COLLEGE OF
LICENSED PRACTICAL NURSES
OF ALBERTA

Relational Practice

Beyond Introductions and Interviewing

CLPNA Self-Study Course
2018

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Published by:

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Acknowledgements

The development of this resource guide is an initiative of the College of Licensed Practical Nurses of Alberta (CLPNA). Production of this professional development initiative has been made possible through a grant from Alberta Labour, Foreign Qualification Recognition branch.

Content and Review

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Design and Programming

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Chapter 1: Introduction & Overview

Overview

Welcome to Relational Practice: Beyond introductions and interviewing!

LPNs realize there is much more to nursing communication than making introductions and interviewing. To work effectively with clients, LPNs need professional communication skills that build relationships with them. Sometimes these relationships are referred to as helping relationships, interpersonal relationships, or therapeutic relationships. But note what isn't said but is implied. Each of these places the client first and foremost. They also help nurses learn the skills of 'being in relation' with the entire team revolving around the client. This includes loved ones, significant others, groups and cultures, the interprofessional team and the public. Relational practice is a new approach to partnering with clients that builds on general nursing communication skills.

The goal of this course is to enhance and advance the LPNs skills of engagement with clients and others. Learners will be introduced to the relational practice approach as part of that while understanding that communication is a key element within it.

How to Use the Study Guide

This course is delivered through a Study Guide. It is self-paced meaning you can do it on your own time and schedule. Chapters include exercises that help LPNs think about their relational practice. Take the time to do these to reinforce what is being read. Turn reading into stored knowledge and develop your nursing practice in a meaningful way! Quizzes and self-assessments are also included for additional learning.

Each Chapter is designed around key topics. For examples, the topics in this one are:

1) Review of Professional Communication
2) Relational Practice Defined

Evaluation

Upon successful completion of a final examination, CLPNA is pleased to offer a certificate of completion for *Relational Practice: Beyond introductions and interviewing*. This course can be used as a Continuing Competency activity.

Topic #1: Review of Professional Communication

Professional, interpersonal communication within relational practice is the main focus of this course. The context of that communication is more specific to working with the care team across disciplines and agencies, providing continuity of care, and being in relation with indigenous peoples. Prior to learning about more that, a review of aspects of professional communication theory and skills will be helpful. This sets the foundation for a new way of thinking about the nurse-client relationship and working with others: relational practice (RP). RP will be incorporated into Chapters as a focus.

Communication is a transaction: an interaction or exchange between the people involved. Communication happens in a loop called the feedback loop. While we might think that some communication is purely one way, like when giving a firm direction to someone, this is not necessarily so. Communication is generally a two-way phenomenon. There is a sender and a receiver for the message. Even when the receiver doesn't respond, the message is processed in the mind his or her mind. This is the act of interpretation. See Figure 1.

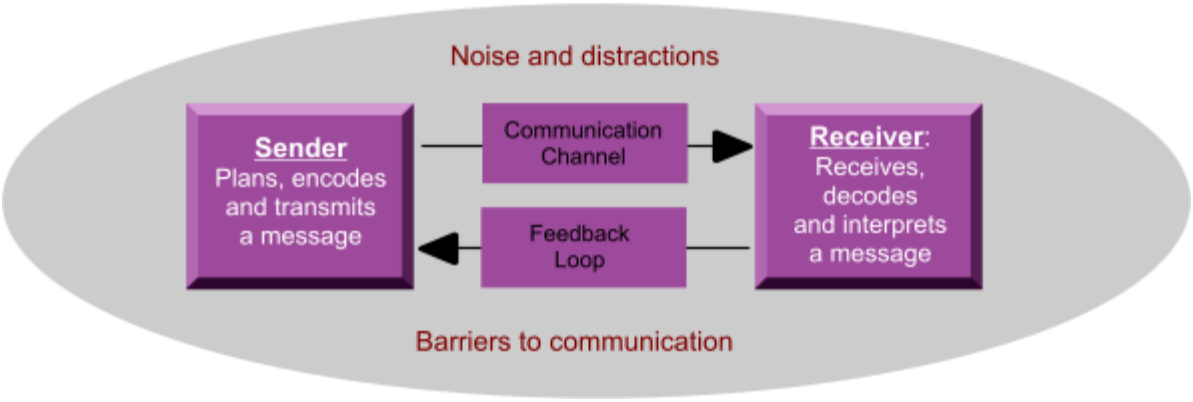

Figure 1: A Communications Model

Interpretation of messages relies on the receiver's personal perspectives, experiences and values and he or she tries to decipher meaning. The responsibility relies on the sender to ensure the message is encoded (or worded, demonstrated) in such a manner that the chance of misinterpretation is minimized. For nursing professionals, that means being clear rather than vague. It means choosing words carefully and professionally, limiting use of slang and colloquialisms. LPNs use professional language when speaking, not common language. Table 1 gives some examples. There is no guarantee that a message will not be misinterpreted no matter how well formed it is. LPNs and all members of a care team carry the responsibility for ensuring their messages are received as intended. That means attentive listening or observation of the responses. Clarification or rewording may be necessary.

Exercise 1.1: (**PDF** | **MSWord**) Take a look at Table 1 about *Slang and Colloquial Terms*.

- Take the slang or colloquial words in the first column and write them into a full sentence or question.
- Using those same sentences, correct them. Replace those terms with proper ones by rewriting all of your sentences using the proper terms. You are given these terms to help you.
- Finally, can you add some more to each column? If yes, then repeat this exercise with your new words.

Table 1: Slang and Colloquial Terms

Slang or Colloquial Terms	Proper Term to be Used
Puke , throw-up, barf	vomit
The runs, the shits, the trots	diarrhea
The john, the loo, the facilities	the bathroom
Ripped	clearly defined and developed muscles
Spare tire	extra weight (located around the middle of the body)
The shakes	tremors
Cooking, boiling	hot (temperature)

Misunderstanding and miscommunication can occur when vague, general terms are used. They leave the receiver of the message wondering how to interpret what the sender actually meant in his/her message. LPNs reduce this possibility by choosing clear, specific and appropriate terms. Table 2 gives some examples.

Exercise 1.2: (**PDF** | **MSWord**)*

Review Table 1 again, reflecting on your own communication.

- Do you use any of these vague terms? Just as you did in the previous exercise, take a moment to write these out in full sentences. Then try to rewrite them using more clarity. Be specific.
- Add some more terms if you can. Be careful. Don't guess. If you think you know another word, be sure to look it up in a dictionary or on-line. Be accurate. Be specific rather than vague. That's an important consideration for LPNs.

** The exercises in this Study Guide are available separately as PDF or MSWord documents. Click on the links in this Study Guide or links on the course home page to open, view and/or print the exercises.*

Table 2: Vague Terms

Sender uses vague terms	**Receiver must decide if this means:**
Upset Ex: *You seem upset*.	Angry Disappointed Confused Anxious Sad Frustrated Embarrassed
Kind of worried Ex: *You look kind of worried about your surgery*.	A little bit worried? Worried
Soon Ex: *I'll bring your pain medication soon*.	When? How long?
Sort of Ex: *You sort of have a temperature*.	Almost a temperature? An abnormal temperature?

Topic #2: Relational Practice Defined

Relational practice is the current term for what nursing usually refers to as interpersonal communication skills but it encompasses much more. It refers to a means of building and sustaining health-promoting relationships with clients, families, colleagues and others. It is very client-focused and concerned with healthcare needs situated in the complexities of a client's lived experience, especially within health. Relational practice for nursing involves communications and behaviours that involve the entire care team again, putting the client at the center.

Relational practice sets a goal of partnership with the client, learning first about the client's personal, subjective views about health and illness and then working collaboratively towards health goals (Finlay, 2016). Only through this partnership are the nurse and the client both able to see what factors in the client's life positively and negatively influence the current situation or experience with a health concern (Zou, 2016; Jonsdottir, Litchfield and Pharris, 2004). These can include interpersonal, social or merely personal factors (Zou, 2016).

Exercise1.3: (**PDF** | **MSWord**)

Think back to what you have learned previously about the nurse-client relationship.

- What does that approach have in common with the relational practice approach?

Summary

Relational practice is a philosophical approach to engaging clients in their health journey whether in regard to wellness or acute or chronic illness. Through partnering, both the nurse and client gain insight into coping, adaptation, beliefs and the client's personal, subjective experiences with health, illness and the health care system. Relational practice occurs within the nurse-client dyad as well as with the entire care team. The client and client issues are always the focus.

Review Exercise*

1. Relational Practice is:
   a. a communication style
   b. an approach to care
   c. a synonym for interpersonal relationship
   d. an authentic style

2. Communication is a transaction. This means it:
   a. is interpersonal
   b. is always changing
   c. can happen without sound.
   d. is an exchange between at least 2 people.

3. Communication requires language.
   a. true
   b. false

4. An important aspect of relational practice is:
   a. partnering
   b. involving
   c. educating
   d. advising

*(*Correct answers are on the next page*).

Glossary

Colloquialisms – phrases or terms in everyday ordinary speech. Colloquialisms are generally quite informal.

Communication – a process used to exchange information. Communication can be verbal or non-verbal and include body language.

Dyad – a pair or couple; two people.

Interpersonal communication – an exchange or interchange of ideas or emotions between two or more people. Ninety-five percent of the time, this is always done face-to-face although now it may include some person to person exchanges on venues such as *Facebook* or *Twitter*. Interpersonal communication is not public communication.

Transaction – an exchange between at least two people.

References

Finlay, L. (2016). Relational Integrative Psychotherapy: Processes and Theory in Practice, Chichester, E.Sussex: Wiley

Jonsdottir H., Litchfield M. & Pharris M.D. (2004): The relational core of nursing practice as partnership. Issues and Innovations in Nursing Practice. *Journal of Advanced Nursing* 47(3), 241–250

Zou, P. (2016): Relational Practice in Nursing: A Case Analysis. Nursing and Health Care Volume 1, Issue 1, 102: 9-13

Review Exercise Answers

1. Relational Practice is:

   (b) Rationale: it is an approach to care that includes communication skills and strategies.

2. Communication is a transaction. This means it:

   (d) Rationale – the term transaction means exchange or interchange. Communication exchanges messages for response via the feedback loop.

3. Communication requires language.

   (b) false

4. An important aspect of relational practice is:

   (a) partnering

Chapter 2: Review of Core Relational Practice Skills

Overview

This chapter helps LPNs become even more familiar with the concepts of the relational practice approach. As you work through it, you'll begin to notice how your knowledge is being enhanced; it is being improved by gaining new knowledge beyond the foundational knowledge you already have.

Topics in this Chapter:

1) Relational Practice

2) Posing Questions

3) Rapport

Being 'in relation' to and with the entire team brings satisfaction and cohesion.

Topic #1: Relational Practice

The concept of relational practice has gradually been introduced to nursing practice over the years. It is a fresh approach to engaging with clients and others in the LPNs work world. Relational practice is not just about communication, but about being with clients authentically and fully as they experience their health in wellness or in illness. It is based in the context of the client's life and experiences with health (Doane, G.H.and Varcoe, C., 2007). In other words, relational practice is about how the LPN gains an appreciation of the whole client in his or her health experience. (Jonsdottir, H., Litchfield, M. and Pharris, MD, 2004). Furthermore, the nurse is 'in relation' with all members of the client's care team.

Relational practice takes a participatory stance (Jonsdottir et al., 2004). This means the LPN will be working with the client and the team as a participant in the client's journey to health. Partnership with clients includes a fuller sense of mutuality in the relationship. The client is able to share concerns not always directly related to care in the here and now, but to aspects of his or her life that impinge upon it. LPNs appreciate that clients often come with chaotic or complex backgrounds and needs. Through relational practice, the nurse actively wants to know more about this. Why? Because optimal client outcomes requires awareness and consideration of all factors that can positively or negatively impact recovery, rehabilitation or maintenance of health. Through relational practice, client insight can be improved. Most professional, inter-personal relationships theories identify and value partnering but the end goal is not as extensive or far-reaching as this.

One important element of relational practice is nursing presence – the nurse's availability and openness to partnering with the client on his/her health journey. *Being fully present* is a term (nursing jargon) that means the nurse puts aside all other matters and tasks when engaging the client. This is not an easy thing to do. Attentive-listening and genuine caring necessitates it! Being fully present and available, communicates the value the LPN puts on him or her. The relationship is enhanced.

All nurses work with intentionality: they have intent for most of their interactions with clients. They know what they want to learn or do prior to engagement. However, relational practice

requires the LPN to spend more time with the client, rather than just interacting over tasks or procedures. This nurse has the intention of coming to know the client more holistically; more deeply in the context of his/her life. To clarify, an interaction from this perspective advances beyond those interpersonal skills used for interviewing, checking in and having brief conversations (although these remains in the nurse's repertoire).

Exercise 2.1: (**PDF** | **MSWord**)

Think of a time you needed to admit a new client to a hospital unit or care setting. That process required an interview. Reflect back. Be honest with yourself. That is how one learns and grows.

- What was your overall intention when you met that client? Did you want the facts and nothing but the facts or did you want to 'come to know' the client in any way?
- Did you simply ask the questions on the admissions form or did you take the extra time and effort to relate and build a relationship with that client?
- Did you stick to the questions on the form only? If so, what were your reasons for that? Now that you have the time to think about it, were you completely client-focused?

Reflection is another key element of relational practice (Jonsdottir et al., 2004). Nurses come away from interactions full of wonderings about not only what was gained from it from the client's perspective, but also about what skills and behaviours by the nurse contributed to that. This is a type of relational inquiry (Doane, G.H.and Varcoe, C., 2007). LPNs are familiar with the need for self-awareness and do engage in self-reflection about their interactions, but they may practice post-reflection at varying degrees.

Exercise 2.2: (**PDF** | **MSWord**)

Stop for a minute and think about reflection on your own interpersonal practice. Particularly, do you self-reflect on your own contributions to the nurse-client relationship after an interaction? Gather your thoughts and put them in writing. Examine what you've written in light of what you've previously learned about interpersonal communication and now about relational practice.

- Reflect: what did you learn from this exercise?

Topic #2: Posing Questions

Interviewing skills focus on how to effectively pose questions. The process is full of questions. Many of these are closed questions for fact finding. Basically, they elicit yes/no answers or provide specific facts. Some open questions or encouragers seek clarification, descriptions or examples. But overall, interviewing doesn't explore the client's health care expectations or the depth of concerns and circumstances that relational practice approaches do. Unless facts are needed, nurses using a relational practice approach will be more inclined to use open questions and encouragers to explore the context of the client's situation. The examples in Table 3 offer a review of question types.

Consider what you've just read. Do you have the habit of putting 'can you', 'would you' and other courtesy words at the beginning of questions? In other words, are you turning open questions into closed questions by doing this? There are ways to be courteous and polite without using these terms to start a question.

Remember that people who are thought disordered, confused, or have some significant cognitive impairment still require courtesy but may not do well with choice-making. That's what closed questions offer them … a choice to say yes, no, maybe or I don't know.

Table 3: Review of Question Types

CLOSED QUESTONS	OPEN QUESTIONS	ENCOURAGERS
Have you ever had the measles?	What were your symptoms when you had the measles?	Tell me more about the time you had measles.
Do you use marijuana?	What types of drugs, if any do you use?	Let's talk now about any drug use.
Can you tell me if you have pain?	How would you rate your pain right now?	You appear to be in pain. Describe that for me, please.
May I ask you about your eczema?	How are you managing your eczema?	Tell me about your eczema.
Is exercise something you enjoy?	What types of exercise do you enjoy?	I sense exercise is important to you. Please tell me more.
Would you like a prn now?	What prn medication do you take for this?	If you are considering a prn please describe the effect of one.

Exercise 2.3: (**PDF** | **MSWord**)

Practice here. Change the question into one that isn't closed but will still elicit the information you are seeking. Imagine you are speaking to a client with moderate dementia. In other words, write an open-ended or encourager type of question.

May I sit down and talk to you right now about your bath schedule today?

Rewritten: _____

Can I roll you over on your side now?

Rewritten: _____

Would you like to take your medication now?

Rewritten: _____

Topic #3: Rapport

Nurse-client relationships require rapport. The skill of building rapport begins the moment the two meet and continues each time they meet. Mutual trust ensues as communication stemming from the LPN demonstrates characteristics of respect and empathy. Most importantly, genuine interest in the client as a unique human being is clearly evident from the LPN. Rapport helps ease the client's fears or concerns.

Non-verbal rapport is established through the LPN's actions and body language. Looking a person in the eye when talking or asking questions is a very important Canadian behaviour. LPNs engage in it because it communicates the nurse's genuine interest and is a non-verbal cue of honesty. Whether or not the client reciprocates does not affect this. There may be many reasons why he/she does not. As the LPN builds rapport with words, a relaxed and open posture is facilitative.

The role of 'chit-chat' in the nurse-client relationship is based on finding some common ground with him or her that is not solely based in health or a health challenge. Finding something meaningful to the client to chat about during the day shows genuine interest by the LPN. It demonstrates the nurse has truly listened to what is important to the person in life beyond the health challenges and treatment. This activity is relational. The LPN comes to know even more about the person and can use this information in a meaningful way in care planning that includes the psychosocial domains of personal health.

Read Figure 2, Best Practices: *Gerard Loves Hockey* to see a client's particular interest and the LPNs efforts to include this in the relationship. The nurse is also striving to find common ground.

Key Message:

"*Building rapport through communication is an art, which begins with a genuine desire to know the client as a person, as well as a client*."

Arnold, E.C. (2016): Chapter 5, pg. 81. *Interpersonal Relationships*, 7th Edition

Figure 2: Best Practices

Best Practices: Gerard Loves Hockey

In chit-chat this morning, LPN Joan has come to know that the new client, Gerard loves hockey and loves to talk about it. She, herself is not particularly interested in that sport. Even so, later that night at home she makes an effort to learn just a little about hockey. She has seen how happy her client is when this subject comes up. She's noticed how his mood brightens when he talks about it. Joan wants to have good rapport with him and hopes gaining at least a little knowledge about one of his favourite subjects will contribute to a strong foundation for their relationship.

The next day when they meet, Gerard is surprised and pleased that Joan made efforts to learn about his interest. Actually, he says it's amazing that she did that. His trust and respect for the LPN rises significantly. He believes she sees him as a unique and valuable individual since she went to all of this effort. They talk some more.

In Rounds later that day, the LPN shares with the team how much hockey excites and inspires the client and lifts his moods. She mentions that it takes his mind off his hospitalization at least for a while. Working with the team, Joan helps arrange that Gerard is able to watch hockey games on TV in the evenings. The Care Aides will help him get to the Day Room where the TV is. Additionally, by sharing this information about Gerard, other members of the team also have a subject to chit-chat with him about. Joan encourages the team to share their own findings about other clients.

Exercise 2.4: (**PDF** | **MSWord**)

Consider the following questions.

- Have you ever met a client that you don't think you have anything in common with whatsoever?
    - If so, reflect on the actions you took to resolve this, knowing how important this is to establishing good rapport. (You might want to consider the Best Practices example of Gerard.)
- While talking about the weather is a form of chit-chat is it actually deeply meaningful? Is it an example of relational practice? For example, does it promote happiness, alleviate anxiety? Does it bring back good memories that lead to good discussions? Does it help the nurse get to know the client in a deeper and more holistic manner? Or rather than being helpful or therapeutic, is it simply superficial?

In relational practice, the concept of common ground goes well beyond simple chit-chat and general conversation. Working in partnership and fully coming to know the client and his/her health situation, those involved find common ground in the goals they set. These goals can be focused on recovery, maintenance of health or prevention of illness. They can be grand goals they need time to be realized or they can be short, easily achieved goals that are part of the client's health journey.

A final note: relational practice should NOT be considered counseling or therapy. Each of these takes time and works through psychosocial issues. Relational practice is concerned with promoting health by learning about the person's lived experience with it. (Jonsdottir et al., 2004). It doesn't provide 'therapy' for it. Instead, it helps the nurse in planning care that will involve considerations for discharge planning, inclusion of social work, physiotherapy and so forth. The nurse will share information with other disciplines as appropriate or ask for their involvement.

Table 4: Relationship vs. Relational Practice Skills Used by Nurses

Examples of Interpersonal Relationship Skills	Examples of Relational Practice Skills
Trust Respect Mutuality Rapport Active listening Confidentiality Empathy Unconditional regard *Warmth Self-awareness	Trust Respect Mutuality Rapport Active or attentive listening Confidentiality Empathy Select, skillful self-disclosure *Unconditional warm regard Self-awareness Intentionality Reflection

*The term 'warm regard and warmth' in interpersonal relationship skills or relational practice skills connotes how the nurse conveys verbal and non-verbal behaviours. Some ways warmth is communicated is by open and relaxed body, appropriate close physical proximity; friendliness, and the appropriate use of touch.

Summary

In summary, interpersonal skills are the professional communication skills that most nurses have learned in their nursing programs to date. They are the skills used today in practice. As with everything, practices and approaches change over time. Now, nurses are incorporating relational practice skills into their approaches to care. While client interaction using interpersonal relationship skills compares quite closely to relational practice skills there are a few differences. Each has caring processes at their heart.

Table 4 provides some examples. But remember, this is a just a look at some skills. The table is not meant to cover all aspects of the philosophical approach inherent in relational practice.

Review Exercise

1. The LPN greets her client in the morning. Her client hasn't been sleeping well. She wants to pose an effective question. Which of these is an open ended question that will achieve this?
   a. How did you sleep last night?
   b. Were you able to sleep last night?

2. To achieve common ground, people must find a topic, goal or idea they both know about and are interested in sharing or working together on to some degree.
   a. true
   b. false

3. To build rapport with others, the LPN needs to be
   a. adaptable
   b. courteous
   c. genuinely interested
   d. efficient

4. True relational practice is the same as counselling.
   a. true
   b. false

Glossary

Authentic – real, true, genuine. Not phony or fake.

Client-centered care – putting the client prominently in the middle; in the midst of all care. Synonyms include person-centered, patient-centered, client-focused, patient-focused, and person-centered care.

Client-focused care – putting the client first and foremost at the center of all care. Synonyms include person-centered care, patient-centered care; client-centered, patient-centered and person-centered care.

Facilitative – providing assistance; helping.

Genuine – sincere, honest, authentic, true. Not phony or fake.

Intentionality – being deliberate or purposeful.

Interprofessional team – a team consisting of many professions such as doctors, nurses, occupational therapists, social workers, care aides.

Lived experience – personal knowledge and insight gained from direct experience.

Nursing presence – a nursing action of being with, attending to; being attuned to the client and his/her needs.

Phenomenon – occurrence, event, situation.

Relational practice – a philosophical concept and approach that is a means of building and sustaining health promoting relationships with clients, families, colleagues and others.

Repertoire – a stock or collection of skills, talents, behaviours, vocabulary.

Superficial – on the surface; appearing as if real and true until examined more closely.

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Arnold, E.C. (2016): Chapter 5, pg. 81. *Interpersonal Relationships*, 7th Edition

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Review Exercise Answers

1. The LPN greets her client in the morning. Her client hasn't been sleeping well. She wants to pose an effective question. Which of these is an open ended question that will achieve this?

   (a) Reason: client must describe the sleep. In answer (b) the response will only be yes/no or I don't know. It is a closed question.

2. To achieve common ground, people must find a topic, goal or idea they both know about and are interested in sharing or working together on to some degree.

   (a) true

3. To build rapport with others, the LPN needs to be

   (c) genuinely interested

4. True relational practice is the same as counselling.

   (b) false

Chapter 3 - Client-centered Relational Practice (RP)

Overview

Nursing programs always include a course on interpersonal communication and building communication skills. While they seem to be about the nurse, all of these courses have one thing in common: they put the client at the center, not the nurse. Successful relationships with clients cannot occur if the nurse does not have the appropriate knowledge and skills to facilitate this.

Topics in this Chapter:

1) Professionalism Reviewed
2) Professional Boundaries Reviewed
3) Language of Relational Practice
4) Concept of Relational Inquiry

Topic #1: Professionalism Reviewed

The concepts of relational practice apply to how LPNs and others build relationships with those involved in a client's care. This is an interprofessional exchange. For example, in case management meetings, Doctor's Rounds, or even at shift change, the client remains the central focus of sharing information and discussing care options. Much more will be said about this in Chapter 4 but to begin this review of professionalism, review the practice standard of the College of Licensed Practical Nurses of Alberta (CLPNA) in Figure 3.

Exercise 3.1: (**PDF** | **MSWord**)

Answer this question in your own words before continuing.

- How is the integrity of the profession of Licensed Practical Nurses maintained?

Figure 3: CLPNA Practice Standard on Professionalism

> The Therapeutic Nurse-Client Relationship: Practice Standard 6
> College of Licensed Practical Nurses of Alberta
>
> "The LPN is accountable to conduct his/herself in a manner that promotes the integrity of the profession, while establishing and ensuring therapeutic nurse-client relationships."

Professionalism is hard-earned and needs effort to be maintained. The nurse's ways of speaking, mannerisms and other behaviours communicate the he or she is a professional member of the healthcare team. This is important. This message instills confidence in the client and family that the LPN is professional. In turn the concept of being professional for the client is experience in the perception that this person is well-educated. The positive results are that the client is more accepting and develops a sense of safety and trust with the nurse.

What is a profession? Who exactly is a professional? A number of criteria identify these. Here are some. The term profession is sometimes synonymous with discipline or field of practice and knowledge. Nursing is a discipline. It's a unique field of practice. As you studied to become a nurse, you developed nursing knowledge. Now, you practice it in the field of nursing. You present yourself as a professional. CLPNA's *Practice Statement 6 of the Therapeutic Nurse-Client Relationship* articulates this in the relationship between nurse and client. See Figure 4.

Figure 4: CLPNA Practice Statement 6 – Therapeutic Nurse-Client Relationship

> "A therapeutic nurse-client relationship is established and maintained by the LPN and the client, through the use of professional nursing knowledge, skills, attitudes and judgment in order to provide nursing services that contribute to the client's health and well-being."

To be considered a profession, the discipline and knowledge base must exist and a prescribed amount of education is required to practice in the field (or practice in the discipline). And, that educational component must be accredited or recognized by a regulatory body. Subsequently, upon graduation, this education leads to professional entry-level competencies. But, just like in practical nursing, that is not the end! Mandatory registration exams are required to be able to call yourself a professional in this career!

Exercise 3.2: (**PDF** | **MSWord**)

Think carefully now about professions. As you know, Licensed Practical Nurses belong to the profession of nurses. More specifically, they belong to the profession of Licensed Practical Nurses and are regulated by the College of Licensed Practical Nurses of Alberta (CLPNA).

- Can you say the same for occupational therapists, social workers, lawyers, accountants, doctors, sonographers (ultrasound technicians)?
- What about taxi drivers, waiters and waitresses, hospital porters, health care assistants, and life skills workers? Do these fit the criteria you've just read?

Although there are strong working and collegial relationships between all members of the team, not all members are professionals. Does that matter? **No**. Relationally, LPNs strive to maintain a level of professionalism with the entire team and support staff. Healthy, collegial relationships amongst team members are most certainly conveyed to clients and their care. Clients can perceive unhealthy, non-professional ones! This is reinforced in the Canadian Council for Practical Nurse Regulators (CCPNR) and the CLPNA Code of Ethics found in Figure 5.

Figure 5: LPN Code of Ethics

> The Code of Ethics for Licensed Practical Nurses in Canada, Canadian Council for Practical Nurse Regulators and the College of Licensed Practical Nurses of Alberta, 2013
>
> Principle 4: *Responsibility to Colleagues*
>
> LPNs have an ethical responsibility to develop and maintain positive, collaborative relationships with nursing colleagues and other health professionals.
>
> 4.2. Collaborate with colleagues in a cooperative, constructive and respectful manner with the primary goal of providing safe, competent, ethical, and appropriate care to individuals, families and communities.
>
> 4.4 Acknowledge colleagues' roles and their unique contribution to the inter-professional team.
>
> 4.5 Respect the expertise of colleagues and share own expertise and knowledge.
>
> Review the LPN Standards of Practice and Code of Ethics.

Exercise 3.3: (**PDF** | **MSWord**)

In Table 5, list members of a healthcare team that belong to a profession, and those members that are not considered professionals.

Table 5: Professional and Non-Professional Members of a Healthcare Team

Members of the Healthcare Team who belong to a Profession	Members of the Healthcare Team who do NOT belong to a Profession

Exercise 3.4: (**PDF** | **MSWord**)

Now look at your table again. Remembering that this is a course in relational practice, did you put the client in the left column? Stop and consider that. Using a relational practice approach, the client and perhaps also family members or other supports should appear in that column. If you didn't, please review Chapters 1 and 2.

Topic #2: Professional Boundaries Reviewed

LPNs recognize the difference between social and professional relationships. It is the nurse's responsibility is to delineate and maintain these boundaries. LPNs use professional judgment and adhere to professional standards of practice and a Code of Ethics that uphold this responsibility. In small towns – rural and remote communities, this can sometimes pose a challenge (National Council of State Boards of Nursing, 2014). Just the same, the LPN keeps the boundary between a social and professional relationship very clear with each and every client. Whenever in doubt, the nurse should check the Standards and Code or consult with the CLPNA.

An important aspect of relational practice is reflective practice or self-awareness. This means taking the time frequently to self-assess to reflect not just on nursing skills, but on own behaviours, responses, and initiatives. In this case, self-awareness also includes not only one's own values, beliefs and so forth, but awareness of professional boundaries and limits placed on the professional role. It also includes honest knowledge about self and one's own abilities (Registered Nurses Association of Ontario (RNAO), 2006). This means honest appraisal by the LPN of whether or not he/she feels competent and knowledgeable enough to engage the client in a procedure or significant discussion about client issues. For example, if the LPN has not inserted a urinary catheter in 10 years, reflective self-awareness will allow that nurse to seek guidance, support or retraining for that skill. Psycho-socially, if the LPN self-reflects and finds he or she is not confident about doesn't feel skilled enough in discussing the client's journey with a terminal illness, the same solutions can apply. Reflective practice is also known as reflexive practice.

Honest self-reflection is a professional obligation.

LPNs maintain a professional boundary between self and client even though in relational practice they are partnering with clients on their health journeys. How can this be achieved? Professional boundaries are maintained using the RP approach by being open and honest; genuine and caring from the very beginning of the partnership with the client. This begins with the proper nursing introduction that includes voicing that this relationship will end at some point. Usually, this is at the end of a hospital stay or visit to the clinic. In long term or residential care, the introduction might include 'as long as I am assigned to this unit' or words to that effect. LPNs know that clients are emotionally and physically vulnerable and can bond to them. Through relational practice strategies, this is openly recognized and professional boundaries gently re-asserted.

Professional Responsibility and Accountability

As regulated health professionals, the public expects Licensed Practical Nurses (LPNs) to be professionally responsible and accountable to deliver safe, competent and ethical nursing care. Responsibility can be defined as the ability to respond and answer for one's actions and obligations, and to be trustworthy, reliable and dependable; whereas, accountability is the obligation to answer for the professional, legal, and ethical responsibilities of one's activities and actions.

As professionals, LPNs are expected to:

- provide safe, competent and ethical care to their clients;
- maintain the standards, guidelines and continuing competence required by their regulatory college (CLPNA); and
- work within the role, expectations, policies and procedures of their employer.

Review the entire document, Professional Responsibility and Accountability.

Exercise 3.5: (**PDF** | **MSWord**)

Practicing professional boundaries takes practice! Using the concept of reflective practice, consider how you might respond to the client with a full, thick head of wavy hair who asks you to completely shave his head, 'for fun'. Do 3 things:

- reflect on your skills and abilities to shave someone's head
- reflect on your professional boundaries and decide if this a social activity or professional one
- respond to the client in a manner that is respectful and does not harm the partnership in care that the two of you have.

Topic #3: Language of Relational Practice

More and more frequently in nursing and health care, the LPN will be exposed to the language of relational practice. These may be new terms to add to what you already have from previous courses in interpersonal communication and nursing courses in general. For example, rather than genuineness, the term authenticity is used in relational practice.

Exercise 3.6: (**PDF** | **MSWord**)

Enhance your learning through recall. Define the following relational practice terms and concepts from Chapters 1 and 2 of this Study Guide.

- Nursing intention
- Presencing or being fully present
- Participatory relationship
- Mutuality and partnering

Honouring complexity is a term not confined to a condition of health (Hartrick, 1997). This concept takes a much more holistic view and is fundamental to the language of relational practice. Each individual is complex in his/her unique lived experience and that does not go away when someone becomes ill or in need of the guidance or support of health care professionals. As LPNs know, a client is not just a medical diagnosis! For example, if a single parent with a full time job suddenly found himself/herself with two broken legs from an accident, the situation would be full of complexity. Each of these complicating factors would influence this client's ability to accept care, partner with the nurse and team towards recovery, and so forth. Imagine then, as is common in health care, that this client also had diabetes, no family nearby, and no extended health benefits. How will the LPN respond? Using relational practice, the nurse will be open to learning about these complexities. This will not simply be part of an assessment or intake interview! This LPN will give recognition to the client about these major issues in his/her life. Then, the nurse will incorporate this information into the care plan created mutually with this client. This is an example of honouring complexity. This will facilitate the client's ability to accept health care and participate in it. He/she will soon see that the LPN and care team are responsive and respectful of the complications surrounding this health event.

Interviewing clients can be very superficial because by only focusing on collecting facts and information related to the here and now of the health event, the LPN runs the risk of missing the complexities of the client's life. For example, socio-economic factors affect all of us, well or unwell. The relational practice approach helps LPNs recognize the impact these factors can have on a client's health care (Zou, 2016). The above is a good example of something called *contextual factors*. In relational practice, this means the LPN looks beyond the superficial of what a person says and through relationship and partnership building, is able to find out the issues and complications in the person's life that may affect care.

To avoid the trap of being superficial in client care, relational practice stresses the important of openly hearing the client's *narrative.* This is how the nurse or physician comes to truly know about the client's experience with the health condition. Narrative or telling one's own story about this experience, can help the team discover how the client is coping and adapting. Narratives shed light on whether or not the client has a positive or negative past experience like this or with health care in general. They can explain how the client acted in other health difficulties as well. All of these factors can also influence the way the client engages today. The information gathered helps guide care. Narratives offer the team insights on the client's expectations and their own related to this health experience (Jonsdottir, Litchfield, Pharris, 2004). Listening attentively to the client's narrative is an advanced technique for coming to know the client. It facilitates the establishment of empathy in a way that the nurse more truly sees the client's subjective experience (RNAO, 2006).

Exercise 3.7: (**PDF** | **MSWord**)

Read the following case study and think about it beyond the superficial. What is the client really telling you through his narrative? What is deeply meaningful to him?

Figure 6: Case Study

Raymond, 88 years old, lives in residential care. You've noticed he sits for long periods looking out the window at the park just next door. You sit and talk with him, open to explore this and anything else he might like to talk about right now. You begin by commenting on the pretty park and you note how green it is. Raymond engages. He tells you about the farm he grew up on. He says the trees in the park are the same as the ones that his parents planted for a wind break around the house. He asks you if you know what a windbreak is and laughs when you say you do not. In a very friendly way, he tells you. You ask him to say more about the farm. He begins a long conversation about growing up there. He talks about the sounds of the wind in the trees and the smell of the leaves in the different seasons. He recalls the sound of crunching in the dead leaves at the end of autumn. He talks about sitting under a big tree like one across the street, making small talk with his new girlfriend, whom he later married. They were wed 55 years before she passed away. He pauses and gazes out the window then in silence. You touch his arm gently and invite him to go outside to sit in the park for a while. You have time – not much, you admit, but you have some time. He is very touched; very pleased to accept.

- Question: What was the underlying theme in Raymond's narrative?
- Question: Why did the LPN do what she did? What did she 'hear' beyond the superficial conversation about trees and the farm that she responded to?
- Question: Is there anything therapeutic about the nurse's intention to take Raymond over to the park?

Topic #4: Concept of Relational Inquiry

Beyond curiosity, LPNs have a professional responsibility to learn what they can about clients in order to achieve positive client outcomes. Relational inquiry is a term used to explain how nurses do this (Hartrick Doane and Varcoe, 2013). Listening to narrative is a form of relational inquiry. Can you see the benefits arising from that?

Another form is actual research. For LPNs, this stems from wondering about the client and the health challenge. Employing reflective practice, the LPN recognizes when he or she does not have enough information about the health concern and takes action to remedy this. It is the LPNs professional responsibility to be knowledgeable: to seek out this information. This can be achieved in a number of ways: asking a colleague, asking an expert on the subject, or searching the Internet.

LPNs also recognize that the Internet is full of good, appropriate and correct health information and material that is not. Critical assessment of the source of the research is required so that truth, evidence or valid and appropriate information is accessed. LPNs should not attempt to use or share information that has not been appropriately assessed. Miscommunication and misunderstanding and actions could occur as a result.

Summary

Relational practice is an approach; a method for LPNs to go beyond the superficial presentation of a client and his/her health concern. While maintaining professional behaviours, knowledge, skills, and boundaries, relational practice reaches beyond the surface. Being open and actively listening to a client's narrative sheds light that person's ability to cope and adapt to challenges to health care, offers insights on the client's belief's about or responses to health care historically, and provides important information about the contextual factors in the client's life that may positively or negatively affect client outcomes in the here and now. Working relationally with clients and others involved in the care, enhances the trust, respect and sense of safety the client experiences.

Review Exercise

1. Which of the following best describes a therapeutic nurse- client relationship?
   a. psychotherapy and counseling are provided by the LPN
   b. the nurse befriends the client like family to help support him/her towards wellness
   c. the LPN focusses solely on physical treatment, psychomotor skills and medication administration to help the client get well
   d. a caring, goal-oriented relationship is established to help the client to wellness

2. Which of these answers reflects the difference between a professional and social relationship?
   a. a social relationship is interpersonal; a professional relationship is not
   b. a professional relationship ends when care is complete; a social relationship can be on-going and without end
   c. professionals cannot accept gifts from clients; clients can accept gifts from professionals
   d. professionals can talk about clients outside of work; clients are restricted from talking about professionals once they've been discharged

3. When a LPN engages in relational inquiry related to something she learned about the client today, the nurses is
   a. demonstrating professional curiosity
   b. demonstrating unnecessary conduct
   c. engaging in research to support client care

4. To engage in relational inquiry, the LPN must complete a research study.
   a. true
   b. false

Glossary

Accredited – officially recognized or authorized.

Authenticity – genuineness and honesty in relating to others.

Boundary – a boundary is the point at which the relationship *changes* from professional and therapeutic to unprofessional and personal.

Contextual factors – the bio-psycho-social-economic-spiritual factors of life that influence our way of being or experiencing our current situation. These factors can also include the social determinants of health such as unemployment or lack of access to acute medical, mental health or substance abuse care.

Discipline – a branch of knowledge, skills, education and practice.

Narrative – the telling of one's own story; one's own life experiences.

Practice – the application of knowledge and skills to work.

Regulatory – control or management by policy, legislation and oversight.

Relational inquiry – research that is client-centered; the goal is to enhance care by gaining more information.

Social determinants of health – influences in society on a person's lived experience and health. These include: access to housing; food security; access to education and employment; access to health care; access to society and human connectedness.

Superficial – on the surface. Not deep. An example is very casual conversation or chit chat.

References

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Review Exercise Answers

1. Which of the following best describes a therapeutic nurse- client relationship?

   (d) a caring, goal-oriented relationship is established to help the client to wellness

2. Which of these answers reflects the difference between a professional and social relationship?

   (b) a professional relationship terminates; a social relationship can be on-going

3. When a LPN engages in relational inquiry related to something she learned about the client today, the nurses is

   (a) demonstrating professional curiosity AND
   (c) engaging in research to support client care

4. To engage in relational inquiry, the LPN must complete a research study.

   (b) false

Thoughts about Case Study (Figure 6)

Raymond is feeling nostalgic (sentimental) about his earlier life. He is triggered* into happy memories of his time in the outdoors, especially as he grew up on the farm with his parents. Being outside in nature also triggers him to recall a special, loving time with his wife. Mostly, he is missing his freedom to go outside and to be with nature, able to see it, smell it, touch it, and enjoy it. The relational nurse perceives this and makes an effort to fulfill this for him. Taking him over to the park, sitting and being fully present with him there is therapeutic in assisting him engage in an activity that he loves and reminds him of people and times he has loved in his life.

*To be triggered means to be cued, prompted or caused to initiate an action or thought.

Chapter 4: Collaborative and Collegial Relational Practice

Overview

You have been learning that relational practice is always client centered. Working with the team from this approach means that no matter what the discussion, client care will be at the center of it. This chapter will explore a number of venues in which collaborative and collegial relational practice occur. It addresses concepts of civility and respect, workplace culture, marginalization, othering and professional expectations.

Topics in this Chapter:

1) Cultural and Professional norms of the workplace
2) Collaborative and Collegial RP
3) Reporting and Documenting
4) Delegation
5) Conflict and Resolution

Topic #1: Cultural and Professional Norms in the Workplace

There are many types of diversity in care teams that LPNs may experience. These can be diversity of culture, religious beliefs, gender, age, credentials, and position. To discriminate against or marginalize on the basis of any of these characteristics goes against the standards of practice and ethics of Alberta's LPNs. It is also contrary to the Canadian philosophical approach to multiculturalism. No matter what the characteristics, common ground and a common workplace culture must exist for employees. There are professional norms and expectations in every workplace. Figure 7 explains. It is up to you to find that common ground. Reach out: create one!

Figure 7: Cultural and Professional Expectations in the Workplace

> Canadian workplace culture expects you to be good at speaking, listening and socializing with other people; to know the etiquette of working harmoniously with co-workers, colleagues and supervisors; and to understand a good range of cross cultural differences in the workplace.
>
> The Working Centre (n.d.):
> Canadian Workplace and Cultural Expectations.

Cultural Norms for the Canadian Workplace

Before moving on, study Figure 8 for some cultural norms of the workplace in Canada.

Figure 8: Cultural Norms in the Canadian Workplace

Some Cultural Norms in the Canadian Workplace

- Everyone will speak the same language in the daily work to coworkers and clients (unless there are extenuating circumstances).
- Introduce yourself and your role in the workplace if there is no one available to introduce you.
- Everyone will be on time to work and for appointments and duties.
- When calling in sick, sufficient notice will be given so a replacement may be found.
- Honour commitments: promises to clients, patients, residents will always be kept unless there are specific extenuating circumstances. Staff will speak with the client about this and re-schedule or apologize for any changes.
- Tell the truth. Honesty and integrity are valued immensely.

- Alcohol and drugs will not be consumed on the job.
- Personal text messaging or use of social media will not occur.
- Eye contact will be given with colleagues, clients and others.
- Before entering, doors will be knocked on and staff members will identify themselves.
- Say please and thank-you frequently and appropriately.
- Address people by their names or titles (i.e., Dr. or Mr. / Mrs. /Ms.) until given permission otherwise.

Excerpts from:

Qadir, S.(n.d.): What is Canadian Etiquette at Work? Settlement.org., Ontario

Monster.ca (na., nd): Canadian Business Culture

The Working Centre (n.d.): Canadian Workplace and Cultural Expectations.

Multi-ethnic and Multilinguistic Care Teams

How do LPNs use a relational practice approach when working with team members of multi-ethnic and/or multilinguistic backgrounds? Consideration of the culture of the workplace as well as the professional norms there are paramount. They must be identified and understood first. Figure 9 identifies a responsibility LPNs have to the public. The same can be said to be true for working with colleagues: this is a professional norm. It contributes to good morale.

Figure 9: LPN Responsibility to the Public

The Code of Ethics for Licensed Practical Nurses in Canada
Canadian Council for Practical Nurse Regulators and the College of Licensed Practical Nurses of Alberta, 2013

Principle 1: *Responsibility to the Public*

Licensed Practical Nurses respect the rights of all individuals regardless of their diverse values, beliefs and cultures.

Since English is the *lingua franca* – the main, common language for Canada, new employees in health care can expect to have to speak in English while working. There are legal precedents for determining this. An example can be found in Figure 10 from the Ontario Human Rights commission. Nursing in Canada has been identified as a bona fide (true) occupational requirement (except in Quebec where French is the dominant language). The *Canadian Charter of Rights and Freedoms*, Part 1, Sections 16 through 22 identify English and French as the official languages in this country (Government of Canada, 1982). All citizens have the guaranteed rights under the Canadian Charter to have services, rights and privileges in either of those two languages. Section 23 identifies this for the language of instruction (education) in Canada. English is the main language used for business, school and everyday life in Alberta.

Figure 10: English Proficiency

The requirement for English proficiency, and the degree of proficiency required must bear an objective relationship to the essential requirements of the job, and be a *bona fide* occupational requirement that is imposed in good faith.

Fluency in a particular language could be a bona fide requirement in some employment or service situations.

Ontario Human Rights Commission (rev.2009)

In Canada it is quite possible that care teams consist of members for whom English is not the first language. But they must speak English. Remember that even in discussing, assigning or reporting tasks or client status, English is the shared medium. Speaking other languages at break times and away from clients is generally acceptable, but there are some cautions to doing this. Hull (2016) is one of a number who have has described how conflict, mistrust, marginalization and a sense of 'othering' occur when this happens. (If you need help with English for work, access CLPNA's self-study module *Medical Language & Terminology*.)

Othering

Othering is neither relational nor collegial, nor is it professional. Othering occurs when people separate themselves from other people on purpose or unconsciously. Individuals can 'other' just as groups can (Powell and Menendian, 2016). It embodies prejudices against people on the basis of language spoken, appearance, behaviours, cultures, religions, and lifestyle. In health care, even credentials and where staff went to school can be a source of othering!

When prejudicial beliefs lead to action, discrimination occurs. An example is when one person (or group) is marginalized – separated and informally kept separate from another (Powell and Menendian, 2016). Does this occur in health care? Unfortunately, yes.

Research has found that newly hired nurses of non-English speaking backgrounds face the challenge of being othered or othering. Yes, this happens on two sides. The English speaking staff may informally marginalize the newcomer because of lack of English-speakers to clearly understand the new person or doubts about that person's abilities due to communication barriers (Hull, 2016). On the other hand, the newcomer may find relief; solace in befriending and staying close to others of the same linguistic background (Hull, 2016; Kessler, 2011). There is comfort for them in this. In this case, both parties 'other' each other.

Othering also occurs in the English-speaking workplace when staffs speak in languages other than English in the presence of clients and coworkers. This is considered rude by Canadian social and work norms, especially if the workplace is English language dominant (Hull, 2016; The Working Centre (n.d.); Woon, (n.d.).

Discriminatory behaviours harm morale for the entire unit (workplace). They foster suspicion and disrespect for and by each group. At first, clients are may be only indirectly affected, but over time, as communication and understanding on the team break down further, client care is directly affected. As you will recall from a previous chapter, clients are very sensitive to problems between staff members. They can most certainly sense this one.

From a relational practice perspective it is difficult to imagine how the client can remain at the center of care when the team is divided by the social constructs of prejudice, discrimination, othering and marginalizing. When it does occur, management as well as staff can engage in developing activities that promote tolerance and mutual respect while still adhering to workplace requirements and norms.

Exercise 4.1: (**PDF** | **MSWord**)

Think of a time at one of your jobs when othering or marginalization has occurred.

- What was your role in that?
- What was the effect of othering and marginalization on the morale of the entire unit or work team?
- What did you, personally do about this?
- Suggest at least 2 ways you can promote inclusion of others into the whole of your care team.

Topic #2: Collaborative and Collegial Relational Practice

Healthy work environments require that all members of the care team participate in a way that respects each other. Belief in the concepts of collegiality and collaboration are essential so that the client can remain at the center of care.

This in turn supports mental and emotional wellness amongst staff members. Collegiality is able to flourish.

Collegiality promotes healthy work environments.

Figure 11 is an example of working with a supervisor when there is a healthy work environment that is client-centered, collegial and cooperative. Notice how both parties problem solve together towards a mutually satisfactory outcome.

Figure 11: An Example of Collegial and Collaborative Problem-Solving

Sitting with her unit manager, the LPN is requesting vacation time for very specific dates this summer. Her manager mentions the need to consider the coverage in the LPNs absence – possibilities based on client acuity, and staffing availability to replace her. The LPN contributes to this discussion, noting perhaps recent care levels or new auxiliary staff that has been hired. The LPN points out that there will also be two employed student nurses working on the unit at the time. Together they acknowledge this will compliment staffing levels but not completely replace them. They talk some more and share ideas in an attempt to problem-solve. Finally they come to an understanding. Based on expected client needs and staffing availability, the unit manager grants the vacation time.

Review:

Notice how that the client came first in the decision making yet the unit manager worked positively, respectfully and collaboratively with the LPN to problem-solve the issue of vacation dates. Without saying it, both know that everyone is entitled to vacation time. However the dates of that are not always possible. A respectful conversation ensured that again, always take client care into consideration as the primary focus of decision making. This is an example of relational practice.

Exercise 4.2: (**PDF** | **MSWord**)

Consider the example you've just read of the Unit Manager and the LPN. Consider how you might replicate these positive behaviours in your own interactions with colleagues in the workplace.

- How might you show respect, positive regard, collaboration and collegiality when problem solving?
- Beyond problem-solving, how might you, the LPN positively influence the relationships between members of your care team?

Civility and Respect

Civility and respect are two conjoined concepts in the Canadian workplace. They form working norms and guide activities when working with the public and in care teams. When team members are civil and respectful with clients, trust is garnered; the chance of partnering towards health is improved. Relationally, being civil and respectful with colleagues on the care team and

others (such as visitors to the unit) creates an environment that is open and appreciative. People are more likely to reach out and ask questions, seek guidance and engage in meaningful conversations. Morale improves. The environment becomes a healthier place for clients and staff. Civility includes many of the cultural norms already discussed in this chapter. Figure 12 supports this and explains further.

Figure 12: Civility and Respect

Civility and respect are present in a work environment where employees are respectful and considerate in their interactions with one another, as well as with customers, clients and the public. Civility and respect are based on showing esteem, care and consideration for others, and acknowledging their dignity.

Samra, J.; Gilbert, M., Shain, M. and Bilsker, D. (2017): On the Agenda: facilitator's guide. The Great West Centre for Mental Health in the Workplace. Canada

Canadian customs and norms offer insight into what might be considered incivility or disrespectful behaviours. The norms of civility are generally the norms of society. Specific to nursing and health care, you've studied these in your nursing program when you looked at working collegially and cooperatively. Incivility and disrespect bring emotional harm and can even lead to bullying (Luparell, 2011). Simply put, they can create a toxic work environment. Being personal and professional about your own behaviours in this regard are essential to promote healthy workplace environments. Figure 13 gives examples of the negative expressions of incivility and disrespect in the Canadian workplace. Read them. Did you know these were distrustful or considered a form of incivility?

Exercise 4.3: (**PDF** | **MSWord**)

Refer to Figure 13 about incivility and disrespect. Make a new table. Take each of the negative characteristics and write the opposite of each – turn them to positives to show civil and respectful behaviour in the Canadian workplace.

The College of Licensed Practical Nurses of Alberta (CLPNA) recognizes the harm that incivility and disrespect can have on nurses when nurses, themselves are harsh or abusive towards each other. The Practice Guideline, *Addressing Co-Worker Abuse in the Workplace* (2013) lays out a clear definition of abuse, describing the harmful effects that result both psychologically and physically. Furthermore, clear examples are given of types of abusive behaviours. These include: "nurse-to-nurse violence; horizontal (or lateral) hostility, psychological harassment, emotional abuse, verbal abuse and mobbing" (CLPNA, 2013, p 2).

Figure 13: Did you know? Examples of Incivility and Disrespect in the Canadian Workplace

- Calling people derogatory names (e.g. calling someone stupid or using gender-based labels)
- Stomping out of meetings before they are over
- Being frequently late
- Being rude to clients and visitors
- Not saying please and thank you frequently and appropriately
- Rolling your eyes or making a loud sigh when someone is speaking
- Yawning when someone is speaking
- Texting or using social media on your cell phone when someone is speaking
- Raising your voice when it is not necessary
- Arguing loudly
- Poor personal hygiene (e.g., not wearing deodorant)

- Spitting on the sidewalk or in to a cup
- Telling lies
- Whispering to another person in the presence of others
- Failure to complete assigned tasks
- Lateness
- Lack of courtesy on the phone

Some more specific examples of abusive actions against a colleague include: embarrassing them, not speaking to them, ignoring, criticizing and fault-finding, breaking confidentiality, isolating or othering and much more.

Remember that in Canada, you have a right to feel safe from co-worker abuse.

Exercise 4.4: (**PDF** | **MSWord**)

It is very important for every LPN to read CLPNA's Practice Standard, *Addressing Co-Worker Abuse in the Workplace* (2013).

- Go to the CLPNA website, www.clpna.com Search for the title of the document (above). Or, try this direct link http://www.clpna.com/wp-content/uploads/2013/02/doc_Practice_Guideline_Addressing_Co-Worker_Abuse_Workplace.pdf

- Critical thinking: as you read the *Standard*, notice that it reflects the Canadian cultural norms you have been reading about in this chapter, but that it also takes these one step further to include a relational practice perspective. Notice from this Standard, that the effect on client care is not forgotten. The client; the client remains as a central focus of the work environment. Study the recommendations for identifying and resolving co-worker abuse so that you can contribute to a positive, civil, respectful and healthy working environment.

Topic #3: Reporting and Documenting

All LPNs recognize the absolute importance of reporting and documenting client care and incidents with conciseness and accuracy. Reporting and documentation are parts of information sharing: professional communication that centers on client care. This process should also include be respectful of the client. Language choices count! This shows professionalism. This is relational practice.

In most professional situations, writing or speaking about clients should not include slang terminology. As discussed in Chapter 1, slang is casual language, not professional. For example, LPNs would refer to incontinence of urine rather than saying a client 'wet himself'. Accuracy in assessing and reporting emotion is also important. Remember the example from Chapter 1, Table 2 when simply saying a client is 'upset' didn't give much information to colleagues who will also be caring for him or her. This led to the question, what does 'upset' actually mean? Is the client angry, sad, frustrated, impatient, irritated, worried or anxious about something? As stated before, remember to be specific. The nursing interventions that the LPN will take for each one of these can be quite different. Accuracy and specificity are very important when sharing data that will inform or guide client care.

Narrative Charting and Reporting

Recall from Chapter 3 that narrative is a way to express oneself. In relational practice, we often think of the narrative as coming solely from the client. That is not always true. Narrative-style reporting and documenting may also be used in nursing practice.

The skills of observation and noticing are important aspects of relational practice and nursing in general. They provide extra information to help LPNs gain a better understanding of the context within with a client is situated. Observation and noticing are forms of gathering collateral information. This in turn helps nurses and the care team consider how and why a client is behaving or responding a certain way. It helps them problem-solve and adapt nursing care to meet changing needs. And so, the context of a situation, too needs to be reported and documented accurately and as appropriate.

In relational practice, full descriptions like these are called contextual factors. In narrative charting, this information is documented. If another type of charting is used on your unit, this information, narrative-style is still shared with the care team. Figure 14 provides an example of observation and noticing; reporting and documenting.

Please be aware that if you are unfamiliar or struggling with the expectations of charting and other documentation, there is help available from the CLPNA. Go to their website, www.clpna.com and search for the study module called Documentation. Or try this direct link: http://www.studywithclpna.com/nursingdocumentation101/

Figure 14: Example of Observation and Noticing

During ward checks at mid-day, a client was discovered in his room, lying in bed, curled up, crying. The room was dark: drapes drawn closed, lights out. The skilled LPN noticed the environment and wondered if the client darkened the room on purpose. Was this an indication that something had happened to him? Why had he done this? The LPN realized that the environment of this room was part of the context of the crying. The nurse moved to engage the client in a quiet, thoughtful and compassionate approach to discover what was happening: what led to the tears and isolation in this darkened room.

Afterwards, the LPN verbally reported to her colleagues what she'd seen and learned from this encounter. They decided to keep a closer watch on the client and while allowing him some time alone, they would also encourage him to come out onto the unit a bit during the shift. They would seek him out for one-to-one interactions to assess his mood while also allowing him time to vent and explore his concerns. The LPN then documented this situation with the client using the narrative charting style. This included a very brief description of what he or she encountered: describing the room and the client's situation. She did include time, date, situation (observations), her nursing actions and the client's response to them.

Reflection:

Note that the LPN used a relational practice approach by not automatically switching on the overhead lights, opening the drapes and then after all of that, asking the client. The client remained at the center of the nurse's approach. The LPN engaged the client first, demonstrating genuine caring, respect and the continuance of a relationship based on trust and established rapport.

When reporting and documenting, the LPN painted a picture of the entire situation to provide some context. This will help other team members be alert to the situation and able to intervene as appropriate. Imagine that without the description of the environment, a nurse might simply say "I found the client crying in his room today. I sat with him and we talked about it. He's okay now." This description doesn't convey important aspects about the severity of the situation as reflected through darkness of the room and the client's behaviour.

Exercise 4.5: (**PDF** | **MSWord**)

Reflect on narrative charting and reporting. Next, answer the following questions or respond to the tasks.

- Think of a chart you read that lacked a good description of the situation or condition a client was in and when you went to the client's room you were very surprised to see what was actually occurring. For example, maybe the chart reported that this client (who cannot speak) was pale and shaking on last rounds. The note describes that the client's sheets were pulled up to his chin. Nothing is charted about what the client said or did in response to any care. When you went into the room you saw the paleness and 'shaking' but, you also saw that the window was open and a cold wind was blowing in. You saw that the client wasn't 'shaking' but instead shivering and unable to reach the call bell to call for assistance. And you saw that the client had a blanket at the foot of the bed but wasn't physically able to pull it up to warm himself. Can you think of something like that – when the charting wasn't descriptive enough to describe what was really happening?
    - What is a narrative?
    - Give one example of a situation with a client where you used narrative to describe the scene (the environment) and the client's status. Did you do this verbally or in documentation? Explain your motives.

Topic #4: Delegation

Recall that Chapters 3 and this one, Chapter 4, have identified the importance of respect, collegiality and collaboration on the care team. Relationally, delegation of tasks and responsibilities must also be undertaken with civility, respect, collaboration and a sense of collegiality.

Delegation of tasks is a client-centered activity that falls within the professional realm of practical nursing in Canada. There are very specific standards of practice for delegation that must be adhered to. They must be understood by all LPNs on the team. Furthermore, LPNs and others need some understanding of whether or not others on the team can delegate to them or each other. Only with this clear understanding or roles and standards are caring interventions completed professionally, collegially and to the best interest (and safety) of the client.

To attest to the importance of this, a joint document approved by the College of Licensed Practical Nurses of Alberta, the Registered Psychiatric Nurses of Alberta, and the College and Association of Registered Nurses of Alberta sets this out in the Decision Making Standards for Nurses in the Supervision of Health Care Aides (2013). The document clearly and succinctly outlines the rationale and processes for delegating tasks. See Figure 15.

Figure 15: Standard of Practice of Delegation

> … The three nursing groups recognize the importance of consistent interpretation and application of the *Health Professions Act* and regulations in all settings where nurses practice to promote safe, competent and ethical nursing care, and the importance of clarity of communication between and among health care workers and the public they serve.
>
> Excerpt from:
>
> *Decision Making Standards for Nurses in the Supervision of Health Care Aides*. College and Association of Registered Nurses of Alberta, College of Licensed Practical Nurses of Alberta, Registered Psychiatric Nurses of Alberta (2013):

Exercise 4.6: (**PDF** | **MSWord**)

Consider this scenario and write a respectful statement that delegates the task to a healthcare aide.

- Your resident was incontinent of urine and feces this morning, just before shift change. You hear this in Report from the Night Shift who haven't been able to attend to this because of shift change responsibilities. They are worried about it. The client's situation needs attending to, quickly. Report ends. You will delegate this task to a health care aide. How will you do so? What will you say that demonstrates collegiality, respect, civility and promotes collaboration?

Exercise 4.7: (**PDF** | **MSWord**)

Consider the following situation and respond.

- Two LPNs are on duty on the evening shift. The only Care Aide tonight is off on a break. There is a loud crash. A client has fallen out of bed. Who will delegate to whom? Is delegation needed here? Explain. If delegation is not needed, thinking from a relational practice approach, what is? (*See some thoughts on this exercise at the end of this Chapter*).

Topic #5: Conflict and Resolution

Conflict is a stressor. Some of the more common conflicts that nurses encounter at work are those of a social nature (for example, othering and cliques), those based on ethical standards (of individuals, team members as a group, or around client care), and those of employer-employee. Conflict arises when the feelings, needs or want of one person or group differ from another. In other words, conflict arises in the face of opposing positions: opposition.

Conflict at work can also be good. It keeps the staff from becoming complacent and 'stuck in their old ways'. Conflict stimulates problem-solving and creative thinking. It simply needs to be dealt with in a timely and respectful manner.

Practical Nurses have learned some skills around conflict and conflict resolution but these have mostly center on identifying how and why conflict occurs in the workplace, and how the use good communication skills to resolve them. Practical nursing education programs also teach the difference between passive-aggressive, assertive and aggressive behaviours in conflictual situations. However, civility, respect, trust and professionalism are also key ingredients in dealing with conflict. They should not be forgotten. As you know, situations can quick escalate into hostile or aggressive situations that can close down any hope of resolution. The relational practice approach must be remembered. The client is at the center of the nurse's world; the nurse's work. Conflicts between staff of a personal nature need to be resolved, but should never interfere with client care. When they do, care is jeopardized and professionalism is risked.

So, how is conflict resolved? All conflicts should be approached by issues, not personalities. Remember, to stay away from blaming and incivility. Talk about the issues. Search for resolution, don't demand it. Begin by requesting a meeting, briefly stating the purpose of it, the time and place. Then prepare yourself to be calm, respectful, open-minded and focused.

Here is a 6 step process recommended by ALIS.Alberta.ca (Government of Alberta).

Six Steps to Conflict Resolution

1. Explore the issue(s) ensuring the client is at the center even if the conflict is between staff or other people.
2. Understand interests in the issue (self and others) with the client centermost
3. Develop options and alternatives
4. Choose the best solution
5. Implement the solution
6. Evaluate the outcomes and identify how they will contribute to client outcomes.

What about conflict resolution when personalities clash? Using the relational practice approach where the client is more important to focus on than each other's personality, this conflict should be resolved very, very early. If not, morale may be negatively affected. At times, this type of conflict requires a mediator with strong communication and mediation skills before the situation gets out of hand. This should be someone objective and neutral. However, it is reasonable for an LPN to reach out to someone he or she is having conflict with at work, and attempt to meet with them to resolve the issues. Remember, LPNs put the client first and although all members of the team may not be 'best friends', there should be a professional level of civility and respect; collaboration and professionalism within the team.

Exercise 4.8: (**PDF** | **MSWord**)

Take a look at the 6 Steps to Conflict Resolution again. Could you apply it to a personality conflict? Try it. Keep the client at the center of all that you think about and do. Write it out. Does it work for you? Could you/would you be able to assertively ask someone you had a conflict with at work to meet with you to resolve it?

Summary

Chapter 4 has presented concepts of collegiality and collaboration from a professional and relational practice perspective. Notice how the idea of having the client at the center of interactions with team members helps in decision-making, problem-solving and assertiveness for nurses. This chapter has also asked you to look at your own way of being and doing in regard to any prejudice or biases you might have towards members of the care team who differ from yourself. Self-reflection on these concepts will help LPNs find ways to promote healthy work environments free of such biases and behaviours. The importance of accurately reporting and documenting using context as well as assessments of a client's status or behaviour has also been highlighted. Delegation was explored from the stand point of relational practice, putting the client's safety first when considering delegating to a care aide.

Review Exercise

1. The difference between prejudice and discrimination is:
   a. prejudice is an action taken against others; discrimination is an action taken against others
   b. prejudice is othering; discrimination is stereotyping and negative beliefs about people
   c. prejudice is a negative belief about someone; discrimination is an act based upon prejudice
   d. prejudice and discrimination are the same as othering
2. Conflict at work based on personality clashes can negatively impact the morale of:
   a. clients
   b. the care team
   c. management
   d. visitors
   e. all of the above

3. Speaking quietly at work is a cultural norm of the Canadian healthcare workplace.
   a. true
   b. false

4. In nursing, reporting the context of a situation
   a. is not necessary
   b. is helpful but not necessary
   c. is not to be added to the client chart
   d. is helpful, appropriate and necessary in certain situations

Glossary

Abusive – offensive, cruel, disrespectful, derogatory, belittling, harmful, violent.

Civility – reasonable, respectful, appropriate and courteous behaviour.

Cliques – small groups that share interests, etc. and who spend a lot of time together. They are very unlikely to let newcomers into their group.

Collaborative – working together for a mutual goal.

Collegial – a positive state involving shared responsibilities or duties; shared work.

Discrimination – the act of treating others unjustly or unfairly based on prejudice.

Festers – becomes worse, intense or even rotten.

Lingua franca – the main language.

Norms – written or unwritten rules of normal or appropriate social conduct Othering – treating people differently from the way you treat yourself or others you deem similar to you. Othering excludes people from your personal, social or occupational sphere.

Prejudice – personal beliefs or preconceived notions about someone or something that may not be true; bias.

Precedents – previously cases in law or society that set the example to be followed.

Retribution – punishment or revenge.

Salient – standing out; noticeable or important.

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Review Exercise Answers

1. The difference between prejudice and discrimination is:

   (c) prejudice is a negative belief about someone; discrimination is an act based upon prejudice

2. Conflict at work based on personality clashes can negatively impact the morale of:

   (e) all of the above

3. Speaking quietly at work is a cultural norm of the Canadian healthcare workplace.

   (a) true

4. In nursing, reporting the context of a situation

   (d) is helpful, appropriate and necessary in certain situations

Reflection on Delegation Exercise

Each LPN has the right, responsibility and ability to delegate to another LPN but in this case it is not necessary. These two nurses are working on the same team and will be sharing tasks. There should not be conflict. However, if the person who has fallen is a client assigned to one of the LPNs in particular, he/she may request the help of the colleague or delegate a task while he/she does another. An example would be having one LPN call the physician while one attends the client. Relational practice keeps both nurses centered on the provision of client care. Conflict from a power-over perspective (one nurse over another) should not occur here.

Chapter 5: Relational Practice with Healthcare Team Members

Overview

Chapter 5 continues the discussion of relational practice within the realm of the care team. In this chapter the focus is primarily on communication within the nurse-physician relationship. This includes learning more about the assertive nurse. A communication tool, SBAR will be provided to facilitate communicating with physicians by phone. This relationship also necessitates a discussion of the role of status on the Canadian health care team. The chapter also includes an exploration of gender-based communication within the interprofessional care team and between nurses and clients.

Topics in this Chapter:

1) Status on the Care Team
2) The Assertive Nurse
3) Communicating with the Physician
4) Gender-based Communication

Topic #1: Status on the Canadian Care Team

As the education levels and competencies of the health professions has expanded over the last decades, each is becoming more aware of the roles and value of the members of inter-professional, multidisciplinary teams. A variety of health professionals work alongside each other. They discuss, consult, collaborate and inquire mutually and respectfully, each appreciating the others' scope of practice and expertise. When an interest in one's own professional status becomes a barrier to open, effective and direct communication between members of the care team, morale, trust and respect diminish.

Equality on the health care team.

Status can be a form of othering. And it creates communication barriers as seen in instances between physicians, nurses and/or any members of the healthcare team. This is important because increasingly, research is giving evidence that adverse events, mistakes, and poor client outcomes are based on communication difficulties between physicians, nurses and the rest of the care team (Hull, 2016; Eggertson, 2012; Lyndon, Slatnik, Wachter, 2011; Dingley, Daugherty, Deirieg et al., 2008). The good news is, this has been changing. Canadian care facilities and hospitals embrace codes of conduct of respect and civility amongst employees. Status is losing its place in the culture of the Canadian health professions. Status is not important in the relational practice approach, the client is!

Exercise 5.1: (**PDF** | **MSWord**)

Reflect on a time you observed nurses and doctors working together.

- Did you hear any language that conveyed a special status to the doctor or the nurse? For example,
  - Did the nurse say 'yes sir' to a male doctor or 'yes, ma'am' to a female one?
- Now reflect on a time when you saw or experienced the expectation of status by another health professional. Was this a

nurse, a psychologist, a physiotherapist, a dentist, a social worker? Who? Does that matter? What makes you think status was involved?

- Can you think of any other examples that you saw?
- If you did not see anything like this, what does that fact teach you about status within the care team?

Topic #2: The Assertive Nurse

In Canada, nurses are expected to be assertive rather than subservient or hold a less-than-equal place on the interprofessional care team. What does this mean? It means the nurse will speak up and advocate for the rights and needs of clients when it is necessary. For instance, they are able to speak clearly and with purpose when the client's needs are not being met or there is an error in the medication order. By speaking up, the nurse gains the respect of the care team and demonstrates his or her commitment to professional care. And seeing this, team members may feel more inclined to support, trust and collaborate with this nurse. Assertiveness lets nurses be proactive rather than reactive (Gregory, Raymond-Seniuk, Patrick, Stephen, 2015).

Assertiveness is a skill that doesn't come easily to many people. It is the ability to express your own feelings without fear of disrespect or retribution. However, being assertive does not give a person the right to put down others, blame them or make them feel bad. That is aggressiveness. Assertive nurses use 'I' language and focus on the issue at hand, not a person's personality (Gregory, Raymond-Seniuk, Patrick, Stephen 2015).

Assertive nurses seek clarification. Having used self-appraisal, they are honest about their own knowledge and skills levels. In Canadian nursing, the cultural norm is for all nurses to ask questions of each other and work together to provide safe, competent care.

Exercise 5.2: (**PDF** | **MSWord**)

Think back to an experience you've had working with Canadian nurses.

- Did you see them asking each other for information, clarification or help? For example, did you ever hear one nurse ask another to help her/him calculate a medication dose? Maybe you heard a nurse ask another to help clarify something in a chart or, to help refresh a skill such as tracheostomy care.
- What about your own nursing practice? How often have you asserted yourself in the pursuit of good client care? If you have not, what stopped you?

Assertive nurses also seek clarification, information and guidance from physicians. It is an expectation in Canadian nursing that all nurses will enter into dialogues with physicians about clients. When a concern arises that the physician misses or does not see something as important as you (and the client does), the Canadian nurse will assert himself or herself and advocate for the client. In these instances, the nurse becomes the voice of the client.

"Effective clinical communication is respectful, clear, direct, and explicit" (Lyndon, Slatnik, Wachter, 2011, p91). Through assertiveness, physicians and nurses can refocus on the client and openly discuss and collaborate on issues of care. Additionally, asserting oneself to a physician when there may be questions about the physician's verbal or written orders for care, medication and other treatment is the absolute responsibility of the Canadian nurse. Remember, using the relational practice approach, the client comes first and is at the center of all care. Assertion is not undertaken to prove anything about a nurse's knowledge, status or even

character. It is undertaken on behalf of the client and his/her health.

Exercise 5.3: (**PDF** | **MSWord**)

Now think back to an experience you've had working with Canadian physicians.

- How frequently have you asserted yourself to a physician in the pursuit of good client care? If you have not, what has stopped you?

If you would like to take a course in assertiveness training for professional development, please inquire about this with your employer. Or, perhaps you'd like to learn more on-line. You might want to watch the video, below and read the accompanying interview on-line.

Racco, M. (2017): *How to be assertive in the workplace without being a jerk*.* In Lifestyle; Smart Living. Global News video. June 7, 2017. Includes discussion with Dr. Jennifer Short, Psychologist at the Achieve Centre for Leadership and Workplace Performance in Alberta. http://globalnews.ca/news/3507267/how-to-be-assertive-in-the-workplace-without-being-a-jerk/

*Note: Alternatively search for the title of this video on-line.

Topic #3: Communicating with the Physician

As you saw in Chapter 4, accuracy and specificity are very important when sharing data that will inform or guide client care. One of the most recognized methods of doing this is to use a specific model called the *Situational Briefing Model* (SBAR). SBAR, an acronym for **Situation**, **Background**, **Assessment** and **Recommendation**, is a technique used to facilitate prompt and appropriate communication by helping to organize thoughts and information. The College of Licensed Practical Nurses of Alberta supports the use of SBAR by LPNs in their competency profile for LPNs (2015). See Figure 16.

SBAR is a communication tool used for verbal reporting. It's used when nurses need to communicate clearly and succinctly with physicians and other members of the care team about the status of their clients/patients (Arnold, 2011). SBAR is a standardized approach commonly used by LPNs, RNs and RPNs in Canada.

The SBAR model, or tool helps nurses gather their thoughts and put important client data into an orderly, logical fashion prior to speaking about it. In that preparation, he or she also formulates at least one solution to the issue she or he would like to report. This is given as a recommendation (R) at the end of the interaction. During that time, the nurse can also ask to physician or other team member for guidance and their own recommendations. Sometimes, new Doctor's Order arise from these conversations.

Figure 16: SBAR Competency Requirement

College of Licensed Practical Nurses of Alberta Competency Profile for LPNs, 3rd Edition (2015) Competency Band D

D-2-6 Demonstrate knowledge and ability to utilize a standardized communication tool to enhance communication process such as: SBAR situational briefing model:

S-situation
B-background
A-assessment
R-recommendation

A further description of SBAR is helpful to learn what information a nurse should include in his or her communication.

Situation (S) begins the conversation. The LPN provides some context. For example in a crisis, the nurse might call a physician after hours to say "*Mr. Jaeger fell out of bed. He hit his head. His nose is bleeding. He is alert and oriented*."

Background (B) provides more context so the listener (the receiver of the message) can understand how this situation occurred. It would sound like this: "*We had the side rails up. He was sleeping when last checked. He says he was dreaming he was at home. He woke up and had to go to the bathroom. He tried to get over the side rail to do so and fell*."

Assessment (A) is then reported. "He appears to have fallen on face down. He hit his face. His nose was bleeding. We've stopped it. He's been assisted back to bed. I examined his nose. It's swelling, painful and he cannot breathe through it. He's developing what looks like periorbital hematomas."

The **recommendation** (R) does not include a diagnosis. LPNs are not allowed to diagnose. Only physicians and some Nurse Practitioners can do that. In the R stage, the LPN offers a suggestion to solve an issue or a problem or seeks guidance, advice or orders. For example the nurse might say: "*I wonder if Mr. Jaeger needs an x-ray?"* Or the nurse might say: *"Mr. Jaeger doesn't have an Order for analgesics and I think he could use one for pain. What do you advise*?"

Exercise 5.4: (**PDF** | **MSWord**)

Practice using SBAR. Take the example of Mr. Jaeger, above. Draw an SBAR table like the own below. Place each piece of that communication into it.

Table 6: SBAR

S-situation	
B-background	
A-assessment	
R-recommendation	

The use of SBAR is especially helpful to nurses who feel nervous around physicians and for nurses who may be new to Canada. This tool provides a helpful strategy for not only preparing and organizing this communication event, but also gives this nurse some time to rehearse the report aloud if necessary prior to the interaction. For nurses new to Canada and for whom English is not their first language and who may have a cultural background that confers superior status on physicians, the use of SBAR is helpful to overcome that type of cultural bias.

Remember, if you are calling a physician or supervisor to make a verbal reporting request, you must always identify yourself, state your role (ex., LPN), and identify your location (ex. Unit 6-

A). Next, you must clearly identify the client or patient you are going to be talking about.

Exercise 5.5: (**PDF** | **MSWord**)

Complete this case study in which you, the LPN need to make a phone call to the physician. Create a table like the one given and fill it in.

Earlier in the day, you and the doctor talked about your client and you were under the understanding the intravenous would be discontinued today. Now, the doctor has left the unit but you see that the intravenous medication was not discontinued. The IV order still stands. The bag currently hung at the bedside is almost finished. You don't think you should hang another but you are unsure. You don't want to call the doctor but the other nurse on your team says you must. Using the concepts of assertiveness and relational practice …

- What will you say? Using the tool, SBAR, prepare for that conversation. You are given the script for the beginning of the call.

Table 7: SBAR Exercise

Introduction & beginning	Hello, Dr. Smithski. My name is _____ and I am the LPN working on Medical Unit 5C. I am working with Mrs. Belowski, your client.
S-situation	
B-background	
A-assessment	
R-recommendation	

Topic #4: Gender-based Communication

Canada believes in gender equality. This is one of our cultural norms. The concept is identified as sexual equality in the *Canadian Charter of Rights and Freedoms*, Part 1, Section 15 (Government of Canada, 1982). This equality is guaranteed by the Charter and therefore the laws of the country. This means that we must not discriminate on the basis of being male, female or transgendered persons. Using the principles of relational practice, we nurses should also role-model gender-neutral, inclusive language (Trout-Wood, 2015).

To begin to understand and self-reflect on any biases a nurse might have, he or she must be clear on what gender identity is. It means how a person personally and identifies themselves as male or female; both or neither (Trout-Wood, 2015). This identify may be acknowledge overtly or covertly. Fear of stigma and discrimination may cause the person to keep their gender identity very private, even secret from others.

Gender-bias does occur in Canada. It is our responsibility as Canadian citizens to try to prevent it and promote equality when we can. Gender-bias is stereotyping people by gender. It stems from our personal values and beliefs. They come from our early learning and are based in our own ethnic, cultural or religious backgrounds. They have no place in healthcare. LPNs understand the principles and privileges of the Charter of Rights and uphold them. As professionals, they adhere to regulatory standards that all clients are treated equally. Stereotyping, prejudice and discrimination in care should never occur in healthcare.

Gender-bias also occurs within the care team, itself. This is sometimes seen in incidence of male privilege. In this case, more status is conferred on males in the health professions than females. This can sometimes be seen the way that female staff defer to male physicians. However, there is also gender-bias against males in health care. This occurs more frequently in nursing. Since nursing was traditionally a female job, male nurses have sometimes been treated as if they are homosexual males whether they are or not. This is suggestive of gender-bias and stereotyping.

Exercise 5.6: (**PDF** | **MSWord**)

Think of an experience you've had with health professionals at work in Canada.

- Have you witnessed a difference between the ways the nurses speak to male doctors versus female doctors? If so, that is based in gender-bias. If not, you may have seen some very good role-modelling of the concepts of gender equality.

Gender-bias in healthcare extends to women, too. A good example of this is when female staff are told by others (including clients) to "smile, you'll feel much better if you do" or "smile, you look so pretty when you do." Male nurses are rarely asked to smile like this. Gender-biases against female nurses is sometimes seen in the way physicians speak to them. This is evident if a physician uses a term of endearment such as 'honey' or 'you are a doll' to a co-professional such as a nurse. Or perhaps the male physician requests the female nurse to sit somewhere else so he can have her chair. All of these are completely inappropriate.

Exercise 5.7: (**PDF** | **MSWord**)

Reflect back to an experience on a hospital unit or in a care facility in Canada to answer these questions.

- Have you ever seen male nurses treated differently than females?
- How do you explain that?

- Do you treat male nurses differently? How so?
- Have you ever been told to smile when you are at work? How did that make you feel?

Gender-bias on the healthcare team is a barrier to good morale and a healthy work environment. In diverse care teams of multicultural, multiethnic, multi-religious members, it must be prevented. Education and awareness are key to eradicating these types of prejudices. Employers as well as individual employees all hold the responsibility to maintain a workplace of gender-equality in all that they do.

Summary

Chapter 5 has focused on clarity in communicating with physicians and others. This communication should be succinct and to-the-point; clear and understandable. It should also be free of any gender-bias. Assertive nurses learn the skills of advocating for self and others. By being assertive and working from a relational practice approach, these nurses are role-modelling their knowledge, skills and professionalism to others.

Review Exercise

1. An assertive nurse is free to openly blame another team member in front of others for not doing his work.
   a. true
   b. false
2. Using SBAR, how many solutions or recommendations should an LPN have prepared prior to call to a physician about a client?
   a. 1
   b. 2
   c. 3
   d. 4
3. SBAR stands for
   a. short, brief assessment report
   b. standardized, best assessment report
   c. situational brief assessment recommendation
   d. situation, background, assessment, recommendation
4. Gender-bias means
   a. stereotyping people by their gender
   b. suggesting people have no specific gender
   c. recognition of sexual preferences
   d. condoning interracial marriages

Glossary

Bias – prejudice; tendency to hold a view or opinion without any facts.

Gender – a class or state of being such as being male or female.

Hierarchy – classification by a system of ranking or ordering.

Status – position or social standing by ranking or classifying.

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Review Exercise Answers

1. An assertive nurse is free to openly blame another team member in front of others for not doing his work.

   (b) false

2. Using SBAR, how many solutions or recommendations should an LPN have prepared prior to call to a physician about a client?

   (a) 1

3. SBAR stands for

   (d) situation, background, assessment, recommendation

4. Gender-bias means

   (a) stereotyping people by their gender

Chapter 6: Relational Practice for Continuity of Care

Overview

Relational Practice for continuity of care is the focus of Chapter 6. You'll learn about team work across practice sites. Examples will be given that show how care is client-centered and continuous across primary, secondary and tertiary care sites. This includes acute care, community care and residential care for example. This chapter will heighten your awareness of the importance of consent and confidentiality when client information is going to be shared across sites. Finally, the chapter ends with a brief overview reporting for transfer or discharge.

Topics in this Chapter:

1) Acute Care and Community Care

2) Continuity of Care

3) Sharing across care sites: legal and professional boundaries

4) Skills of Reporting, Team to Team

Topic #1: Acute Care and Community Care

Before relational practice for continuity of care can be discussed, it is important to review the types of care in Canada. These are primary, secondary and tertiary care.

Primary care involves health promotion and illness prevention. While usually this work is mostly in the community by nurses, nurse practitioners, physicians, dentists, pharmacists, dieticians, optometrists and so forth (Betker and Bewick, 2012) in offices, clinics, or homecare, it also occurs in the Emergency Room of hospitals. Primary care is the first contact a client makes with a health provider. It also "…coordinates patients' health care services to ensure continuity of care and ease of movement across the health care system when more specialized services are needed" (Government of Canada, n.d.). Community care nurses attempt to prevent and reduce the need for hospitalization.

Secondary care occurs in an acute care setting or in long term, residential care. For these areas, a medical referral for need must occur and a physician will follow the case for continuity of care. Sometimes secondary care occurs in a person's home or a group home. Moving from acute care community will depend on need for an 'Alternate Level of Care' (ALC).

Tertiary care in Canada involves clients who require specialized care. In acute care, this may relate to a need for surgery, for example. In community care, this person may need specialized care over a long period. An example is a ventilator-dependent client who might live in a personal (private) care home, group home, a long term care or a residential care facility. Another example is the client with a chronic mental illness who in unable to live on his/her own in the community.

You've seen how acute care is generally situated in hospitals. There are a few exceptions to that. Emergency personnel such as paramedics and other emergency responders in the community are involved in acute, life-saving care sometimes. At other times, they are involved in primary care activities such as transferring clients from one facility to another. The role of an acute care LPN involves working in a hospital environment with multiple supports of interprofessional staff, care aides, technicians and equipment.

Community care nurses are supported by care teams too. However, they go into people's homes and are more autonomous in the care they engage in and the decisions they make (Bardha, 2014). Community care/community healthcare

LPNs need to be strong in knowledge, skills and professionalism. They must also be honest in self-reflection about this prior to engaging clients in care.

Strength in relational practice is paramount in partnering with home care clients and working towards the client's chosen health outcomes. Examples of this are working with clients who refuse to stop smoking but are struggling with oxygenation and taking medications for Chronic Obstructive Pulmonary Disease and those clients who are palliative and choose to be at home when death occurs. In each case the LPN works closely and mutually with the client to make the best of the client's journey through health.

Strong relational skills are paramount in home care nursing.

Exercise 6.1: (**PDF** | **MSWord**)

Now that you understand the types of care in Canada, complete this exercise. Decide which example is acute care and which is community care. Some of your answers may be the same.

Care Type	Acute or Community
Mental health group home	
Surgical unit	
Palliative care facility	
Obstetrics & Gynecology unit	
Walk-In Clinic	
Dental Office	

Topic #2: Continuity of Care

The concept of continuity of care centers on providing a smooth transition for clients from one care site or program to another and sometimes back again. These are sometimes referred to as connected client-care events that occur within health care institutions (ex., when a client changes wards) or across numerous settings (Arnold, 2011). It is a clear example of comprehensive, holistic care and it is always relational. And while it facilitates positive client outcomes, continuity of care also help bridge any gaps between acute care, specialist care and community care (Emms, 2014). Specialist care means that which includes surgeons, dermatologists, urologists, plastic or cosmetic surgeons, and so forth.

Multiple care providers are involved in the continuity of care process as they occur across or within primary, secondary and tertiary care. In any and all of these situations, LPNs use a relational practice approach, keeping the client foremost in their planning and interactions with others. In essence, the LPN is involved in relational continuity (Arnold, 2011).

In an in-patient hospital setting, continuity of care refers to collaborating with team members for their expertise, guidance and support. However,

when a client moves from hospital back into a community setting, it is also the nurse's role to help the client prepare for this (Duggleby and Lueckenotte, 2010). This is a form of relational continuity.

Additionally, the concept of continuity of care may require the in-patient or acute care LPN to have some degree of involvement with the receiving care home or a facility's care providers. This may happen in documentation (such as a transfer record) or in joint team meetings where care providers from outside of the hospital attend pre-discharge planning meetings. An example of this might be the collaboration of maternity nurses with public health nurses who do well-baby visits to new mothers.

In the community, continuity of care is visible as the LPN and the care team assist, assess, monitor and collaborate on the health needs and wants of clients. For example, a community health care LPN may notice a change in a client's eyesight over the months she/she has been visiting to assist with insulin injections. Consulting and collaborating with the team, the client may be referred to an optometrist. Continuity of care occurs when an actual eye examination has occurred and if needed and the results become part of the care activities of that nurse. Continuity of care occurs when a community health nurse sees changes in wound status and follows up with the client's physician, initiates care from new Doctor's Orders, and again follows up with a report back to the physician (as well as the community care team). Depending on the case, continuity of care practices in the community can help reduce the need for hospitalization (Emms, 2014).

Exercise 6.2: (**PDF** | **MSWord**)

Using the case study here, map out how continuity of care might occur. Use the template with the arrows. Identify who you will involve along the client's journey to wellness. The blank lines are for you to identify who is contacted and which steps each takes. Use a big piece of paper to map this out. You are given an example to see how this works.

> EXAMPLE: Kailey has multiple sclerosis (MS). She is living in her own apartment. She is ambulant but her gait is slow and shuffling. For distances she uses a motorized scooter. At home, she prefers to keep walking. While her muscles are less strong now, she is still able to do her ADLS, prepare her meals and do some simple cleaning around the house. She worries about falling and so receives some assistance from Home Support Services/Community Health to take a shower, help her with laundry and grocery shopping. Socially, she is an avid reader and belongs to a book club and volunteers at a local thrift store when she's feeling strong enough. When there, she always uses her scooter. She also receives a visit from a Home Care LPN once per week to assess her physical status and needs. Today when the LPN visits Kailey in her home, she assesses fever, a slight cough and sniffled and the client reports a sense of not feeling well (general malaise).
>
> The LPN calls her supervisor, the Community Health RN, → because → Kaleigh has signs of illness (a cold or respiratory infection) and → (steps taken) the LPN and RN confer, deciding the next step is to call the physician because → symptoms of MS can worsen with a cold (next step) → the physician orders lab work and wants to see the client → Community Health Nurse advises the LPN → LPN tells client, who then calls Doctor's office for appointment → LPN and client know transportation needs to be arranged and LPN does so to ensure client sees physician and lab → lab sends report to physician →

physician diagnoses and advises not only Kailey but also the Community Health Nurse who advises the LPN because → the LPN will alter her focus of care dependent on the outcome of lab tests and physician diagnosis and → Community Health Nurse assigns LPN to visit twice per week for now rather than once per week to make health assessments and → Community Health Nurse advises Home Support Workers regarding Kaleigh's health status → because of need for more care daily until illness passes → LPN and Community Health Nurse collaborate to provide progress note to Physician at the end of one week.

Now it's your turn:

Bobby has Cerebral Palsy and lives in a privately-owned group home with 2 other residents who also have the disease. He has some difficulty breathing and mostly breathes through his mouth. He is non-ambulant, verbal (with some communication challenges) and is quite intelligent. He is currently working on a distance education course in first year university Sociology. You, the community health LPN visit him once per week to assess his health. The group home staff have called you today because they detect a change in Bobby's breathing and note he has begun to cough occasionally. This concerns you. You go to see him today. You decide he may have a cold but you want to rule out any other type of respiratory infection since he is highly susceptible to infection. What do you do next and who do you involve?

Care home calls →(who) _____ because _____ and steps taken_____ →→

Next person is _____ and steps taken by that person _____→→ Next person is

_____ because _____ and steps taken by that person _____ →→Next person is

_____ because _____ and steps taken by that person.

Add more steps if you like. Complete this map until Bobby is well again.

Exercise 6.3: (**PDF** | **MSWord**)

Look back now at your map. Where does Bobby appear in it? If you have used a relational practice approach, he had to be consulted and partnered with along the way. Answer this question honestly and then reflect on your answer for its meaning to your practice as an LPN.

- Did you or did you not consult with Bobby about your plans for his care at the beginning? Explain.
- Did you or did you not engage with him at various steps in this process to update him and involve him in planning for the next steps towards wellness? Explain.

Topic #3: Sharing across Care Sites: Legal and Professional Boundaries

You've been learning that continuity of care is health promoting and illness preventing just as primary care is. You have also seen now that the client cannot be forgotten as the center of all activities the care team is involved in. However, there are a number of parameters – boundaries that come into play when sharing across agencies, facilities and hospitals. These are also grounded in the legalities of privacy and consent. So, what can or cannot be shared with others about your client.

Client consent is paramount to continuity of care. The LPN has to recognize who, what, where and when client information can be shared, especially when in-patient and community care providers are involved. This relies legally on the client being informed (through partnering and mutuality in relational practice) and then giving consent for others to know about all or part of his/her medical history and needs.

The concept of 'need to know' applies. While you or the social worker for example may know a lot about a client's history and the current bio-psycho-social-spiritual and environmental components of his/her situation, it may be that the client does not want all of that shared. For example, if your client has a history of drug addiction but has been in recovery for 14 years, it is not necessary to tell everyone involved in care this information. The critical thinking, professional LPN understands this. Exceptions might only be made in this instance if the client needed analgesia in the form of narcotics. The LPN would engage the client in a one-to-one interaction to explore who should or might divulge the client's past history. In this case, there may be ramifications for not telling – the client may again become addicted. However, the client may be the one to report this and ask the LPN not to.

Clients must also give consent for any discharge or transfer information about them. This however is usually included in the admission and treatment form. The responsibility of the nurse thought is to identify whether or not the receiving agency or facility is part of the same health authority and if that consent still applies. When the client is going to be transferred or discharged outside of the health authority system, the LPN will take care to limit the amount of documentation that goes with the client. The summary or report will be specifically focused to the reason for admission, the results of treatment and any continuing treatment that may be needed. Personal or historical information should not be included.

If you are ever unsure or unclear about practice expectations, consult your employer. You can also contact the College of Licensed Practical Nurses of Alberta to ask a question on-line, or speak to a Practice Consultant by phone.

Exercise 6.4: (**PDF** | **MSWord**)

Answer the following questions based on this case study.

Jagdeep, 33, lives in a private group home for mentally ill clients. He contracted pneumonia and was admitted to hospital on your medical unit. Now, 10 days later, he is being discharged back to the group home. You call the home to let them know and, you also tell them you will be sending a discharge summary outlining any care he needs to be continued.

- The staff person at the group home asks:
    - If Jagdeep needs to still take antibiotics. You know the answer. Are you allowed to tell them? Whatever your answer is, write it down.
    - If Jagdeep's girlfriend visited him in hospital and if so, was he sexually appropriate with her? She did visit but will you tell them? Whatever your answer is, write it down.

- If Jagdeep's parents visited him and gave him some money. You know that they did, but will you tell them? Whatever your answer is, write it down.

- Now, look back at your review the section on *Sharing across Care Sites*. Reconsider your answers to this exercise. Do you still believe you are correct in your answers or would you like to revise them? If so, do so now. (*See suggested answers to this case study at the end of this chapter*).

Topic #4: Skills of Reporting, Team-to-Team

Reporting across teams or team member to team member requires the same skills of accuracy, conciseness and professionalism LPNs use every day. In some cases this is more important than others. Do you know when? A good example is at Report, when shifts are changing and you need to communicate important information in a short period of time. Additionally, in Chapter 5 you learned about SBAR and when it should be used. This chapter concerns itself with continuity of care across teams or care-provider sites and the SBAR tool is an excellent strategy for communication. And while all of the above-mentioned skills and behaviours are still required, the LPN must not forget the primacy of consent to share information from the client.

Reporting always begins with identification of the client, who remains at the center of all matters being shared. Optimally, it takes place in an environment free of conflict; an environment that confirms professionalism and a culture of regard by all members of the care team (Arnold, 2011). It is a collaborative effort. A nurse shares and the receiving shift asks questions of clarification. Brainstorming for new strategies or sharing of other findings by other team members is welcome. Optimal outcomes for client care remain at the heart of the communication.

Communicating for continuity of care or relational continuity is interprofessional, and interdisciplinary in nature. Participants work together for the client's goals but also work independently within their own disciplines. For example, a medical social worker will be part of discharge planning right along with nursing staff, the physician and a number of other professionals. Figure 17 provides explains more about relational continuity within an interdisciplinary team.

Figure 17: Relational Continuity within an Interdisciplinary Team

> "… an interdisciplinary team develops a collective vision and common language to support a collaborative, unified working approach to clinical problems."
>
> "An interdisciplinary team actually integrates services, using teamwork principles…"
>
> Excerpts from
> Arnold, E. (2011, p 473)

Sometimes reporting for transition or discharge is referred to as *Handing Off* or Handoffs (Arnold, 2011). This generally refers to moving a client from one unit to another in a hospital or care facility: a transfer. Discharge on the other hand is when the client leaves one care environment completely. He or she is no longer their responsibility. Just the same, to ensure optimal client outcomes, and using relational practice principles, a report – some documentation must facilitate that change. Discharge notes should include: reason for care (or hospitalization), any significant or relevant findings to share (ex., the most recent lab results), treatments or procedures and their outcomes, the client's current health status, and any other appropriate

information that will ease transition to the next care site and prepare the location receiving the client to continue care. If you recall the steps in SBAR, you will see how this information can easily fit into it. Remember, Discharge Notes should include the LPNs name and designation. A physician's Discharge Note might also accompany this, or a combination of both. However, there must be a written document authorizing discharge by a physician. All of this constitutes steps in the process of continuity of care.

Exercise 6.5: (**PDF** | **MSWord**)

There are many examples of discharge summaries available on-line. Find at least 6 different versions of discharge summaries and study their formats. Do they look like anything that has been talked about here in Chapter 6? Explain. Write down your thoughts; your comparisons.

Exercise 6.6: (**PDF** | **MSWord**)

Is it within the Scope of Practice for LPNs to write Discharge or Transfer Summaries? If you do not know the answer to this, you need to find out. Where will you find the answer? (Hint: *Competency Profile for LPNs*).

Summary

Chapter 6 has introduced the concept of continuity of care and how the LPN, as an integral part of the care team, takes a role in that. The definitions of acute care and community care were given were primary, secondary and tertiary care. The importance of clear communication based in a philosophical approach of relational practice was threaded through-out the chapter. Attention was drawn to the legalities and professional responsibilities of confidentiality through an exploration of consent and informed consent across care teams and care-provider sites.

Review Exercise

1. Which of the following is not an example of primary care?
   a. the maternity ward
   b. Mrs. Smith's house
   c. the Walk-In Clinic
   d. the Community Health Care Team
2. Continuity of care means
   a. clients return to the hospital again and again
   b. sick clients can always be cared for at home
   c. care across multiple settings
   d. discharge from acute care
3. In order to share information with a private residential care facility where your acute care client usually lives, a signed consent form is not necessary.
   a. true
   b. false
4. Within the SBAR format, information is …
   a. clear, focused, informed
   b. clear, situational, contextual, central
   c. concise, clear, situational, contextual
   d. clear, concise, relevant, situational, contextual

Glossary

Concise – brief but comprehensive; using a few words carefully chosen to convey information.

Constitutes – makes up, establishes, creates, or contributes to.

Continuity – continuous over time; an unbroken process.

Designation – title, official description or status.

Relational continuity – client-centered care that appropriately crosses the boundaries from hospitals to community to residential care, etc. The concept means that a larger team is involved in caring for the client promoting, recovery, rehabilitation or maintenance of physical and/or mental health.

Ward – synonym for unit; hospital unit.

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Review Exercise Answers

1. Which of the following is not an example of primary care?

   (a) the maternity ward

2. Continuity of care means

   (c) care across multiple settings

3. In order to share information with a private residential care facility where your acute care client usually lives, a signed consent form is not necessary.

   (b) false

4. Within the SBAR format, information is

   (d) clear, concise, relevant, situational, contextual

Reflections on Jagdeep Case Study

The client lives in a group home. It is appropriate and important to let them know about his medications. This information will also be included in discharge summary to them.

Whether or not Jagdeep had any visitors is not particularly confidential and you might say. However, whether or not he had sexual interaction of any sort with his visitors is inappropriate to disclose. To do so is a breach of confidentiality. If there is a concern the matter should be dealt with discreetly and sensitively among appropriate members of the healthcare team who are best suited to deal with the situation.

Whether or not Jagdeep got any money from his parents is also private and confidential unless there is some mechanism in place where he is to only have certain amounts of cash available. This will likely be identified on his care plan at the group home. It may have been established through the psychiatrist based on Jagdeep's ability to manage money as well as perhaps legally through a trusteeship or Legal Guardianship where his money is taken care of for him. If you do not know this, you do not talk about this subject. It's confidential. If you do know about it (perhaps through the admission report or the psychiatrist), you may only briefly provide this information. You are not to discuss it otherwise.

Chapter 7: Relational Practice with Indigenous Peoples

Overview

Chapter 7 focuses on relational practice with the indigenous (aboriginal) peoples of Canada. Practice Standards requires LPNs to provide culturally competent care (Canadian Council for Practical Nurse Regulators and the College of Licensed Practical Nurses of Alberta, 2013). And so, this chapter explores relational practice with indigenous peoples by providing a bit of historical and cultural background as well as current, salient factors in the lived experience of indigenous people of this land. For indigenous people, this refers not only to individuals, but to groups and communities of ethnically, culturally similar (yet not identical) peoples.

Chapter 7 also asks for honest self-appraisal of knowledge, beliefs, and efforts being undertaken by LPNs individually to respond to nursing concepts of cross-cultural nursing and cultural safety. The goal is to enhance not only a relational practice (RP) approach to working with indigenous clients now and into the future, but to become aware of the whys and wherefores of current and historical practices that need to change. This contributes to informed practice. Once again, the client remains at the center of care and caring. The context for this chapter may be broad, but is all relevant to RP and health care.

Topics in this Chapter:

1) Impetus and Rationale
2) Coming to Know
3) Relational Practice
4) The Way Forward

Topic #1: Impetus and Rationale

Today, nurses are expected be aware of and knowledgeable about the indigenous peoples of this land. Furthermore, they are expected to be able to adapt their communication and relational practice approaches to create an open, informed, genuine and respectful partnership with indigenous clients, their families and communities. Nursing across Canada has always been committed to cross-cultural care but this is even more so now in response to the *Calls to Action of the Truth & Reconciliation Commission of Canada* (2015). Nurses don't stand alone in their response to these calls.

Adoption of the recommendations from the work of the Commission (2015) is mutually supported by Health Canada and other health professions. Nursing programs for practical nurses (LPNs) are in the process of adapting their curricula to reflect this (*Truth & Reconciliation Commission: Calls to Action*, Health, No. 24). This is referred to as indigenizing the curriculum.

To access the full document online search for Truth and Reconciliation Commission of Canada (n.a.) (2015): Calls to Action. Truth and Reconciliation Commission of Canada. Available at http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Calls_to_Action_English2.pdf

For your information, Figure 18 provides the recommendations from the *Calls to Action* for the Health sector. The *Calls to Action* document includes many sectors of society including education and citizenship. For example, Figure 19 specifically speaks to the need for newcomers to Canada to learn about indigenous people.

Figure 18: Recommendations from the Calls to Action for Health

Section: **Health**

22. We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

23. We call upon all levels of government to:

i. Increase the number of Aboriginal professionals working in the health-care field.
ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
iii. Provide cultural competency training for all healthcare professionals.

24. We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

Excerpts from:
Calls to Action
Truth and Reconciliation Commission
Canada, 2015 (p3)

Figure 19: Recommendations for Newcomers for Knowledge of Indigenous People

Section: **Newcomers to Canada**

93. We call upon the federal government, in collaboration with the national Aboriginal organizations, to revise the information kit for newcomers to Canada and its citizenship test to reflect a more inclusive history of the diverse Aboriginal peoples of Canada, including information about the Treaties and the history of residential schools.

Excerpt from:
Calls to Action
Truth and Reconciliation Commission
Canada, 2015 (p11-12)

Topic #2: Coming to Know

As with every client and client-group, LPNs strive to 'come to know' them. This cannot happen without an understanding of who this special population is. We are focusing on the indigenous people in Canada.

***Exercise 7.1*:** (**PDF** | **MSWord**)

Answer the following questions. Write down the answers. You should come back to them after you've finished this chapter and reassess yourself.

Assess your background knowledge about the indigenous people of Canada.

- Do you know who they are?
  - Name them as the groups recognized in the Constitution of Canada.
- Do you know anything about indigenous beliefs or languages?
  - Give an example of a cultural or spiritual belief of one of the indigenous peoples.

    - Are you sure about this? How do you know this is correct or true?

- Give an example of 1 of the indigenous languages in your specific geographic location.

- What do you know about indigenous cultures?
    - Give an example of and name which indigenous group(s) and 'nation' or tribe they belong to.

- What are your beliefs about the indigenous people in Canada?
    - Are those beliefs based on any statistics, research or evidence or are they personally based? In other words, are you biased towards indigenous people based on your personal beliefs?
    - If so, in your role as an LPN, what steps might you take to become more knowledgeable?

- Did you ever take the personal or professional initiative to learn more about indigenous people in this country?
    - If so, congratulate yourself.
    - If not, ask yourself why not. Indigenous people are an integral part of the fabric (composition) of Canada.

- What is the Truth and Reconciliation Commission?

*Remember to keep the answers to this self-test for review at the end of this chapter.

History

The indigenous people have been on this land for at least 10,000 years. Compare this to non-indigenous peoples.

Non-indigenous explorers and settlers first came to this part of North America during the times of the Vikings, approximately 1000 years ago. Those settlements did not last. Next came the French, the English and others from Europe laying claim to land and taking full advantage of all the land had to offer. Many were met in friendship by the indigenous people. Some mixed. This was the origin of the Métis people. Across the country on the Pacific side, Spanish explorers arrived in the 1590s through the mid-1700s but did not settle. British explorers arrived by the late 1700s and settlers soon followed coming from both the East and West. The majority of other non-European immigrants to the West Coast, who arrived under various circumstances, were immigrants from India in the 1800s and the Chinese.

From the perspective of the people of this land prior to all of these newcomers, their arrival in numbers became an invasion. Colonization ensued. Indigenous people were pushed aside or given promises of treaties and land. In the end, colonization led to oppression, marginalization, lack of access to the benefits of mainstream society, and an attempt by the colonizing governments to eradicate indigenous ways. From an indigenous perspective, they were the victims of an attempted cultural genocide. Yet they live on and are coming again into their own as nations within a nation.

There are over 600 nation-groups of First nation people in Canada. Some of these are the Haida, K'tnaxa, Denesolin (Dene), the Siksika (Blackfoot), Kainai (Blood), Tsuu T'ina, Innu and the Lingit Nation. Amongst these are smaller nations and tribes. The Cree is the largest nation in Canada spread from the Rocky Mountains east to the Atlantic and up towards the sub-arctic.

When the northern Cree first came in contact with the French explorers, there traditional name was Kenistenoag (Alchin, n.d.). The French called them Cree. Today, they choose their own names or refer to themselves as Cree. Some of the traditional ways you may hear them refer to themselves are Ayisiniwok (true men); Nehiyawok (speakers of our language) or Lyiniwok (the people). They share the Algonquinian language but with a number of dialects (Native Languages of the Americas, n.d.).

Exercise 7.2: (**PDF** | **MSWord**)

Answer the following questions.

- Where do you live?
- Who are the First Nations people in your area?
  - Is this their traditional territory?
  - What is their 'nation' and what is their mother tongue?
- Who are the Métis people in your area?
  - How do you know?
  - What is their mother tongue?
- Who are the Inuit people in your area?
  - Is this their traditional land?
  - What is their mother tongue?

Figure 20: First Nations in Alberta gives identifies how many nations exist in this province. For many, their traditional territories (or traditional lands) have been reduced to reserves or 'assigned' under treaties made with the colonial government of the Dominion of Canada in the early years of settlement by non-natives.

Figure 20: First Nations in Alberta

In Alberta there are:

45 First Nations in three treaty areas
140 reserves
Approximately 812,771 hectares of reserve land

The most commonly spoken First Nations languages are: Blackfoot, Cree, Chipewyan, Dene, Sarcee, and Stoney (Nakoda Sioux)

Source:

First Nations In Alberta,
Indigenous and Northern Affairs Canada (2014)

The process of reclaiming their identity, culture and ways of knowing, doing and being has been extremely difficult for all three indigenous groups in Canada. And the struggle is not yet over. They are not fully healed from the years of oppression and poverty; marginalization, stigma and discrimination. The Truth and Reconciliation Commission report and the Calls for Action are addressing this. LPNs will particularly be interested in the Section on Health. See Figure 21.

Figure 21: Calls for Action - Section: Health

Section: **Health**

22. We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

23. We call upon all levels of government to:

i. Increase the number of Aboriginal professionals working in the health-care field.
ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
iii. Provide cultural competency training for all healthcare professionals.

24. We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

Excerpts from:
Calls to Action
Truth and Reconciliation Commission Canada, 2015 (p3)

Cultural Competence

Cultural competency is part of relational practice. The term means the nurse has the behaviours, attitudes and understanding that contributes to informed, respectful and effective practice cross-culturally. Cultural knowledge is necessary for this. This section provides some insights and examples.

The Inuit, Métis and First Nations particularly have a collective versus individualistic culture. This means that these clients see themselves less as unique individuals and more as members of a community. These communities are sometimes referred to as nations, bands, Métis settlements or tribes and are usually (but not always) based on kinship. For example, posing the question of 'who are you' may gain a response of "I'm Cree" or "I am Joe. I am Siksika", "I am Métis" or perhaps "I am Innu."

A Canadian study by Kelly and Brown (2002) found that it is not uncommon to encounter a First Nations client who is inseparable from his/her relationships within the community, its culture and values. Indeed, First Nations clients may wish to discuss their health concerns and recommendations for care with community members before deciding what actions to take. They might invite the LPN to participate in this with the community, if that nurse has established a relationship of trust and respect with them.

Culture safety is another important concept related to cross-cultural caring. Northern Health Indigenous Health (2017) in British Columbia defines it as respect and dignity in relationships. The idea originated with the aboriginal people of New Zealand about 2 decades ago. The definition appears in Figure 22. Indigenous clients have a right to expect the same respectful care that others in society do, free of stigmatization, marginalization, and prejudice. And they have the right to be supported in their cultural beliefs and community.

Figure 22: Definition of Cultural Safety

> Cultural safety is defined as effective practice determined by the individual and family. "Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual"
>
> Nursing Council of New Zealand, 2005
> In Bird, C.E., Thurston, W. E., et al.(2013)

Topic #3: Relational Practice

You've learned in this Study Guide how narrative is an important aspect of relational practice and how the nurse should be open, patient and make dedicated time to be truly engaged with and attentive to a client's narrative. Indigenous cultures are based in oral traditions, not written ones. Narrative is the practice of story-telling and this is a respected way of sharing both directly and indirectly. Indigenous story-telling about self or one's health for example, may be couched in a story that indirectly lets the nurse know what is important to the client. Kelly and Brown (2002) found that story-telling, the use of metaphor and humor were intrinsic to native culture.

Building relationships is paramount to engagement and partnering with indigenous clients in health care. This requires recognition of the importance of relationships in kinship and community. Nurses will need to develop a relationship that remains professional but also begins each time on an easier, almost social foot. Indigenous people prefer this and look for genuineness, openness and approachability. Again, on occasion, the nurse must extend the relationships with the client to include others he/she deems significant. For example, the role of elders is significant in indigenous cultures. Elders are esteemed for their knowledge, wisdom and guidance. In health care instances, elders may become part of the significant others involved in an indigenous clients care. Informed LPNs will be aware of this and accommodate as able.

Health and healing practices may be cultural and based on a combination of Western medicine and traditional medicines and alternative ways of healing. Through relational practice, the LPN will explore this with the client so that caring initiatives and treatment can be mutually understood and agreed upon. However, do not assume that they are but be open and attentive to exploring this. Assuming traditional practices may be seen as stereotyping and jumping to conclusions. The best practice is to utilize an effective relational practice approach.

Exercise 7.3: (**PDF** | **MSWord**)

Figure 23 identifies some of the types of barriers that LPNs will be faced with and need to overcome. Can you identify which of these pertains to your ability to work with indigenous people in Canada?

Figure 23: Effective Communication

> Alberta Licensed Practical Nurses Competency Profile – **Effective Communication**
>
> Demonstrate ability to use alternative communication techniques to create a therapeutic relationship in situations such as:
>
> - cultural / religious barriers
> - hearing loss
> - language barriers
> - mental impairment
> - physical impairment
> - speech and language impairment

Word Choices

Words carry messages that can be respectful, disrespectful, caring and accepting or hurtful and rejecting. As you are no doubt aware, this chapter has been referring to the aboriginal people; the native people of this part of North America as indigenous. This is the term preferred by the people (Joseph, 2016). Note the term 'First Nations in Canada' is highly acceptable. And this is the proper way to say it. It is disrespectful and suggests ownership of a people when you say 'Canada's First Nations.' Even the term 'aboriginal' is no longer preferred. The Inuit People should not be called Eskimos. One of the Inuit is an Inuk, two are Inuuk and any more are Inuit (Joseph, 2016).

All people desire to be called by their real and true names. The indigenous people are not different. The term Indian is still sometimes used by the First Nations people themselves. LPNs should not use it in their practice. To do so chances creating a barrier to relational practice. The only times in which the term 'Indian' can still be used are in legal and legislative matters. For example, in the Constitution Act (1982, Section 35.2), the three indigenous groups of Canada are actually identified as Indians, Inuit and Métis (Canadian Encyclopedia, 2016) but today we refer to First Nations or simply indigenous people.

Joseph (2014) offers some suggestions for developing rapport and relationships with indigenous clients and even though he is not referring to health care clients, the advice is appropriate. It is based in feedback from the people, themselves. Suggestions include not overly using technical terms, not using acronyms when talking, and avoid using colloquialisms (idioms or common, popular, mainstream expressions). To do so chances a breakdown in communication. A sense of othering can also occur. And he suggests being less focused on time and deadlines when interacting. For Indigenous cultures time orientation may be more tied to cyclical changes in life, present circumstances and past influences than it is for other cultural groups in Canada. (Methot, 2012; Alberta Education, 2005; Winz and Cooper, 2000, 2001.)

Exercise 7.4: (**PDF** | **MSWord**)

Use honest self-appraisal to answer these questions.

- Are you finding this chapter interesting?
  - Why or why not?
  - Does your answer have anything to do with your beliefs about indigenous people?

Topic #4: The Way Forward

Relational practice is about building relationships. The way forward to working positively, effectively and relationally with indigenous persons is to begin with knowledge about them. Again, this is your responsibility: your professional duty in coming to know your clients. This responsibility requires desire and motivation. How to start? A good deal of the research and literature dealing with cross-cultural caring and engagement identifies that visiting the local First Nations, Inuit or Métis communities in your location frequently to attend and support cultural events is an excellent way to learn and be seen as someone genuinely interested.

As you become more familiar with the indigenous people around you, learn their names. Rather than the broad sweeping terms of Inuit or First Nations, many indigenous people are returning to the traditional names of their people. For example a client may identify as Siksika instead of Blackfoot, K'tunaxa rather than the Kootenay. Thomas and Paynter (2010) believe that by reclaiming traditional names for the land; the traditional territories, the general public becomes more aware of indigenous people, their history, and their languages begin to enter everyday Canadian English or French. Relationally, LPNs should know the proper, traditional names for the indigenous people and their territory in their locale. It is respectful.

Exercise 7.5: (**PDF** | **MSWord**)

Reflection on learning. Go back to your answers at the beginning of this chapter, first exercise.

- Would you answer any of those questions differently now?
    - Would this affect your ability to be more relational in your approaches to working with indigenous people? If so, explain.
    - If your answers have not changed, ask yourself why not and if this will affect your ability to enter into partnerships with indigenous people towards their health care needs and goals. Explain.

Summary

Kelly and Brown (2002) suggested that an orientation to the indigenous community in a location and its history would be helpful to health professionals in coming to know their clients. This chapter has attempted to provide an orientation however it has not been specific to any one community. More importantly, this chapter should not in any way be considered a complete and adequate orientation to working with indigenous people in your own area. Again, that is the responsibility of each LPN. Remember the self-test at the beginning of the chapter? It asked you to consider what your responsibility is.

In closing, it cannot be stressed enough that it is your own professional responsibility to make efforts to come to know and build relationships wherever possible with the indigenous people of your area. It is important to know on whose traditional territory you live and work. Identify it. Acknowledge the people. Respect the land and its people. Acknowledge that they are distinct and made up of many nations and languages. Make those efforts to attend and support social, not only medical events to learn about cultural, community values (Joseph, 2015; Kelly and Brown, 2002).

Finally, refer to Figure 24: LPN Code of Ethics for key points that you have agreed to as a Licensed Practical Nurse.

Figure 24: LPN Code of Ethics

Code of Ethics for Licensed Practical Nurses in Canada (2013)
Canadian Council for Practical Nurse Regulators and the College of Licensed Practical Nurses of Alberta

Preamble
Respect for the inherent dignity and rights of clients, colleagues and LPNs underpins the five ethical principles encompassed in the Code.

Principle 1. Responsibility to the Public

- 1.3 Demonstrate an understanding that community, society and the environment are important factors in the health of individual clients.
- 1.4 Respect the rights of all individuals regardless of their diverse values, beliefs and cultures.
- 1.5 Provide care directed toward the health and well-being of the person, family, and community.

Principle 2. Responsibility to the Client

- 2.10 Apply new knowledge, technology and scientific advances to promote safety, client satisfaction and well-being.

If you have found this chapter interesting and you are inspired to learn more about First Nations approaches to Health and Wellness or Mental Wellness, please go on-line to search for the First Nations Health Authority. www.fnha.ca

If you would like to learn more about the Métis people, search for Métis Nation on-line at http://www.metisnation.ca/ and the Métis Nation of Canada http://www.metisnationofcanada.org/. For Métis health, try The National Collaborating Centre for Aboriginal Health at https://www.ccnsa-nccah.ca/275/the-missing-picture-in-metis-health.nccah

The University of Alberta offers a 12-lesson online course called Indigenous Canada that explores Indigenous histories and contemporary issues in Canada. From an Indigenous perspective, this course explores key issues facing Indigenous peoples today from a historical and critical perspective highlighting national and local Indigenous-settler relations. Topics for the 12 lessons include the fur trade and other exchange relationships, land claims and environmental impacts, legal systems and rights, political conflicts and alliances, Indigenous political activism, and contemporary Indigenous life, art and its expressions.

Review Exercise

1. Marginalization of a people is a form of

   a) cultural practice
   b) othering
   c) disgracing
   d) manipulation

2. The indigenous people have been on this land for

   a) 500 years
   b) 2017 years
   c) 10,000 years
   d) 1,000 years

3. Métis people are part of the Innu Nation.

   a) True
   b) False

4. An aspect of cultural safety for indigenous people means

   a) fair and equitable access to health care services
   b) feeling non-violent and well cared for
   c) the right to respect and dignity in relationships
   d) free from physical harm for being of another culture

Glossary

Aboriginal – Indigenous; native.

Cross-cultural care – the provision of care that is knowledgeable and respectful of others' cultural beliefs and practices to enhance the care experience of the client.

Cultural safety – feeling safe to express one's own culture in all of its ways and forms in an environment free from judgement or denial about the validity of the culture, its beliefs and practices.

Impetus – Motivation.

Intrinsic – Inherent; core.

Native – Indigenous Native and First Nations are used throughout this article to denote the original inhabitants of Canada and their descendants.

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Review Exercise Answers

1. Marginalization of a people is a form of
   (b) othering

2. The indigenous people have been on this land for
   (c) 10,000 years

3. Métis people are part of the Innu Nation.
   (b) False

4. An aspect of cultural safety for indigenous people means
   (c) the right to respect and dignity in relationships