, talk with her a little bit.'

(Care worker, Indian background)

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2016 39

Now consider the care worker's perspective in the previous slide.

- How does she explain her culture? How does she understand 'respect'?
- How is 'respect' gained in your culture?

The strategies all have in common an effort to bridge linguistic, cultural and faith-based differences. It can be called an *intercultural* approach to safety and care.

(contd over)

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2016 39

(contd)

Discuss and note down how you think this intercultural approach to safety and care actually works in practice.

- Who should be involved in an intercultural approach to safety and care?
- How do we best achieve it in the workplace?

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2016 40

After participants have written down what works, elicit some of their ideas and emphasise that sharing what works and working together is crucial for developing practical strategies in an environment of emerging risks and opportunities.

Bringing it together

In developing strategies for an *intercultural* approach to safety and care, it is important to note and understand that:

- safety and care are a *reciprocal accomplishment*. It's not just about others; it's about all of us and our respective world views
- the practices, the *doing*, come from the linguistic, cultural and faith framework that people have developed and use to interpret what it is that is going on
- using the language resources available in the workplace will be valuable. Care workers, families, nurses, volunteers, chaplains can act as cultural mediators.

(contd over)

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2016 41

In bringing the discussion together, emphasise the *intercultural* nature of doing safety and care as outlined on the slide, making connections with the ideas the participants have discussed and shared.

(contd)

Strategies for doing safety and care include:

- recognising that there are different cultural expectations, norms, assumptions, values, attitudes and beliefs, and demonstrating a willingness to learn about and come to understand them
- maintaining attentiveness to language, culture, faith is an ongoing practice
- recognising the local methods that work 'on the ground'
- reflection – on how we understand each other, how we are understood by others, how we react/respond in interaction – is a crucial process.

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2020 42

A concluding reflection

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2020 43

'Australia is a multicultural country where people from different backgrounds could get to work together and obviously speak with different accents/languages but the most important thing is to build the ability to listen to each other. People should not just conclude that I don't understand or I will not understand what he/she has to say. I have heard people saying, "I don't understand her accent/language"; some people saying, "Did you understand what he said?"

'... I believe that if people listen more, they will understand. Because most people have already made up their minds that they will not understand, usually lost them in the middle of the conversation. When people listen more and take time to understand one another there would be safety for all.'

Research Centre for Languages and Cultures
(Care worker, African background)
2020

Consider the thoughts of the African carer – in the highly complex, intense pressured environment, he advises a crucial skill to be developed in an intercultural approach to safety and care.

Reflect on your own daily experience. How do you respond to his reflection?

What next?

What will you try out on your next shift?

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2020 45

Emphasise the importance of *reflecting* on and *acting* on developing understandings of the role of language, culture and faith in doing safety and care.

Before finishing this session, ask participants to share with a partner or their group something they will do on their next shift.

Further resources

O'Neill, F, Scarino, A, & Crichton, J 2016, *Developing English language and intercultural learning capabilities*, [Case Study 2: The Intercultural Learning Project](#), prepared for the Division of EAS.

Evaluating learning after this module: Key questions for reflection

Reflecting on what you have learned in this module, consider the following questions and write a brief response for each one:

1. How does the linguistic, cultural and faith-based profile of participants in aged care (those being cared for, care workers, nurses and families) come into play in their safety and care?

-
-
-
-
-
-
-

2. How does this matter for safety and care when there are *challenging behaviours* or *unmet needs*?

-
-
-
-
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-
-
-

3. What will I now do on my next shift?

-
-
-
-
-
-
-

Module 3:
Communicating in relation to *challenging*
behaviours or unmet needs

Module 3: **Communicating in relation to *challenging behaviours or unmet needs***

Objectives

In this module participants will:

- understand how choices in language use matter to safety and care
- consider how understanding and responding to the language of the person can enhance care and reduce risks for staff and residents
- develop strategies for communicating and doing safety and care by using the language of the person where appropriate/possible
- explore ways of understanding and using language beyond words.

Outline

1. Understanding how people's use of language accomplishes safety and care
2. Considering how each person uses and understands language
3. Developing strategies for using the language of the person
4. Exploring language beyond words

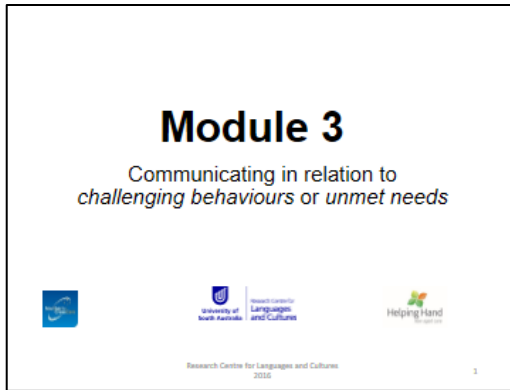
About this module

The aim of this module is to develop shared understandings of the importance of language in providing care.

The focus is on how staff and residents together can reduce risk and optimise care through the choices they make in language. Every conversation involves choices about the language that a person uses, how they understand what others say, and how each person responds to the other. When there are challenging behaviours, these choices become more important and the stakes are higher. When linguistic, cultural and faith-based diversity is in play, the choices become more complex. The key message is that people understand what is meant and how they should best respond primarily through the language that they use together. The upshot is that to make safe and caring choices, people need to understand how others will understand them. This understanding is never 'finished'. It can only be developed, supported and shared together in an ongoing way.

This module consists of a series of activities/segments relating to the ways in which nurses, care workers, residents and their families communicate with each other in accomplishing care. The module builds on key ideas, safety and care principles, and practical strategies introduced in the previous two modules.

PRESENTER'S NOTES



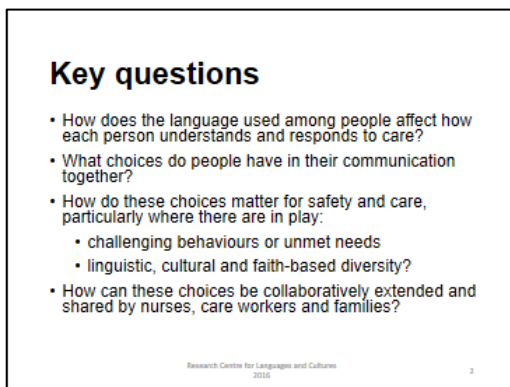
Module 3
Communicating in relation to
challenging behaviours or unmet needs

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Research Centre for Languages and Cultures
2016

1

Briefly present the topic.



Key questions

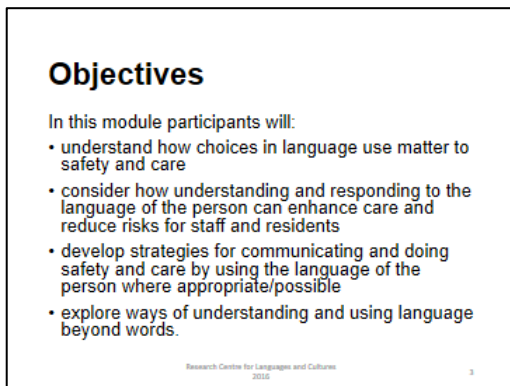
- How does the language used among people affect how each person understands and responds to care?
- What choices do people have in their communication together?
- How do these choices matter for safety and care, particularly where there are in play:
 - challenging behaviours or unmet needs
 - linguistic, cultural and faith-based diversity?
- How can these choices be collaboratively extended and shared by nurses, care workers and families?

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2016

2

Introduce key questions to be considered.

Emphasise the importance/focus that will be given to safety and care in this training.



Objectives

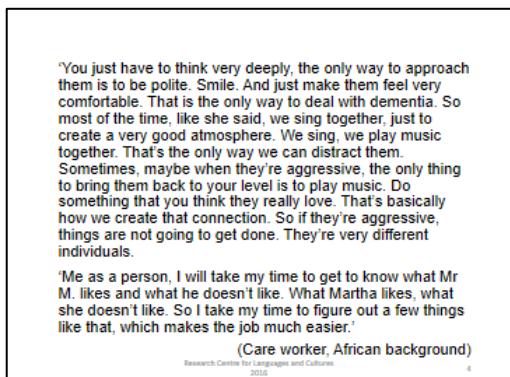
In this module participants will:

- understand how choices in language use matter to safety and care
- consider how understanding and responding to the language of the person can enhance care and reduce risks for staff and residents
- develop strategies for communicating and doing safety and care by using the language of the person where appropriate/possible
- explore ways of understanding and using language beyond words.

Research Centre for Languages and Cultures
2016

3

Outline objectives for this module.



'You just have to think very deeply, the only way to approach them is to be polite. Smile. And just make them feel very comfortable. That is the only way to deal with dementia. So most of the time, like she said, we sing together, just to create a very good atmosphere. We sing, we play music together. That's the only way we can distract them. Sometimes, maybe when they're aggressive, the only thing to bring them back to your level is to play music. Do something that you think they really love. That's basically how we create that connection. So if they're aggressive, things are not going to get done. They're very different individuals.

'Me as a person, I will take my time to get to know what Mr M. likes and what he doesn't like. What Martha likes, what she doesn't like. So I take my time to figure out a few things like that, which makes the job much easier.'

(Care worker, African background)

Research Centre for Languages and Cultures
2016

4

Use this slide to contextualise the focus of the module – the choices we make when communicating make a difference to how people understand and respond to us.

Outline

1. Understanding how people's use of language accomplishes safety and care
2. Considering how each person uses and understands language
3. Developing strategies for using the language of the person
4. Exploring language beyond words

Research Centre for Languages and Cultures
2016

5

This module is made up of four segments. (The segments may be completed individually or together.)

Segment 1

Understanding how people's use of language accomplishes safety and care

Research Centre for Languages and Cultures
2016

6

Video 3.1 Consider the perspectives of a trainer and three care workers discussing the role of language in safety and care.

Research Centre for Languages and Cultures
2016

7

Ask participants to consider the perspectives expressed in the video.

Play video 3.1.

Small group activity

In a group of three, take turns doing the following:

- Imagine that one of you and a partner are friends. One friend asks the other to tell you all about what they did at the weekend.
- Now imagine that the two friends are now strangers. One stranger asks the other about what they did at the weekend.
- The third person observes and notes down as many differences as they can between what was told about the weekend each time (e.g. the different words that you choose, the tone that you use in your voice, how you would use silence, the topics you include, and how much you say). (contd over)

Research Centre for Languages and Cultures
2016

8

(contd)

In your groups of three, discuss your responses.

- What do the responses show about your understanding of the relationship between you and the friend and you and the stranger?
- How does what you know about your friend and what you know about the stranger affect your responses? What would the friend and stranger think if you responded to the friend in the way that you responded to the stranger or the other way around?
- How are the two situations similar or different to how you would talk with a someone you care for or another person at work? What are you being careful about when you choose how to tell the story? What are the risks here? What might trigger the person to feel uncomfortable?

Research Centre for Languages and Cultures
2024

Bringing it together

- What key ideas emerged about the choices in language and why these are made?
- What does this tell us about how people choose and understand the language that they use with each other in the workplace?

Research Centre for Languages and Cultures
2024

In bringing the discussion together, emphasise that no one speaks the ‘same language’; that language use is always different and understood differently, depending on:

- a person’s relationship to the other person
- the situation
- the task at hand
- how they understand and relate to each other at the time they are together.

The key point is that it is normal to adjust choices in language to suit the person present and the current situation. *The better we know the language and culture, the person and the situation, the better we are at making these choices.*

If these choices are misjudged even slightly the person may misinterpret, or feel uncomfortable or uncertain about what is meant. These feelings of uncertainty pose risks.

Segment 2

Considering how each person uses and understands language

Research Centre for Languages and Cultures
2024

Occupational Therapist: Something meaningful to them.
Physio: Because people with dementia will just say 'Why?'
OT: So if they're going out with the family, 'So we'll get you up to get ready, you're going out with your daughter today. We'll take you to the shower. To the toilet.'
Registered Nurse: Even though you have to do that task, 'Do you want to pick out the nice blouse today so that you can go out?' 'You're still working towards the end goal, rather than saying 'You need a shower now.'
Researcher: So you link the end goal to the cues? To the person.
RN: You've got to know the person.

Research Centre for Languages and Cultures
2016

Video 3.2 Consider the perspectives of five care workers and a registered nurse on how language is used when approaching someone.

Research Centre for Languages and Cultures
2016

Ask participants to consider the perspectives expressed in the video.

Play video 3.2.

Individual or pair activity

- Think of a recent experience you have had of entering the room of a person you care for. What similarities and differences do you see between your experience and that of the people in the video, and the OT, Physio and RN in the slide.
- Now think of someone you might care for. Imagine that you know that the person is in pain, and that you are about to enter their room and to turn them over in bed.

Research Centre for Languages and Cultures
2016

Consider together

- What are the different ways that you could explain to them what you are going to do?
- Which way would you choose?
- What would you want to understand from them?
- What would you consider if the person was: someone you know, someone you don't know, a man, a woman, an adult, a child, someone for whom English is not their first language?

Research Centre for Languages and Cultures
2016

How might your answers be different:

- if the person was someone that you had not met before?
- if you were about to enter their room?
- if you knew that that the person had dementia?
- if you knew that they might show challenging behaviours or difficulty expressing their needs?

Research Centre for Languages and Cultures
2020

15

In each case:

- How might what you know about the person affect:
 - the choices that you make in your language with them
 - how you understood their responses,
 - how you respond to them?
- How would you tell if the person was becoming confused or upset?
- What would you do if they were becoming aggressive?

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2020

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Discuss together:

- What you would want to know before entering the room.
- What the person would know about you.
- How you would each decide to enter the room.
- How you would talk with the person (e.g. language, tone).
- What you would tell them about yourself.
- What you might be able to tell from their responses to you.
- What you would do if the person appeared upset or aggressive to you.
- What you might not be able to tell.
- How you could confirm/check your understanding.
- What you might still need to find out.
- Who the people are that you would talk with to find out.

Research Centre for Languages and Cultures
2020

17

Bringing it together

What key ideas have emerged about:

- how people make choices in their use of language use, how they understand language, and how they respond to it?
- how these choices can enhance care and reduce risk?
- how it is important to understand the people at the time we are with them in order to make these choices?
- how the people we are with can better understand the person if they are part of a team who can share and support each other's understanding?

Research Centre for Languages and Cultures
2020

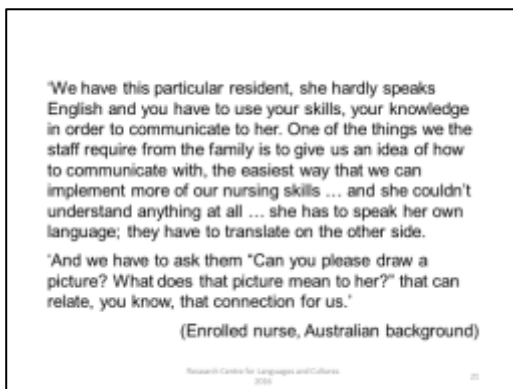
18

In bringing the discussion together, highlight the following:

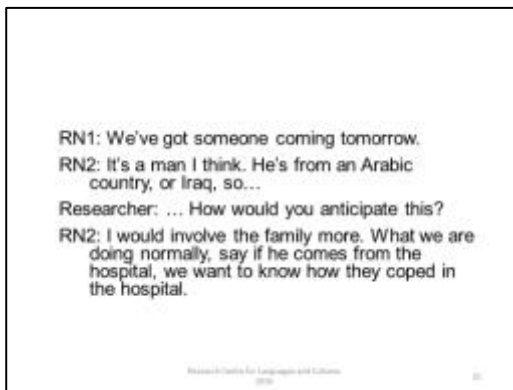
- choices in language are crucial to accomplishing care safely
- these choices are not only about what is said and how it is said, but about how people understand it, and how they respond to it
- making choices that support care and manage risk requires people to understand how they are going to be understood by others
- this highlights that communicating care and safety is accomplished together with those being cared for and in teams who share

different understandings of one another and those being cared for

- this places the responsibility on all to notice and share as much as possible about the whole person for safety and care.



Ask participants to consider the perspectives in the quote.



Small group or individual activity

Consider the experience of the nurses in the previous two slides. Think of an experience in which you are shortly to enter the room and care for a person whose language and culture you do not know.

Consider the risks for safety and care for the person and for you.

- How would knowing something of the person's language and culture help you each to reduce these risks?
- What would the person know of your language and culture?
- How might this become more complex because of language difficulties due to clinical changes?

Research Centre for Languages and Cultures
2024

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Video 3.3 Consider the perspectives of two care workers, an enrolled nurse and a registered nurse on communicating across languages and cultures.

Research Centre for Languages and Cultures
2024

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Ask participants to consider the perspectives expressed in the video.

Play video 3.3.

Small group or individual activity

Consider the ways you can learn with other staff and family about the resident's language ability, language/s and culture/s.

Write down an example of a time when you found out something important about a resident's language ability, language/s and culture/s from someone else.

- What did this help you translate for yourself / for the resident?
- What does this tell you about the resident? About yourself?

Research Centre for Languages and Cultures
2024

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'What are the basic words, we try to learn them, we try to understand. Ok, for the Vietnamese, for the Chinese 'Ni hao' or something. You know, those sorts of things, we try to get that from the family. 'What do you call this?', 'What do you call the shower?' So we'll get those words from the family. For the Vietnamese, I asked the lady, she is Buddhist, and when we've done something good, like when we took her to the toilet, and then after she was doing this (*gestures hands together praying*). And what does that mean? We didn't know. That means she was happy. If she's really, really happy, she does like this (*gestures and bows head*). That's the Buddhism. And one day I was telling her, I know the slogan of the Buddhism, I was praying to her like this, and she was laughing. We just try to get that word from their languages as well.'

(Care worker, Asian background)

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2024

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Small group activity

- In groups of four ask each other how you would answer the questions in the first task.
- Compare your experiences to that of the person in the previous slide. What similarities and differences can you see?

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2020

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Discuss together:

1. What you would want to know about the person's language ability, language/s and culture/s before entering the room
2. How you would each decide to enter the room
3. How you would talk with the person in their language and your language
4. What you might be able to tell from their responses
5. What you would do if the person appeared upset or aggressive to you
6. What you might not be able to tell
7. How you could confirm/check your understanding
8. What you might still need to find out
9. Who the people are that you would talk with to find out

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2020

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Bringing it together

What key ideas have emerged about:

- how you can discover important information about a person's language and culture from family, other staff or others?
- how you can use words or phrases of the person's language to reduce risk and build trust?
- how you communicate this information to others?
- why you should do this?
- how this influences communicating and doing safety and care together when people communicate (or don't communicate) this with others?

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2020

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In bringing it together, highlight the importance of understanding that:

- the diverse languages of staff, those being cared for and their families come into play as sources of knowledge and support for each other
- each person's language is the most important way in which they can make meaning with others
- if a person cannot be understood by others, they are isolated and potentially vulnerable and afraid
- people may revert to their first language because of, for example, dementia
- to use even a few words and phrases of another person's language and to show interest in their language and culture will help to build understanding, rapport and trust and enhance safety and care.

Segment 4

Exploring language beyond words

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2020

20

'The thing is, when you go there, you need to talk to them, eye to eye contact like this, and by touching, by the love, with a smiling face. How you approach them ... that behaviour comes with the approach.'

'That's why I do this myself ... Before when I used to see these people, I think they feel a bit scared of us, so if we touch them and make them secure, like they are secure with us, they feel that relationship between each other.'

(contd over)

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2020

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(contd)

'You were asking what other approach we have, we have Mrs E. who doesn't like to get up. If you just tell her, "I'm going to get you a cup of tea", that really works for her. You can say "Come with me, I'll give you a nice wash or shower and I'll get you a nice hot cup of tea". She'll get up. It depends who the resident is, what works for them. We have different kinds of approaches.'

(Care worker, Indian background)

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2020

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'...you see there is this problem here in Australia because in my country if you are like a year older than me, I have to respect you, I don't have the right to look you straight in your eyes while I'm talking to you ... yeah so when I came to Australia it was very difficult like in Australia here if you're talking to someone and you don't maintain the eye contact they look at you like you're lying to them but in my country it is quite different ... when you're talking to me like I'm talking to you now I don't have the right to look at you straight in the eyes ... it's disrespectful.'

(Care worker, African background)

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2020

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Consider

... the experience of the previous two care workers. Think of an experience in which you have been very anxious or upset and someone has made you feel less anxious.

- How close did they get to you?
- Did they touch you? Where did they look? How did they use their voice (e.g. softness, silence)?
- What did the person need to know about you to behave like this?
- What did you need to know about them?
- How did you know that the person intended to care for you?

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2020

Video 3.4 Consider the perspectives of three carers, one relative and a trainer, discussing different ways of interacting with those they care for.

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2020

Ask participants to consider the perspectives expressed in the video.

Play video 3.4.

Small group activity

Now think of a person you care for or a colleague who has been anxious or upset.

- How have you used your body and your voice to reduce their anxiety?
- How did you change the way you comforted someone depending on what you knew about the person and the reason they were anxious?

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2020

How would knowing something of the person's language and culture help you change the way you comfort them? What are the first things you might want to know about their language and culture? For example:

- How will they understand the way you use your body and your voice, how close you are to them, how and where you touch them?
- How will you understand their responses?
- How might you find out how?
- Who can you ask?
- Where can you look?

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2020

Small group or individual activity

Consider the ways you can learn with other staff and family about their experiences of being with the person.

Write down an example of a time when you found out from someone else something important about a person you care for or a staff member's behaviour and how they understood your behaviour.

- How did this help you to understand the person's behaviour and to behave with the person?
- What does this tell you about the person? About yourself?

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2016

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'It's very much detective work. Everything. Non-verbal things we're experts in. Just by the look of their face, or not participating in something that they'd usually participate in. It can just be so many things ...

'So if I notice that somebody is acting a little bit strangely, I'll ask the carers, 'OK, I had this issue, is this normal for them?' For me I have to ask, I usually ask. I mean, because I've been back for over a year now and even though I've been in each section once a week, I do get to see the residents and spend time with them, so I do get a general idea of what they're normally like, but if I'm not sure, I usually ask the carers.

(Enrolled nurse, Australian background)

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2016

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Small group activity

In groups of four ask each other how you would answer the questions in the first task.

Compare your experiences to that of the person in the previous slide. What similarities and differences can you see?

Discuss:

- What would you want to know about the person to be confident that you could understand their behaviour and they can understand yours?
- What would you do if the person appeared upset or aggressive to you?
- What might you not be able to tell?
- How could you confirm your understanding?
- What might you still need to find out?
- Who should you talk with to find out?

Research Centre for Languages and Cultures
2016

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Bringing it together

What key ideas have emerged about:

- how people might understand your gestures, facial expressions, the ways you stand, how and where you look, and how your language reveals your attitudes?
- how choices in these areas can enhance rapport, safety and care?
- how you can find out how people with different languages and cultures might understand each other's behaviour differently?
- how this information can be communicated to others?

(contd over)

Research Centre for Languages and Cultures
2016 41

(contd)

- why you should do this?
- how this influences *communicating* and *doing* safety and care together when you communicate (or don't communicate) it with others?

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2016 42

Reflection and application

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2016 43

'...some of them when they come here they don't speak a word of English, so we try to get translators interpreters to help out. But what I've done, it's easy to try learning their language and do that, each time I greet them, good mornings and good byes, and then they all start picking up English and then they'll learn 30 seconds, 60 seconds. "How do I say that?" and we'll have a joke about that and how that works. And through that it gets them engaged, to wanting to come back again.

'For those that are successful with these kinds of clients that we have, they actually do that, use their language, try to incorporate it... so for me the crucial thing is to get to know them. What their culture is. How would they like to be approached? How would they like their meal? Do they like hot coffee? Cold coffee? Do they like curry because they're Indian?' (Trainer, Asian background)

Research Centre for Languages and Cultures
2016 44

In bringing it together, highlight the importance of understanding that:

- the diverse knowledge of staff, residents and families come into play as sources of knowledge and support for each other
- each person uses their body (how close they are to the person, how, where and whether they touch them) and voice in their own ways to help others to understand what they mean and how they feel
- these ways are often specific to each individual and their needs
- if a person cannot be understood by others, they are isolated and potentially vulnerable and afraid
- residents may behave in new or different ways that are hard to understand because of, for example, dementia
- to observe and try to understand how another person uses their body and to use your bodies to help the other person understand what you mean and how you feel is important for building understanding, rapport and trust and so also to enhancing safety and care.

Emphasise the ongoing nature of *reflecting* and *acting* on emerging understandings of:

- when, how and why people make choices in their language and how they use their bodies to communicate with others
- how having an understanding of people's languages and cultures makes a difference to how people understand each other
- how understanding what each other means and feels enhances safety and care.

This requires people to work together to share their experience and understandings of communicating with each other to develop new ways of communicating and doing safety and care.

What next?

On your next shift:

- Find out something new about the language ability, language/s and culture/s of a person you care for by asking a family member or staff member.
- Find out how to do greetings in their language and use it when you enter the person's room.
- Ask about a word or phrase that you don't understand, that a person uses or that is important for understanding an object/photo/ornament in a resident's room. Then use it as a cue to have a conversation with the resident while you are caring for them.

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2020

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Over the next week – 'Person of the Week':

Working together with staff (and the family and others), focus on one person you care for at a weekly meeting or handover.

- What knowledge about communicating with the person could be shared to build rapport and a more trusting relationship with the resident, to better understand them and their needs?
- In which activities with the person would this be most important?
- What do you and other staff know/not know/need to know about the resident's language ability, language/s and culture/s that could help you do this?
- Plan and facilitate opportunities to communicate with this resident, for this week. At the end of the week, what have you learned/noticed? What could be done differently? How does this matter for safety and care?

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2020

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Further resources

Candlin, S. (2007). *Therapeutic communication: A lifespan approach*. Pearson Education Australia.
https://www.amazon.com/Therapeutic-Communication-Lifespan-Sally-Candlin/dp/0733985629/ref=sr_1_6?s=books&ie=UTF8&qid=1476345454&sr=1-6&keywords=sally+candlin

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2020

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Further resources

Candlin, S. (2007). *Therapeutic communication: A lifespan approach*. Pearson Education Australia. https://www.amazon.com/Therapeutic-Communication-Lifespan-Sally-Candlin/dp/0733985629/ref=sr_1_6?s=books&ie=UTF8&qid=1476345454&sr=1-6&keywords=sally+candlin

Evaluating learning after this module: Key questions for reflection

Reflecting on what you have learned in this module, consider the following questions and write a brief response for each one.

1. How does the language used among people affect how each person understands and responds to care?

-
-
-
-

2. What choices do people have in their communication together?

-
-
-
-
-

3. How do these choices matter for safety and care, particularly where there are
 - a. challenging behaviours or loss of language ability?
 - b. linguistic, cultural and faith-based diversity?

-
-
-
-
-

4. How can these choices be extended collaboratively and shared by nurses, care workers and families of residents?

-
-
-
-

5. What will I now do on my next shift?

-
-
-

Module 4:
Relating to the person with
challenging behaviours or unmet needs:
Personal histories, life journeys and memories

Module 4

Relating to the person with *challenging behaviours* or *unmet needs*: Personal histories, life journeys and memories

Objectives

In this module we will:

- explore principles for knowing ourselves and others through our past, present and imagined future lives
- consider how residents' personal histories, life journeys and memories impact on their needs and behaviours
- consider how a better understanding of residents' personal history, life journey and memories can contribute to safety, communication and care
- develop strategies for communicating and doing safety and care through knowing the person as a whole over time.

Outline

1. Exploring who we are: our past, present and imagined future lives
2. Understanding the influence of the past on the present self
3. Communicating the whole person in 'person-centred' care
4. Strategies for doing safety and care for the whole person

About this module

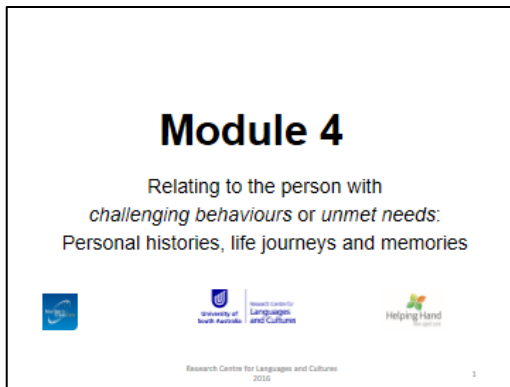
The aim of this module is to explore how residents' personal histories, life journeys and memories impact on their needs and behaviours. In person-centred care we tend to consider the person and their needs in terms of how they are now. We also need to understand a person as whole over time. In considering the role of a person's past, present and future, we can better understand their responses, behaviours and needs.

In a series of activities, this module will build on key ideas, safety and care principles, and practical strategies introduced in the three previous modules.

The focus will be on how a person's history, life journey and memories matter in care and safety. Working together, we will consider the challenges and opportunities presented when the person has challenging behaviours or unmet needs. This becomes more complex when there are multiple languages, cultures and faith backgrounds in play, and/or communication issues because of the person's clinical condition.




We will consider how the significant events and everyday social and work routines of a lifetime influence how people think, speak and act. In this module we will explore challenges and strategies for getting to know the resident as a whole person, to better communicate, plan and provide care in the safest possible way.

PRESENTER'S NOTES



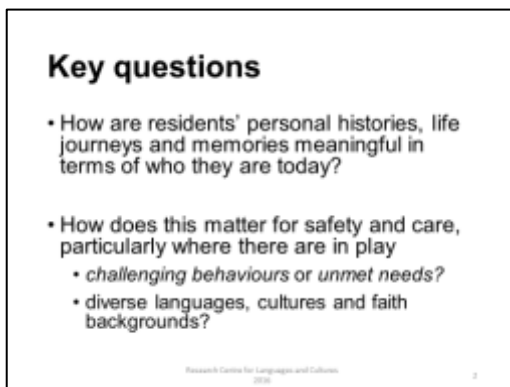
Module 4

Relating to the person with
challenging behaviours or unmet needs:
Personal histories, life journeys and memories

Research Centre for Languages and Cultures
2016 1

Briefly present the topic.



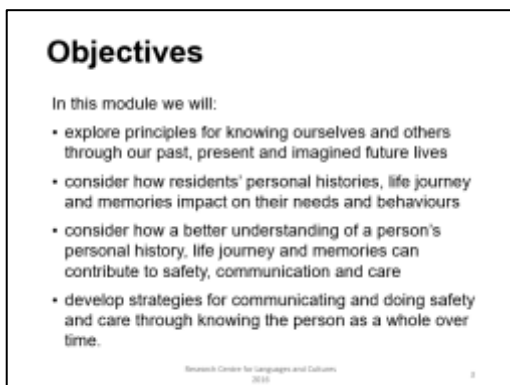
Key questions

- How are residents' personal histories, life journeys and memories meaningful in terms of who they are today?
- How does this matter for safety and care, particularly where there are in play
 - *challenging behaviours or unmet needs?*
 - diverse languages, cultures and faith backgrounds?

Research Centre for Languages and Cultures
2016 2

Introduce key questions to be considered.

Emphasise the importance/focus that will be given to safety and care in this training.



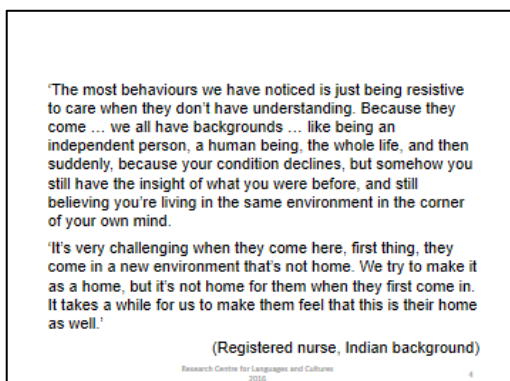
Objectives

In this module we will:

- explore principles for knowing ourselves and others through our past, present and imagined future lives
- consider how residents' personal histories, life journey and memories impact on their needs and behaviours
- consider how a better understanding of a person's personal history, life journey and memories can contribute to safety, communication and care
- develop strategies for communicating and doing safety and care through knowing the person as a whole over time.

Research Centre for Languages and Cultures
2016 3

Outline objectives for this module.



'The most behaviours we have noticed is just being resistive to care when they don't have understanding. Because they come ... we all have backgrounds ... like being an independent person, a human being, the whole life, and then suddenly, because your condition declines, but somehow you still have the insight of what you were before, and still believing you're living in the same environment in the corner of your own mind.

'It's very challenging when they come here, first thing, they come in a new environment that's not home. We try to make it as a home, but it's not home for them when they first come in. It takes a while for us to make them feel that this is their home as well.'

(Registered nurse, Indian background)

Research Centre for Languages and Cultures
2016 4

Use this slide to contextualise the focus of the module – each person has their own life history, journey and memories. This means their care, behaviour and needs will be different.

Outline

1. Exploring who we are: our past, present and imagined future lives
2. Understanding the influence of the past on the present self
3. Communicating the whole person, in 'person-centred' care
4. Strategies for doing safety and care for the whole person


Research Centre for Languages and Cultures
2018

This module is made up of four segments. (The segments may be completed individually or together.)

Segment 1

Exploring who we are: our past, present and imagined future

Research Centre for Languages and Cultures
2018



Research Centre for Languages and Cultures
2018

Individual activity

Write down five things about your past that you consider make you the person you are today and that you would feel comfortable sharing with another person.

- Why did you choose these particular memories?
- How are they meaningful to you?
- How well do these five things capture who you are?

Research Centre for Languages and Cultures
2018

Small group activity

- In groups of three or four, discuss and group the responses.
- What do the responses show about your understanding of the relationship between your past and present? In what ways are these memories meaningful for you?
- How well do these 5 things capture who you are?

Research Centre for Languages and Cultures
2016

9

Video 4.1. Consider the perspectives of two care workers, two nurses, and a manager on the value of exploring connections between past and present for those you care for.

Research Centre for Languages and Cultures
2016

10

Ask participants to consider the perspectives expressed in the video.

Play video 4.1.

Bringing it together

What key ideas have emerged about how our personal histories, life journeys and memories have meaning in our lives today?

Research Centre for Languages and Cultures
2016

11

In bringing the discussion together, highlight how:

- a person understands themselves as a whole over time, even if we can only see them in terms of their present physical self
- feeling 'at home' in a new environment takes time and can lead to a sense of losing part of one's identity.

Segment 2

Understanding the influence of the past on the present self

Research Centre for Languages and Cultures
2016

12

'... you're not just thinking that person in front of you is not capable of things, she was someone else before. Thinking, flashbacks, the kind of things they have been doing before. Just thinking those things, and just acknowledging their thoughts. Just providing them the care, the person in front of you, their whole life, and what their needs and their feelings could be.'

(Registered nurse, Indian background)

Research Centre for Languages and Cultures
2016 13

Video 4.2. While watching the video, consider the perspectives of a trainer, a nurse and a care worker on how the past influences the present.

Research Centre for Languages and Cultures
2016 14

Ask participants to consider the perspectives expressed in the video.

Play video 4.2.

Individual or pair activity

Think of a person you currently care for.

- What do you know about their past? What don't you know?
- How do you think their past influences their needs and their behaviour in the present?
- How do you think this might affect safety and care? What options do you consider?
- How do you explain some of the difficulties? How do you confirm your own understanding?

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2016 15

Small group activity

In groups of four, discuss and group the responses.

- What do the responses show about how you understand another person?
- How does your understanding of a person's past influence how you:
 - know them now?
 - communicate with them?
 - decide what not to do?
 - make decisions about appropriate safety and care?

Research Centre for Languages and Cultures
2016 16

Bringing it together

What key ideas have emerged about:

- how we understand another person, both their present and their past?
- how we understand the relationship between a person's past and their current needs and behaviours?
- how this influences *communicating* and *doing* safety and care?

Research Centre for Languages and Cultures
2016

17

In bringing the discussion together, highlight how:

- to understand what someone's unmet needs might be, we have to know the whole person, not just who we see now
- there are implications for safety and care when a person remembers themselves as independent, but now feels they have less control over their choices in daily life
- in order to make appropriate decisions about safety and care, we need to know the whole person, in terms of their significant past history, life journey and memories.

Segment 3

Communicating the whole person, in 'person-centred' care

Research Centre for Languages and Cultures
2016

18

"You know, to be person-centred, but to find things, normally you go into a person's room and you'll see family photos, that they love horses or dogs, and you pick up something to actually have some discussion with them ...

And it struck me that it's probably something we don't talk to staff about. About how you find those connections, apart from we always say, "That's our policy, you go to the care plan, that's where the information is", but the reality is unfortunately we're not though, that doesn't always happen.

We have to also then think of other cues and other ways we can get that information. Sometimes it is by talking to other staff members, but that can be skewed as well, that becomes difficult." (Trainer, Australian background)

Research Centre for Languages and Cultures
2016

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Individual or pair activity

- Consider the ways you use to find out about a person you are caring for.
 - Who can you ask?
 - Where can you look?
- Consider the ways you communicate with other staff and family about the personal history or life journey of someone you care for.
- Write down an example of a time when you found out something important about the personal history of someone you care for and communicated it to someone else.
- What does this tell you about the person? About yourself?

Research Centre for Languages and Cultures
2016

20

Video 4.3. Consider the perspectives on communication of four carers and a family member in the following video.

Research Centre for Languages and Cultures 2016 21

Ask participants to consider the perspectives expressed in the video.

Play video 4.3.

Small group activity

- In groups of three or four:
 - exchange examples of times when you discovered something important about the personal history of someone you care for and communicated it to someone else
 - exchange examples of times when you were not told something significant about the personal history of someone you care for.
- How might this impact on safety and care for you and the person you care for?

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Bringing it together

What key ideas have emerged about:

- how we discover important information about the personal history of someone we care for?
- how we communicate this information to others?
- why we should / should not do this?
- how this influences doing safety and care together when we communicate (or don't communicate) this with others?

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In bringing the discussion together, emphasise that:

- caring for someone involves knowing more than their behaviours or superficial information, such as likes and dislikes
- caring for the whole person involves making meaningful connections with them in conversation while giving care
- care plans and cues can be helpful, and developing a rapport moment by moment with a person is crucial for safety and care
- sharing what works and drawing on the resource of the family is important.

Segment 4

Strategies for doing safety and care for the whole person

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Video 4.4. Consider the perspectives of four care workers, two nurses and a manager on possible strategies for caring for the whole person.

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Ask participants to consider the perspectives expressed in the video.

Play video 4.4.

'So we, for men, they recommend that we make an area that looks like an office, or creating a shed or something for them, that they can work in. We need to know what happened in the bad past history, that's also helpful for us, to avoid those things with him. Like noise he didn't cope with. So we have happy hours down here on Thursdays, which is quite noisy for him, so we try to limit, minimise that. We either take him for a walk upstairs when we're having happy hour downstairs, or alternatively, move the piano thing happening or anything loud, away from him. And he has particular movies that he likes. I don't know the names because it's been a while.'

(Registered nurse, Indian background)

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Small group activity

- Consider together the different ways you do safety and care based on how you know someone you care for as a whole person (their past, present and imagined future).
- Think of a person you currently care for and how you know them in terms of their past (work / interests / life journey)
 - What meaningful activities do you provide the person with?
 - What activities do you minimise/avoid for this person?
 - How does this matter for safety and care?

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Bringing it together

What key ideas have emerged about:

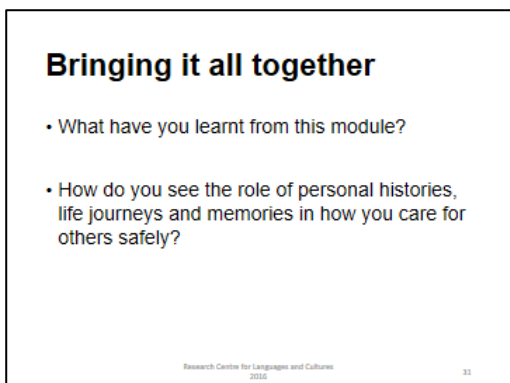
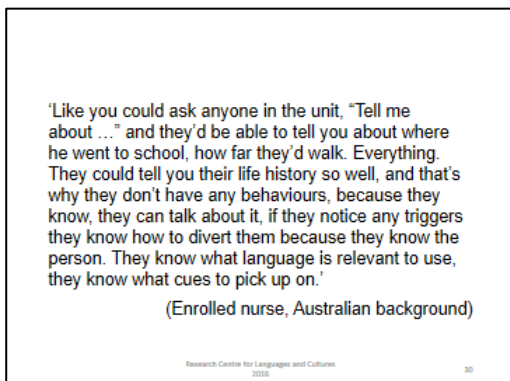
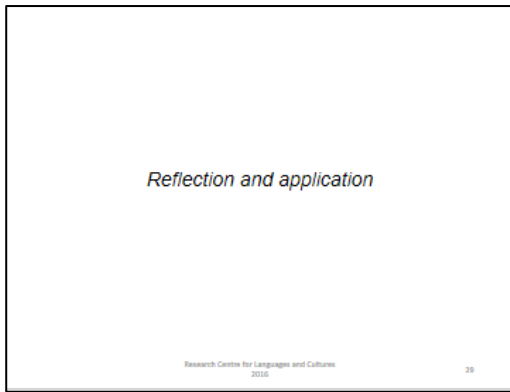
- the value of understanding the whole person over time (past, present, future)?
- how knowing a person as a whole can suggest meaningful activities to engage them in?
- how engaging a person in meaningful activities can make a difference for their safety and care?

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In bringing the discussion together, highlight how:

- knowing a person in terms of their past helps in finding meaningful activities that they will engage in
- there may be some activities that will be best to avoid because of a person's negative past experiences, and it will be important to communicate this with colleagues
- engaging a person in meaningful activities can enhance safety and care.



In bringing the discussion of the whole module together, emphasise the ongoing nature of *reflecting* and *acting* on emerging understandings of how:

- caring for someone involves knowing more than their behaviours and it helps to understand potential unmet needs
- understanding the influence of the past on the present makes a difference in how people understand and communicate, and in developing rapport with one another
- understanding, communicating and developing rapport with one another enhances safety and care
- the value of working together with staff, the person being cared for and family, to know the whole person over time.

What next?

On your next shift:

- Find out something new about the life journey of a person you care for by asking a family member or staff member.
- Ask about an object / photo / ornament in a person's room and then use this as a cue to have a conversation with them while you are caring for them.

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What next?

Over the next week – 'Person of the week':

- Working together (not just 'lifestyle' care workers or 'diversional therapists'), focus on one person you care for at a weekly meeting or handover.
 - What knowledge about the whole person could be shared to better understand them and their needs?
 - What meaningful activities do they participate in?
 - How did you decide what would be meaningful?

(contd over)

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(contd)

- Plan and facilitate a meaningful activity for this person, for this week.
- At the end of the week, what have we learned/noticed? What could be done differently? How does this matter for safety and care?

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Further resources

- Alzheimer's Association information relevant to this module, for example,

https://www.fightdementia.org.au/files/NATIONAL/documents/FamilyAndFriendsMatter_english.pdf

- Movie *Still Alice*, <https://nt.fightdementia.org.au/nt/news/still-alice>

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Point out further resources.

Further resources

Alzheimer's Association information relevant to this module, for example,

https://www.fightdementia.org.au/files/NATIONAL/documents/FamilyAndFriendsMatter_english.pdf

Movie *Still Alice*, <https://nt.fightdementia.org.au/nt/news/still-alice>

Evaluating learning after this module: Key questions for reflection

Reflecting on what you have learned in this module, consider the following questions and write a brief response for each one:

1. How are residents' personal histories, life journeys and memories meaningful in terms of who they are today?

-
-
-
-
-
-
-

2. How does this matter for safety and care, particularly where there are

- a. challenging behaviours or unmet needs?
- b. diverse languages, cultures and faith backgrounds?

-
-
-
-
-
-

3. What will I now do on my next shift?

-
-
-
-
-
-

Module 5:
Managing risk in relation to
challenging behaviours or unmet needs

Module 5

Managing risk in relation to *challenging behaviours or unmet needs*

Objectives

In this module participants will:

- understand how people recognise and identify behaviour as posing risk to safety and care
- consider how risk can be created by people communicating together in care
- explore the communicative choices people have to manage risk
- develop strategies for communicating that build rapport and minimise risk to safety and care.

Outline

1. Understanding how people recognise and identify behaviour as posing risk to safety and care
2. Considering how risk can be created in communication among people
3. Exploring the communicative choices people have to manage risk
4. Developing strategies for communicating in ways that build rapport and minimise risk to safety and care

About this module

The aim of this module is to develop shared understandings of the value for safety and care, of knowing:

- about the choices that are available to those concerned with safety and care for building trust and rapport
- how to plan and enable appropriate choices for each person
- how these choices can reduce risk and support safety and care among residents and staff.

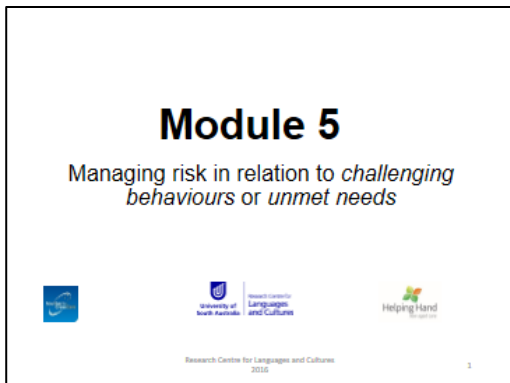
The focus is on how staff and residents can work together to reduce risk and optimise care in situations where a person may show challenging behaviours, especially when the people present may not be familiar with each other's languages and cultures. Challenging behaviour is a response to something that people, including the person showing the behaviour, may or may not understand. It can pose serious physical and psychological risks to those concerned. The behaviour is more likely to occur and be challenging if there is mistrust.

Trust depends on each person being confident that others value them and that what the other people say and do will bear this out. However, the meaning of what people say and do will be interpreted differently depending on a person's clinical condition, as well as the past life, present understanding and language and culture of each person present. The upshot is that people together create trust as well as risk; a behaviour is seen as aggressive or challenging based on what the people involved understand about each other. The less they understand and trust each other, the more likely it is that a person's behaviour will be perceived as

aggressive or challenging and the harder it will be to respond in a way that reduces risk and builds trust and rapport.

This module consists of a series of activities relating to the ways in which nurses, care workers, residents and their families can work together to manage risk in relation to challenging behaviours in contexts of linguistic, cultural and faith-based diversity. The module builds on the key ideas, safety and care principles, and practical strategies introduced in the previous four modules.

PRESENTER'S NOTES



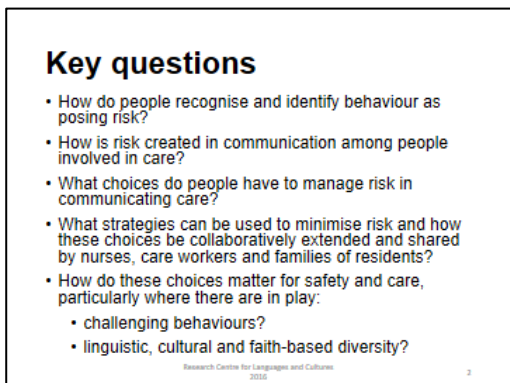
Module 5
Managing risk in relation to *challenging behaviours or unmet needs*

Logos for University of South Australia, Research Centre for Languages and Cultures, and Helping Hand.

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1

Briefly present the topic.



Key questions

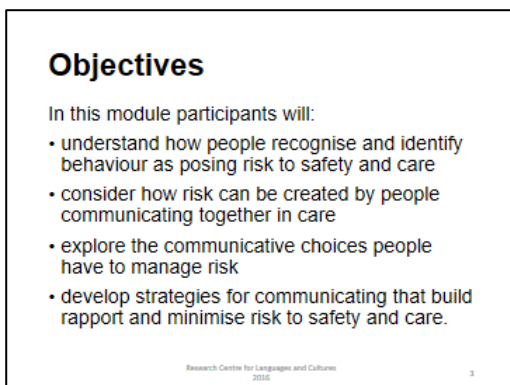
- How do people recognise and identify behaviour as posing risk?
- How is risk created in communication among people involved in care?
- What choices do people have to manage risk in communicating care?
- What strategies can be used to minimise risk and how these choices be collaboratively extended and shared by nurses, care workers and families of residents?
- How do these choices matter for safety and care, particularly where there are in play:
 - challenging behaviours?
 - linguistic, cultural and faith-based diversity?

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2

Introduce key questions to be considered.

Emphasise the importance/focus that will be given to safety and care in this training.



Objectives

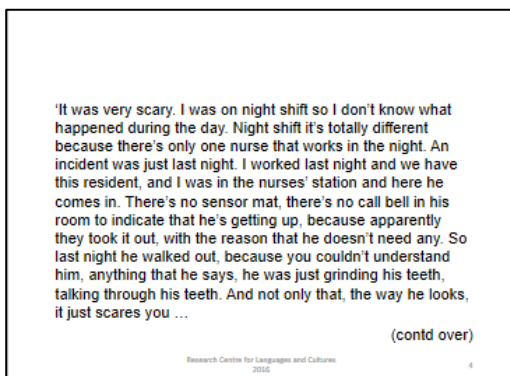
In this module participants will:

- understand how people recognise and identify behaviour as posing risk to safety and care
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3

Outline the objectives for this module.



'It was very scary. I was on night shift so I don't know what happened during the day. Night shift it's totally different because there's only one nurse that works in the night. An incident was just last night. I worked last night and we have this resident, and I was in the nurses' station and here he comes in. There's no sensor mat, there's no call bell in his room to indicate that he's getting up, because apparently they took it out, with the reason that he doesn't need any. So last night he walked out, because you couldn't understand him, anything that he says, he was just grinding his teeth, talking through his teeth. And not only that, the way he looks, it just scares you ...

(cont'd over)

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4

Use this slide to contextualise the focus of the module – that the choices we make impact on how we build trust and relationships. Trust and relationships between people influence how we manage care, safety and risk.

(contd)

'I spoke to the registered nurse who was working this morning and I told her 'Round about 3.30 in the morning, that's when the behaviour arises. When his behaviour arises, I intend to prepare food for him or a warm drink, a cordial, ready for him, and it actually works for him and he goes back to lie down and apparently last night he went straight to room number 9, and it's a lady. She was distraught, she was crying.'

(Enrolled nurse)

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What are behaviours of concern?

'A behaviour of concern is any behaviour which causes stress, worry, risk of or actual harm to the person, their carers, staff, family members or those around them. The behaviour deserves consideration and investigation as it is an obstacle to achieving the best quality of life for the person with dementia and may present as an occupational health and safety concern for staff.'

(DBMAS, 2012, p. 5)

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Outline

1. Understanding how people recognise and identify behaviour as posing risk to safety and care
2. Considering how risk can be created in communication among people
3. Exploring the communicative choices people have to manage risk
4. Developing strategies for communicating in ways that build rapport and minimise risk to safety and care

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This module is made up of four segments. (The segments may be completed individually or together.)

Segment 1

Understanding how people recognise and identify behaviour as posing risk to safety and care

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'The only thing that I tell new people is to be careful, be watchful. You might be having a very good conversation and within a minute they will switch. So you need to watch out for things like that.

'I've been working with someone and they were just talking "Blah, blah" and the next thing "Boom".'
[gestures being punched].

(Care worker, African background)

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Triggers that may contribute to the behaviour

'Trying to identify what might contribute to the behaviour of a person with dementia is a key element of the assessment process – these may be discussed as **triggers** for the behaviour which once identified provides the focus for interventions to reduce the behaviour itself and the impact of the behaviour on those involved.'

(DTSC, 2013, p. 24)

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Individual or pair activity

Compare what happened when someone you know well and someone you do not know was annoyed or aggressive with you. In each case, consider:

- what led up to this, why they were responding to you like this and what the risks were for you and for them
- how and when you knew the person was annoyed with/aggressive towards you
- how you felt and how your feelings affected how you responded

(contd over)

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(contd)

- how you responded (the language that you chose and how you used your body)
- why you responded like that for each person
- what you understood about each person to make sure that they understand your response as you intended it
- other ways you could have responded that might have made the situation better or worse.

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'Yesterday, what happened, I'll tell you. Up there is Vera, she's very good with me. Some people say she is very aggressive with them. She's very good with me. I just go and take my time. I was just taking off her shirt, it was just a little bit, I was just taking it over her head, it was a little bit stuck. She was a bit aggressive at that time. 'No!' I said 'Vera, give me a good hug, don't worry I'm not hurting you,' and she gave me a hug. So I think love is good.

(contd)

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13

(contd)

'But the dementia we can say that, but every time they change their behaviour. So we're just careful at that time. Another carer, she was like 'Just leave her if she's aggressive'. I said 'OK, I'll try, if she's OK I'll try, if she's aggressive I'll leave'. But she was good. Maybe she understood at that time that I was not hurting her, just helping.'

(Care worker, Indian background)

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Video 5.1. Consider the perspectives of three carer workers, an enrolled nurse, a registered nurse and a trainer, on how to recognise and identify behaviour as posing risk.

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Ask participants to consider the perspectives expressed in the video.

Play video 5.1.

Small group activity

In groups of three, compare your experiences to the experience of the care worker in Slide 13 -14 and those in the video.

Consider:

- How you identify whether a person is annoyed or aggressive? What are the differences?
- How do you respond to them if you know them and if you do not?
- What are you being careful of and what it would help you to know about the person in each case?

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Discuss together

- What triggers help you to know when a person is annoyed?
- What do you need to know besides the triggers in order to respond in a way that reduces the risks?
- What difference does it make to know something about the person's clinical condition, their past, their family, their language and their culture?
- How does this understanding change the way you behave with the person?
- What risks does this understanding of the person minimise?

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Bringing it together

- What key ideas emerged about how people identify a behaviour that may be challenging? About what people need to know to identify this correctly and to respond in way that reduces risk?
- What difference does it make if you know something about a person's clinical condition, their past and present situation, their family and their language and culture?

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In bringing the discussion together, emphasise the following:

- A behaviour that is interpreted as aggressive or challenging is a response to something that other people may or may not understand.
- Other people may not interpret this behaviour correctly if they do not understand
 - what it is a response to
 - that the meaning of this behaviour may be different depending on a person's clinical condition, their past life and present situation, and their language and culture.
- The key points:
 - How a person behaves with you is their response to you, based on their understanding of what you mean by your behaviour. How you respond to another person's behaviour is likewise based on how you understand what they mean in response to you.
 - The upshot is that a behaviour is considered aggressive or challenging based on what the people involved understand about each other. The less they understand each other, the more likely either person's behaviour will be interpreted as aggressive or challenging by the other.

Segment 2

Considering how risk can be created in communication among people

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Individual or pair activity

Consider what you would think and feel if you became seriously ill in a country where you were travelling alone, did not know the language or culture, and other people did not know you or your language and culture.

- What would you do?
- What help would you try to get?
- Who would you trust?
- What risks would you fear if a stranger offered to help you?
- What could reassure you to trust the person?
- What would reassure them to trust you?

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'Upstairs there's a lady, she used to like me, but all of a sudden she kept telling people she doesn't want me near her any more. Up to now, I still don't understand the reason why. So I went to speak to the clinical nurse about it, and she said 'she has a new care plan now, it indicates that she doesn't want men any more'. So she has a choice.

'So yeah ... whenever I'm working at that wing, they have to send me to a different wing and get someone over to attend to her care. So I've seen that a lot. I've seen people that don't like me because I'm black. They've said it directly to me.'

(Care worker, African background)

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Small group activity

- In groups of three, ask each other how you answered the questions in the first task.
- Compare your experiences to the experience of the person in the previous slide.
- What similarities and differences can you see?

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'Another example is Sarah. That lady she is very, everybody goes, "I can't do her". "OK, come with me, I'll show you how we can handle her". That lady, you're just telling everything to her. Everything. If it's a small thing you're doing, just let her know. And don't rush. "Sarah, it's time to go to the toilet" [speaking slowly]. She just looks at me and I'm "Yes, time to go to the toilet" [whispers]. "So now, I put the walker here, you just hold it here, now stand up, that's it". She does it. "Now you walk. Come with me. Come to the toilet. Sarah, now it's time to sit up". Every single line you tell her and she is easy. If not, if you rush, she's "Oh! Don't worry, don't do anything. No, no, no, nothing. I don't want anything".' (Care worker, Indian background)

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Video 5.2. Consider the perspectives of four carer workers, a registered nurse and an enrolled nurse on how risk is created in communication.

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Ask participants to consider the perspectives expressed in the video.

Play video 5.2.

Small group activity

Based on your own experiences discuss:

- Which people are you most comfortable being with and who is most comfortable with you, and why?
- What does this reveal about assumptions other people have about you, and that you have about other people (e.g. their personality, age, nationality, language, culture, religion, colour, health, gender, occupation)?

(contd over)

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(contd)

- How can these assumptions lead to mistrust by distorting
 - how you appear to other people and how they respond to you?
 - how they appear to you and how you respond to them?
- To reduce these assumptions and risks, what does another person need to know about you and what do you need to know about them?
- How could you find out and confirm your understanding?
- What might you still need to find out?
- Who would you talk with to find out?

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Bringing it together

What key ideas have emerged about the following:

- How does having assumptions about each other raise the risk of misjudging what each other says and does, and how people respond based on these misjudgements?
- How can these misjudged responses confirm for people their assumptions about each other?
- How can you enhance care and reduce the risk of challenging behaviours arising by reducing assumptions and finding about each other?

(contd over)

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In bringing the discussion together, highlight how:

- making choices that support care and reduce and manage risk requires people to understand *how* they are going to be understood by each other
- assumptions about each other can distort how people choose to understand everything that they say and do with each other
- this highlights how *risk as well as safety is created in communication among people* and how safety is accomplished together, with teams (including staff, residents and families) who can share different understandings of each other
- this places the responsibility on each person to notice as much as possible about the whole person for the sake of safety and care.

(contd)

- How can you enhance care and reduce the risk of misunderstanding, tension and unpredictable responses on each side by seeking to understand a person, not only when you are together, but over time and from their point of view?
- How people can better understand each other if they are part of a team who can share and support each other's understanding?

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Segment 3

Exploring the communicative choices people have to manage risk

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'A lot of us well we have to rely on the regulars a lot more, so we'll be asking them a lot. Sometimes it takes me longer. If you don't know the residents it takes longer. The drug round used to take me a lot longer than it does now, because once you know the residents, you know individual tactics that work for each resident. A lot of them don't want to take their medication, and you'll go back three or four times, but once you work out, "What's the thing that will help with that resident?" Then it usually works unless they're having a bad day...

(contd over)

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30

(contd)

A lot of it is practice. "What do I need to do?" So alright, is the room hot? So if I'm going to shower someone I'm going to need all these things. Towels, soap, everything before I start, and make sure that the room is warm enough.

'So just planning out in your head what you're going to do. So it's like two things, treating people with respect and decency, and planning out what you're going to do before you do it so that you can carry it out smoothly without endangering people's safety.'

(Enrolled nurse, Australian background)

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Individual or pair activity

Consider the experience of the nurse in the previous slide.

Think of an experience in which you are told that a person you are caring for later that week may show behaviours of concern and that they come from a language and culture that you do not know.

Consider the following:

- How would you plan the encounter and what choices do you have in how you appear to the person, how you talk and behave with them?

(contd over)

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(contd)

- What would you need to know about the person and what might the person need to know about you? Knowing something about each other's language and culture could help each of you to build rapport.
- What are the first things that you might want to know about their language and culture?
- How will you talk and behave with the person? E.g.
 - How will you address them?
 - What will you call them?
 - How will you introduce yourself?
 - How you will explain what you are doing?
 - What will you say and do if the person seems agitated or fearful?

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RN 1: This is the priority, we believe in the whole person. At the end of the day, we cannot make them upset, the task is important ... We know the consequences if the care hasn't been met, a particular task hasn't been done, what the bad consequences can be, but the person doesn't understand because that person's going through depression, going through other medical conditions, or maybe pain.

They don't know what's going on, so we need to focus on why. Not forcing that person to do something. Giving them choices about what they'd like to be doing. Sometimes they'll allow you to wash their face. Giving them other options. Giving them the right to choose. (Indian background)

(contd over)

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(contd)

RN2: Sometimes we'll get her to hold onto something, like a baby doll. Or we'll give them a hot towel sponge, and that's a wash. (Asian background)

RN1: So distraction, trying different therapies. The doll therapy works with female residents. There is always some ways we have to find. (Indian background)

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Video 5.3. Consider the perspectives of a manager, a registered nurse and three care workers on communication and managing risk.

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Ask participants to consider the perspectives expressed in the video.

Play video 5.3.

Small group activity

In groups of three:

- compare how you answered the questions in the first task in this segment.
- compare your experiences to those of the people in the video and the RNs in the previous slides.

What similarities and differences can you see?

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Discuss together

- How would you plan to appear to, and talk and behave with, a person who may show challenging behaviours?
- What would you find out about the person to give them choices that can develop trust and rapport between you?
- How would you find out about the person?
- How would you talk with the person in their language and your language about what you have planned, e.g. about a doll if you were giving to the person?
- What might you be able to tell from the person's responses? (contd over)

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(contd)

- What choices would you give yourself and the person if they seem agitated or aggressive?
- What might you not be able to tell?
- How could you confirm your understanding, and what might you still need to find out?
- Who could you talk with about how best to plan and afterwards talk about your experience with the person?

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Bringing it together

What key ideas have emerged about:

- how you can plan to talk and behave with a person who may show behaviours of concern?
- how finding out about the person, including their life, family, language and culture as well as their health can give people choices about how to appear to others and how to interpret what others say and do, that will increase care and reduce risk?
- how you can take a stance to communicating care that reduces risk and builds trust by attending to the other person's world as it is meaningful to them, and therefore includes the use words or phrases of their language and culture?

(contd over)

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In bringing the discussion together, highlight the importance of understanding:

- the importance of planning together the communicative choices that people give to others and themselves
- that knowledge of a person's care plan is necessary but so are the diverse experiences, knowledge, and languages and cultures of staff, residents and families as sources for planning how to be with people, especially in potentially high-risk moments
- that each person's language is the most important way in which they can make meaning with, appear to and come to trust and be trusted by others
- that points 1-3 are important in general, but especially for managing risk in situations that may involve challenging behaviours
 - where you and the person may not be familiar with each other's languages and cultures
 - where the person is losing their ability to use language

(contd)

- how you can communicate care in ways that acknowledge potential language difficulties of the person with dementia?
- how you communicate this information to others?
- why you should do this?
- how this influences communicating and doing safety and care together when people communicate (or don't communicate) this with others?

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Segment 4

Developing strategies for communicating in ways that build rapport and minimise risk to safety and care

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'They're not living in our workplace; we're actually working in their home. And that's where we have to change the perception and attitudes. So all this hurrying up and having this on time and the manager's saying you have to do it, 'Have you done it?', this all comes from the old culture. Now we have just changed the way we work. Full stop. And if they want to have a shower at four o'clock pm well that's their home, so then we have to adapt, simply to give them the shower at 4 pm. Don't wash them at 10 o'clock when they may be drowsy, tired and anxious, not a morning person, whatever the reason.'

(Trainer, European background)

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Individual or pair activity

Consider the experience of the trainer in the previous slide.

In each of the following cases, compare how you would feel if you were ill and a stranger whose language and culture you were not familiar with was treating you (a) in your home and (b) in hospital:

- how you would feel if the person got on with the task but did not seem interested in you or to care about you
- how the person might speak or behave that could upset or make you anxious or not trust them to care for you
- how the person could speak or behave with you to reassure and build trust and rapport with you.

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'The only thing that I tell new people is to be careful, be watchful. You might be having a very good conversation and within a minute they will switch. So you need to watch out for things like that. I've been working with someone and they were just talking "Blah, blah" and the next thing, "Boom".' [*gestures being punched*].'

(Care worker, African background)

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'Sometimes, if you don't want it to escalate, you persuade them, if they refuse to listen, you have no choice, you just go, and come back. Come back with a different approach, change something.'

Care worker, African background)

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'So you can have very, very resistive behaviour where you go in and the person just resists everything that you do. And for that we would say, "Go away, let them settle, come back and try again later".

'They can lash out, they can be verbally abusive, they can be physically abusive.'

(Trainer, Australian background)

Small group activity

- In groups of three or four, ask each other how you would answer the questions in the previous (individual or pair) activity.
- Compare your experiences to the experiences of the people in the previous slide.
- What similarities and differences can you see?

Discuss together

- By how you speak and behave, how can you help a person to understand that they are more important to you than the task that you need to do with them?
- What ways of interacting with the person can you learn from the experiences of other staff and family?
- What can this tell you about the person as they change over time? About yourself as you change over time?

(contd over)

(contd)

- How can this help you predict and manage the situation when you are with the person?
- How could this change how you would speak and behave if the person appears agitated or aggressive?
- How might this change how you would explain what happened in reporting this as an incident report?

Video 5.4. Consider the perspectives of two care workers, an enrolled nurse and a registered nurse on developing strategies for working together and communicating to minimise risk.

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Ask participants to consider the perspectives expressed in the video.

Play video 5.4.

Bringing it together

What key ideas have emerged about:

- how you can help the person to understand that they are more important to you than the task you/they need to do?
- how giving the person and yourself choices in this area while you are with them can enhance rapport, safety and care?
- ways in which you can plan, observe and work together with the person and others (staff, residents, family) to help you to decide which choices to give the person and yourself?
- how this information can be communicated to others?
- why you should do this?

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Highlight the importance of understanding that:

- when care is carried out in a person's home, everyone else may appear to the person as a visitor or guest, and therefore is less trusted and more of a potential risk
- a person can feel especially at risk, vulnerable and afraid if made anxious or uncomfortable in their home
- to emphasise getting the task done rather than what the person themselves would choose may leave the person feeling disregarded in their own home and more at risk
- how to speak and behave appropriately in a person's home to increase trust and reduce perceptions of risk is specific to each individual, their needs, and their language and culture, and may change over time, especially if the person has dementia
- key to building rapport and minimising risk is planning, observing and sharing information together with the person and others (staff, residents, family) to help you to decide which choices to give the person and yourself.

Reflection and application

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'They need to take a deep breath and step back and look at things critically. So 'What do I need to achieve this task?' A lot of it is practice. 'What do I need to do?' So alright, is the room hot? So if I'm going to shower someone I'm going to need all these things. Towels, soap, everything before I start, and make sure that the room is warm enough. So just planning out in your head what you're going to do. So it's like two separate things, treating people with respect and decency, and planning out what you're going to do before you do it so that you can carry it out smoothly without endangering people's safety.' (Enrolled nurse, Australian background)

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Bringing it all together

Consider the different perspectives on managing risk that have been discussed in this module.

- What choices do you and others have to manage the risk of challenging behaviours when you are together?

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What next?

On your next shift:

- Think of a routine task that you do with a person you care for.
- Plan how you speak and behave differently while doing the task to enhance trust with a person. This may mean finding out something new about the person, their clinical condition, their life and their language and culture, from the person, their room, other residents, their family or staff.

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Over the next week – 'Person of the Week'

Working together, focus on one person you care for at a weekly meeting or handover.

- What knowledge about trust and communication with the person could be shared to build rapport and a more trusting relationship with the resident, to better understand them and their needs?
- In which activities with the person would this be most important?
- What do you and other staff know / not know / need to know about the person's language ability, language and culture that could help you do this?
- Plan and facilitate opportunities to enhance trust and reduce risk with this resident, for this week.
- At the end of the week, what have you learned/noticed? What could be done differently? How does this matter for safety and care?

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Emphasise the ongoing nature of *reflecting* and *acting* on emerging understandings of:

- when, how and why people make choices in how they speak and behave with others to develop and build trust and rapport
- how understanding of each person's language ability, languages and cultures makes a difference to how people understand and trust each other
- how understanding and trusting what each other means and feels enhances safety and care

This requires people to notice, record, meet regularly with, and support each other in comparing, sharing, reflecting on and acting mindfully in light of their experience and understandings of communicating with each other. In this way they can create new ways of developing trust in doing safety and care.

Further resources

Dementia Training Study Centres (2013). *Introduction to assessment and management of behavioural and psychological symptoms of dementia for novice clinicians – online educational resource*, <http://dtsc.com.au/resources/online-resources/>

Alzheimers Australia (2012). *ReBOC Guide (Reducing Behaviours of Concern)*, <http://dbmas.org.au/resources/library/>

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Further resources

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Evaluating learning after this module: Key questions for reflection

Reflecting on what you have learned in this module, consider the following questions and write a brief response for each one:

1. How do people recognise and identify behaviour as posing risk?
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 -
 -
2. How is risk created in communication among people involved in care?
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 -
 -
3. What choices do people have to manage risk in communicating care?
 -
 -
 -
4. What strategies can be used to minimise risk and how can these choices be extended collaboratively and shared by nurses, care workers and families of residents?
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 -
 -
 -
5. How do these choices matter for safety and care, particularly where there are in play:
 - a. challenging behaviours?
 - b. linguistic, cultural and faith-based diversity?
 -
 -
 -
6. What will I now do on my next shift?
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