TC-NURSE:

Handbook for intensive teaching and learning

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The project has been co-funded from the Erasmus+ programme of the European Union.

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01. Background and scope of the project

Transcultural Nursing: A European Priority, a Professional Responsibility (TC-Nurse), is a project funded by the Erasmus+ programme under Key Action 203 Strategic Partnerships for Higher Education. The project started on 01 September 2018 ending by 31 August 2021. The TC-Nurse project addresses cultural, linguistic and religious diversity, and promotes ownership of shared values, equality, non-discrimination and social inclusion through education and training at higher education level. This work is underpinned by a series of multinational research projects in transcultural nursing at three levels, namely higher education, healthcare and society involving target groups and stakeholders.

The project represented an international collaboration among 4 European HEIs (Higher Education Institutions) located in Spain, Portugal, Belgium and Turkey: Universidad San Jorge, Spain; Instituto Politécnico de Portalegre, Portugal; Artesis Plantijn Hogeschool Antwerpen, Belgium and Aydin Istanbul University, Turkey.

According to the European Commission, "social inclusion is at the core of the European Social Model and European values enshrined in the Lisbon Treaty". However, in the past few years, social exclusion and inequality have emerged as a major concern in European society. European Higher education institutions (HEIs) have a responsibility to address these issues through the promotion of social, civil and trans-cultural competences, democratic values and fundamental rights, social inclusion, non-discriminating active citizenship and critical thinking.

This project was aimed at addressing cultural, linguistic and religious diversity, and promoting ownership of shared values, equality, non-discrimination and social inclusion through education and training at higher education levels.

Objectives

- Foster the development of social, civic and transcultural competencies, and critical thinking, not only amongst participant nursing students and both teaching and clinical staff, but also amongst key stakeholders and decision/policy makers at local and regional level in all the participating countries.
- Tackle discrimination, segregation, racism, bullying and violence in healthcare through the undertaking of preliminary research on this area, and the subsequent creation of a multinational blended-learning module in trans-cultural nursing.

In line with the above, actions, methodology and outputs have been designed to:

1. Allow the project team to draw a clear and realistic picture of trans-culturality and cultural diversity at academic, healthcare and social levels.
2. Test the implementation of Content and Language Integrated Learning (CLIL) as a teaching approach in higher education, in a multinational, multicultural, multilingual environment.
3. Pilot the delivery of newly developed content and teaching and learning materials on trans-cultural nursing.

2. Participants, activities and methodology

2.1. The summer school prior to the project

A one-week summer school on Trans-cultural Nursing was held in July 2018 at Universidad San Jorge. The objective of this summer school was to introduce the concept to prospective students nurses from partner HEIs, get their feedback and plan out the intensive training programmes within the scope of the project. Two facilitators and six students from each of the four institutions attended the summer school.

The following topics were discussed and workshops were conducted.

- Multiculturalism in society
- Concepts of Trans-cultural Nursing
- Minority groups (Syrian Refugees, Gypsy Roma Travelers, minority migrants from other religions) and their place in the society
- Language and other cultural barriers in communication
- Introduction to the CLIL approach for teaching the content of trans-cultural nursing in a second language

At the end of the summer school, the feedback received from students and facilitators was important in laying out a plan and course outline for the intensive training programs within the scope of the project.

2.2. Clil aspects of the project

It is rare for culturally diverse students to share a common mother tongue, especially in the context of European Higher Education. Thus, learning in a multicultural environment, with culturally diverse students and teachers, must often be achieved through the use of a second language or a lingua franca, in this case, English. In order to address the challenges of teaching and learning in these multicultural and multilingual educational settings, and considering the specific needs of the different stakeholders involved in the process, a CLIL approach has been adopted to support both content and language learning through a second language (Garone & Van de Craen, 2017). Coyle's (2006, 1999) 4Cs Framework is based on the tenet that the strengthening and development of a learner's conceptual understanding involves social, cultural, linguistic and cognitive processes, and offers a comprehensive theoretical and pedagogical foundation for planning CLIL lessons, designing activities and assessing student achievement. The core elements of the 4 Cs Framework are:

- Content: What the students need to know.
- Communication: The language skills that the students need to have in order to work on the content both autonomously and in the classroom.
- Culture: The students' cultural heritage shaping their previous experiences, personal values, reflective processes and behaviours.
- Cognition: The thinking processes that the students need to use in order to engage with and understand course content.

Within the scope of this project, three intensive learning programs (summer school) were held for year 1, 2,and 3 (July 2019, September 2020 and June 2021). Two facilitators from each HEI taught the content using the CLIL approach. Prior to each summer school CLIL training was provided to each facilitator by CLIL experts in Portugal and Spain who were also a part of the project. CLIL training was held in December 2018 in Portugal, December 2019 in Belgium and in December 2020 was planned to be held in Turkey but was held online due to the COVID-19 pandemic. In total, more than 6 facilitators from each HEI (approximately 30) received twelve hours training face to face (and blended learning for the 3rd year). In addition to this training, facilitators also had the support of the CLIL experts while preparing their teaching sessions for the intensive learning programs.

- The intended learning outcomes of the CLIL courses were the following:
- Identify and apply the theoretical principles of CLIL.
- Plan teaching and learning activities through a CLIL approach.
- Adapt teaching materials to facilitate content and language learning using the CLIL approach.
- Apply teaching, learning and assessment strategies to support the use of a second language (English) to teach content in classes.

The CLIL approaches, teaching strategies and learning materials used during each intensive program are available in this Handbook and a guide (*Integrating CLIL in transcultural education: a practical guide for HE teachers*) has been prepared by the team of CLIL experts as one of the Intellectual Outputs of this project.

2.3. Intensive learning programs

Three intensive training programs for student nurses from the partner HEIs were conducted during 2018-2021. Approximately 75 undergraduate student nurses attended these events. The students were selected based on their basic language skills (B2 level) and level of interest to participate in the program. In addition, approximately 30 academic staff members from the HEI consortium had the opportunity to take part in three short-term joint staff training events in CLIL training and the intensive learning programs. These lecturers were involved in the design and delivery of content, teaching and learning materials during the intensive training programs.

The content of the intensive learning program was originally based on the Papadopoulos model for promoting cultural competence in health care (Papadopoulos et al, 2006). The model had four aspects namely: cultural awareness, cultural knowledge, cultural sensitivity and cultural competence. Each partner dealt with one of these aspects using the CLIL approach. In the 2nd year however, the model was developed further adding Cultural desire to the model and making some other changes, as will be discussed in Chapter 2 (Anton-Solanes et al, 2020)

In 2018-2019, the staff training events held at Instituto Politécnico de Portalegre, Portugal and Artesis Plantijn Hogeschool Antwerpen, Belgium, as well as the first intensive training program for students in Portugal was conducted face to face. However with the emergence of the COVID-19 Pandemic in 2020, the second and the third intensive training programs which had been planned in Belgium and Istanbul were delivered online by means of blended-learning modules. Virtual classrooms were set up and online learning materials were provided by means of an online learning platform constructed solely for the project. The students were given pre-training assignments consisting of group and individual work such as presenting their national health care system (group work) or reflection on case studies (individual work). Each partner provided case studies which dealt with several issues regarding competence in the healthcare system. All case studies, teaching plans and learning materials during the three years of the Intensive learning program are presented in Chapter 4.

During the intensive learning sessions, the students were randomly allocated to groups so that every group had students from each participating country. The students could interact with each other while working on the classroom assignments. Out of the five days of each Intensive learning program, each day was assigned to each partner working on each aspect of the model. Each day consisted of approximately 5.5 hour sessions, which were broken into short plenary and group sessions consisting

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of activities, group discussions, student presentations, brainstorming activities and so on. The last day of the program consisted of a general evaluation of the week from students' and teachers' perspectives.

3. Research

Each intensive training programme was preceded by a multinational research project on trans-cultural nursing at three levels, namely higher education, healthcare and society involving target groups and stakeholders.

Ethical approval for the studies was sought from The Secretary of the Clinical Research Ethics Committee of Aragón (CRECA).

A research team comprising of two academic members of staff from each partner HEI undertook the qualitative research in the following three areas:

YEAR 1: Two qualitative studies were conducted by each partner institution. The first was to assess their institution's nursing lecturers' perceived level of cultural competence, and to describe the lecturers' experience of teaching in a multicultural classroom. The second study was to identify the student nurses' (studying in the institution) perceived level of cultural competence, experience of learning in a multicultural context and analyse the student nurses' experience of working with patients from diverse cultural backgrounds.

YEAR 2: For the second year, the first qualitative study was carried out to determine the qualified nurses and nurse managers' perceptions and experience of cultural competence in each HEI country. The second study was aimed at evaluating the work experience of qualified nurses with a migrant and/or ethnic minority background (MEM) working in healthcare services across Spain, Portugal, Belgium and Turkey.

YEAR 3: For the third year, a fifth partner was included in the study, Universidad de Zaragoza (Spain). The first of the two qualitative studies, was to analyse the perspectives of key stakeholders and decision-makers on trans-cultural care, and to understand their views on the design, integration and implementation of strategies to provide a culturally mindful and safe care to all users, regardless of their sociocultural background in four European countries: Spain, Belgium, Portugal and Turkey. The second study was conducted in order to examine the perception and experiences of healthcare users with a MEM background of trans-cultural care across healthcare services in four European countries, namely Spain, Portugal, Belgium and Turkey.

Data collected from the research work of the first year has already been published (Anton-Solanes et al, 2021) and the others are in the process of being published.

4. Achieved results and impact

The activities carried out by the TC-Nurse project team during the project period enabled the development and production of the following intellectual outputs (IOs):

IO1: A multinational research evaluation of trans-cultural nursing at educational, healthcare and social levels.

IO2: A set of guidelines and teaching materials on teaching & learning in trans-cultural nursing in higher education.

IO3: A manual for the implementation of CLIL in higher education.

IO4: A learning platform.

IO5: A joint blended-learning undergraduate module on trans-cultural nursing.

The impact of student learning was not only evaluated on the participants, but also on other target groups and audiences and measured at local, regional, national and European levels based on the following criteria:

- Impact on knowledge through before and after evaluations of participants' learning during the training activities.
- Impact on emotional and behavioral change.
- Impact on opportunity in terms of increased opportunities for student nurses to learn through a second language, and in terms of increased opportunities for training in trans-cultural nursing, not only at HEI level but also at healthcare and professional association levels.
- Impact on access to the project's results and outputs.
- Impact on social media and the wider public.
- Impact on quality and quantity of contacts with key stakeholders.

5. Dissemination and sustainability

Dissemination and sustainability of the project was facilitated by means of :

TC-Nurse website
https://ec.europa.eu/programmes/erasmus-plus/projects/eplus-project-details/#project/2018-1-ES01-KA203-050800

AT LOCAL AND REGIONAL LEVEL: one representative from the corresponding HEI was responsible for dissemination and exploitation of the project and results to healthcare services, shareholders and other target audiences by means of newsletters, university and faculty website and social media accounts.

AT NATIONAL LEVEL: by means of online meetings and seminars with the respective HEs, each participating country strived to engage national authorities in education and healthcare. Student groups, professional nursing associations and cultural associations were also included among the shareholders for dissemination of the project.

AT EUROPEAN AND INTERNATIONAL LEVEL: at least two publications from each year's research findings and results in scientific journals have been planned. Two publications from year 1 have already been published and the rest are being prepared by the research team. Project results were also disseminated through national and international conferences held in Portugal and Belgium.

NATIONAL EVENT: after the completion of the project, a national event has been planned by each HEI in their respective countries with a participation of at least 30 persons.

FINAL EVENT: A final event on 24th June with a participation of approximately 150 persons will take place as the project's final conference.

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02. The TC-Nurse Model

1. Introduction

According to the European Commission [1], "social inclusion is at the core of the European Social Model and European values enshrined in the Lisbon Treaty". Nevertheless, in the past few years, social exclusion and inequality have become a major concern in European society. A changing society, with free movement of citizens within the European Union (EU), distant parts of our globe becoming more accessible, and an increasingly multicultural population, are factors impacting on healthcare, highlighting the need for cultural competence among health professionals [2,3]. European higher education institutions (HEIs) have a responsibility to address these issues in the curricula through the reinforcement of fundamental rights and democratic values, the promotion of social inclusion, nondiscriminatory active citizenship and critical thinking, and the integration of social, civic and transcultural competence.

There is a wealth of models and approaches for implementing cultural content in the nursing curricula, mainly emerging from Leininger's theory of cultural care diversity and universality [4]. However, we have observed that they each o_er partial solutions when implemented in a multicultural, multilingual learning environment as part of a short intensive course. Specifically, some models, such as Campinha-Bacote's [5] Process of Cultural Competence and Je_rey's [6] Cultural Competence and Confidence Model, include a practical component which requires students to demonstrate a degree of cultural skill. This is achieved by exposing the students to cultural encounters with patients from diverse cultural backgrounds. Whereas it is desirable to give students the opportunity to put newly acquired knowledge into practice [7], it is not always feasible to integrate a practical component into a short intensive course, due mainly to a lack of time and resources. Another frequent problem with pre-existing models, such as Papadopoulos Tilki and Taylor's [8] model of Cultural Competence, is the inclusion of a final stage or component entitled cultural competence. Whereas the acquisition of cultural competence is, ultimately, the desired outcome, we do not expect our students to achieve any degree of cultural competence during the course, but rather to develop knowledge, skills and attitudes which may, in future, allow them to gradually become more able to develop a culturally mindful and safe practice. Finally, no pre-existing educational models for the teaching and learning of cultural competence in a multicultural environment, in a nursing educational context, have been identified in the literature. There is an interesting precedent in Banks' [9] five dimensions of multicultural education, which seek to facilitate the conceptualisation and implementation of multicultural education by "transforming the culture and values of the organisation to ensure fair and equitable treatment for all" [10]. We fully agree with this idea and argue that cultural di_erence must be celebrated and acknowledged in order to foster the attainment of cultural knowledge, skills and attitudes among culturally diverse students. However, Banks' model was designed to be implemented on a much larger, organisational level.

In addition to the above, our student and teacher populations are very diverse not only in terms of nationality and language but also in terms of religion, age, culture and educational context. If not addressed, this diversity impacts not only the teaching and learning process but also the process of communication and social interaction between teachers and students and between the students. In particular, frequent problems with our student population included di_culties with the English language, social integration and connectedness, and even some degree of stress and anxiety [11,12].

This paper is part of a larger EU-funded project entitled Transcultural Nursing: A European Priority, a Professional Responsibility (TC-Nurse) [13]which focuses on cultural, linguistic and religious diversity and promotes ownership of shared values, equality, nondiscrimination and social inclusion through education and training at the higher education level. As part of this project, 24 undergraduate nursing students and eight lecturers from four European universities, namely,Universidad San Jorge (coordinator, Spain), Instituto Politécnico de Portalegre (Portugal), AP Hogeschool (Belgium) and Istanbul Aydin University (Turkey), come together for a week once a year to learn about transculturality and cultural competence. All of our students and staff speak English as a second language and come from four European countries. They are culturally diverse in terms of their religion, ethnicity, social class, clinical work experience and exposure to people from a minority cultural background. Culturally diverse students must receive adequate support when learning in an international environment [14,15]. Therefore, we have designed a model for the teaching and learning of cultural competence in a multicultural environment (CCMEn), with the aim of addressing these issues and improving the teaching and learning experience of culturally diverse students and teachers based on our experience and an extensive review of the literature (Figure 1).

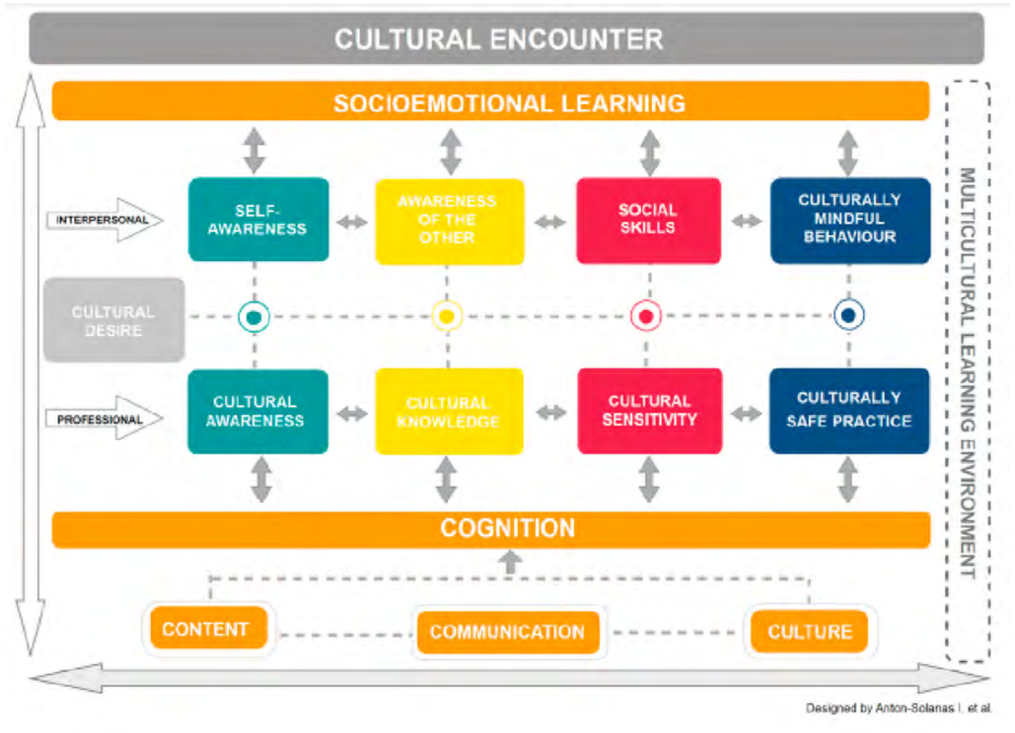

Figure 1. The Cultural Competence in a Multicultural Environment (CCMEn) Model.

2. The CCMEn Model

The CCMEn model is intended to guide the process of teaching and learning cultural competence in a multicultural environment through the use of a second language and has been adapted from existing nursing education approaches and models. The CCMEn model rests on three pillars. First, we have adopted a Content and Language Integrated Learning (CLIL) approach, in order to support student learning of content through a second language [16]. Second, in order to address the problem of communication and social interaction, we have integrated a layer of social and emotional learning competencies [17], which are explicitly integrated into the teaching plans (Table S1) and can be tailored to the characteristics of our student population. Third, we have designed a five-stage process for the teaching and learning of cultural competence in a multicultural environment based on the existing literature [5,6,8,9].

2.1. A CLIL Approach

It is rare for culturally diverse students to share a common mother tongue, especially in the context of European higher education. Thus, learning in a multicultural environment, with culturally diverse students and teachers, must often be achieved through the use of a second language, a lingua franca. In order to address the challenges of the novel multicultural and multilingual educational settings, and the specific needs of the di_erent stakeholders involved in the process, a CLIL approach has been adopted to support both content and language learning through a second language [18]. Coyle's [16,19] 4Cs Framework is based on the tenet that the strengthening and development of a learner's conceptual understanding involve social, cultural, linguistic and cognitive processes and o_ers a comprehensive theoretical and methodological foundation for planning CLIL lessons, designing activities and constructing materials. The core elements or constructs of the 4 Cs Framework are as follows:

CONTENT: What the students need to know.

COMMUNICATION: The language skills that the students need to have in order to work on the content both autonomously and in the classroom.

CULTURE: The students' cultural heritage that shapes their experiences, personal values, reflective processes and behaviours.

COGNITION: The thinking processes that the students need to use in order to engage with and understand course content.

The CCMEn model incorporates all four constructs, but they have been rearranged with the aim of giving the Culture element a much more prevalent role (Figure 2). In the original 4Cs Framework, Content, Cognition and Communication form the basis of content and language integrated learning, whilstCulture permeates the other elements, allowing the students to develop intercultural understanding and reinforcing learning [19]. According toMeyer [20], "realizing that other cultures tend to see things differently, have different values and beliefs, is one of the most valuable experiences that CLIL may offer". However, in practice, the cultural dimension has not been properly exploited yet [20]. In the CCMEn model, Content, Communication and Culture are explicitly integrated into the teaching plan and underpin the design of the intended learning outcomes (ILOs), teaching and learning activities and assessment tasks, all of which are integrated into the fourth C, Cognition (Table S2). The rationale for this change is twofold: the students' culture must be carefully considered when teaching and learning in a multicultural environment and it must be integrated into the teaching plans to promote meaningful cultural encounters.

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Figure 2. Rearrangement of the 4 Cs: cognition, content, communication and culture.

2.2. Socioemotional Learning

Adding a further theoretical perspective to frame Coyle's 4 Cs model, the CCMEn model integrates a fifth element into the multicultural learning environment: socioemotional learning. Socioemotional learning is defined as the process by which individuals acquire the knowledge, learn to understand and manage their emotions, maintain positive relationships, make responsible decisions and demonstrate a caring attitude and concern for others [21,22]. Traditionally, in academic settings, socioemotional skills are frequently and commonly displaced to minor roles in favour of the development of the cognitive domain and academic achievement [23]. However, social and emotional competence is also crucial for adult learners, particularly when teaching and learning take place in a challenging or "emotional environment" [24]. This is the case when students and teachers engage in a process of teaching and learning in a multicultural environment through the use of a second language. In our experience, undergraduate nursing students do not necessarily have the knowledge and skills necessary to perform well in a multicultural learning environment. This phenomenon has also been observed in preceding multicultural teaching and learning experiences. [25]. In particular, some of our students expressed di_culties communicating with students who were perceived as being different and felt uneasy when undertaking group work and speaking in public. Thus, we propose that socioemotional ILOs, teaching and learning activities and assessment tasks are designed alongside cognitive ILOs, teaching and learning activities and assessment tasks, and are integrated into the teaching plans. We argue that careful consideration of the socioemotional skills and attitudes needed to effectively engage in the cognitive teaching and learning activities will contribute to creating a positive learning environment in which students from different cultural contexts can feel safe and comfortable.

Thus, student learning will occur in parallel at two levels, namely, cognitive and socioemotional, and will be supported by three pillars emerging from the CLIL approach, namely, content, communication and culture. Teachers must be mindful of this when designing the teaching plans and must facilitate student learning at two levels, namely, interpersonal—through the acquisition of knowledge, skills and attitudes, leading to the display of a culturally mindful behaviour, both towards their fellow students and the facilitators—and professional—through the acquisition of knowledge, skills and attitudes leading to a culturally safe professional nursing practice.

2.3. A Five-Stage Process

Surrounded and supported by these five constructs: Content, Communication, Culture, Cognition and Socioemotional learning, and promoted through constant cultural encounters, the acquisition of knowledge, skills and attitudes leading to a culturally mindful and safe nursing practice, according to the CCMEn model, occurs in five phases or stages: (1) cultural desire, (2) self-awareness/cultural awareness, (3) awareness of the other/cultural knowledge, (4) social skills/cultural sensitivity and (5) culturally mindful behaviour/culturally safe practice.

The first stage of the CCMEn model is cultural desire. Cultural desire is defined by Campinha- Bacote [25] as the motivation or desire of nurses to actively engage in the process of becoming culturally competent. It requires a personal motivation to develop new skills and acquire new knowledge, leading to culturally mindful and safe personal behaviour and a professional nursing practice [26]. From an educational perspective, this first stage must include activities that allow the culturally diverse students and facilitators to begin to develop a trusting relationship with each other; for example, ice-breakers and group activities, which may include gamification. These activities should focus primarily on areas of common interest and focus on similarity rather than cultural differences. The content should focus on contemporary issues relating to transculturality and nursing care, preferably applicable to the students' sociocultural context. For instance, for European students, the Syrian crisis and ever-growing number of migrants and refugees seeking asylum in the EU are highly relevant and current themes. The establishment of interpersonal relationships in the classroom may be limited by the fact that human interaction is somewhat constrained by the teaching plan. Thus, it may be useful to promote a freer form of cultural encounter between the students through sociocultural activities in which facilitators may or may not participate.

The second stage of the CCMEnmodel is self-awareness/cultural awareness. Froma socioemotional perspective, the students should be encouraged to reflect on their personal identity both as individuals and as professionals. It may be useful to discuss the students and teachers' educational culture, which is understood as the framework in which educational activities take place [27], and promote self-reflection and interpersonal sharing through teaching and learning activities [5]. In addition, the students should begin to identify their own emotions when interacting with students from other cultural backgrounds by recognising how being in a multicultural environment may influence their behaviour and demonstrate self-confidence. From a cognitive point of view, students should be encouraged to reflect on the values and beliefs shaping their identity as nurses and caregivers. Concepts such as ethnocentricity, stereotyping, cultural identity and cultural humility should be addressed at this point [5,8,28].

The third stage is awareness of the other/cultural knowledge. At this stage, the students should now begin to successfully manage their own emotions, thoughts and behaviours. They should feel comfortable in the multicultural learning environment and demonstrate discipline and motivation to learn alongside and collaborate with fellow diverse students. From a cognitive perspective, the students will be given opportunities to discuss and compare health-related beliefs, practices and behaviours, and biological, psychological, sociopolitical and anthropological characteristics of selected cultural groups. They will develop an understanding of current issues a_ecting patient health outcomes, including limited access to healthcare, health inequalities and patient empowerment [26]. Case scenarios may be used to illustrate these concepts and allow the students to apply new knowledge [29].

The fourth stage focuses on social skills/cultural sensitivity. From a socioemotional point of view, classroom activities should encourage the students to take the perspective of and empathise with others, showing respect and appreciation of the other person's viewpoints. Moreover, special attention should be paid to the communication process between the students themselves and between the students and the facilitators. At this stage, the students should be able to communicate clearly with each other using a variety of both verbal and nonverbal strategies and resources. These may include active listening, giving and receiving feedback, conflict negotiation abilities, relationship building and teamwork. These values and attitudes are easily transferable and applicable to the clinical context. For example, lessons learnt while working and learning alongside students from diverse cultural backgrounds may be useful when working in a multicultural team of healthcare professionals. From a cognitive perspective, students should discuss the nature of the nurse–patient relationship in their own cultural context and reflect on the use of power in healthcare. Concepts such as trust, respect, acceptance and negotiation and their impact on the health and wellbeing of culturally diverse

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patients, should be introduced. It is also important to discuss communication barriers and promoters, including language difficulties, misunderstandings and intercultural communication [30,31].

The fifth and final stage is culturally mindful behaviour/culturally safe practice. At this stage, the students will be expected to demonstrate both culturally mindful behaviour towards each other and culturally safe nursing practice. We cannot expect students to become culturally competent individuals and nursing professionals at this point [4,32]. However, we can assess the learning of socioemotional and cognitive cultural knowledge, skills and attitudes through both formative and summative assessment. Facilitators should measure and assess student learning through both quantitative and qualitative means. Problem-solving activities, role play, clinical simulation and group work may be useful to evaluate the students' ability to identify and solve problems, analyse situations, resolve conflict and, in sum, demonstrate safe nursing practice. Other useful resources include validated questionnaires such as Chen's Intercultural Sensitivity Scale [33] and Papadopoulos' Cultural

Competence Assessment Tool [34]. Specific qualitative techniques, including personal and group interviews, observation and debriefing sessions, may generate information about the students' cognitive and socioemotional learning experience, both individually and as a group. The self-assessment of the SEL competencies questionnaire may be used to measure the students' perceived level of socioemotional competence [35]. It is important to highlight that the summative assessment of student learning must be supported through formative assessment and feedback throughout the course. Further, student assessment must be aligned to teaching and learning activities and intended learning outcomes, as proposed by [36].

3. Discussion

The CCMEn model has been designed to guide the process of teaching and learning cultural competence in a multicultural environment through the use of a second language in a nursing education context. It is intended to provide opportunities for interpersonal and professional learning of the knowledge and skills necessary to develop a culturally safe nursing practice and a culturally mindful personal behaviour. The CCMEn model is but a small part in a life-long journey towards cultural competence [32,37]. The students should not be expected to suddenly become culturally competent nurses. Instead, they should be allowed to make and recognise their mistakes, gradually enlarging their knowledge on di_erent cultures and patient groups and refining their behaviour towards not only culturally diverse patients but also colleagues and other people from outside the health system [4].

Furthermore, the process of learning cultural, social and emotional competencies is not linear but will require the learner to shift back and forth from one phase to another, depending on factors such as personal and professional experiences and training, and can be reinitiated as many times as necessary.

As content teachers, facilitators should not necessarily be expected to be able to implement a CLIL approach when teaching through a second language. Instead, we suggest that specific training is provided to ensure that they are able to integrate language and content learning when planning and delivering their sessions [38,39].

It is important to emphasise that the CCMEn model was designed for use in a multicultural atmosphere in a nursing education context, through the use of a second language, and can potentially contribute to improving teaching and learning in multicultural and multilingual contexts. However, it could easily be adapted for use in less diverse contexts and through the students' mother tongue. It should not be forgotten that cultural diversity is not just about race and ethnicity but can also be found in age, gender, sexual orientation, religion, and even professional background [30,40].

Finally, we recommend that a programme of sociocultural activities, leading to the continuation of cultural encounter, be designed alongside the teaching plan [5]. Facilitators should clearly state the ground rules before the start and ensure that all the students feel safe and comfortable within the multicultural learning environment. For example, it is important to be mindful of the fact that most of the students will not be native English speakers and some may find it challenging to adopt an active role in the classroom; therefore, working in small, mixed groups may be a good idea.

4. Conclusions

Teaching and learning cultural competence in a multicultural environment presents incredible opportunities for learning and some di_culties, which we have tried to address in the CCMEn model. Specifically, the fact that both teachers and students come from di_erent cultural backgrounds creates opportunities for learning that emerge from both classroom activities and constant cultural encounters occurring between the students, the students and the teachers, and both inside and outside the classroom [41,42]. However, content learning has to be supported through language learning when the students are not able to speak the language of instruction as a first language [43].

In our model, this was achieved by introducing and implementing a CLIL educational approach. Additionally, we added a layer of social and emotional learning in order to address the di_culties posed by the multicultural learning environment. In order to simplify the design of the teaching plans, we designed a five-phase model in which socioemotional and cognitive teaching and learning can ocur simultaneously. We believe that the CCMEn model can be adapted to other educational backgrounds and can potentially contribute to improving teaching and learning in multicultural and multilingual contexts. It must be taken into account that teaching and learning in a multicultural (and, frequently, also multilingual) environment has become a reality in the European higher education context as a result of the implementation of policies such as the Bologna declaration and the internationalisation of European curricula [44], which encourages both teachers and students to engage in academic exchanges and placements abroad.

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03. Pedagogical Approach of the Learning Module

Dr. Benjamin Adam Jerue

Introduction:

This chapter presents the pedagogical ideas and considerations that have underpinned the TC Nurse Intensive Programs (IPs), which took place between 2019 and 2021. Our experiences and lessons from these three IPs have in turn informed, guided and shaped the TC Nurse blended module that can be used in the future (Intellectual Output 5). In the following pages, we will reflect on the design and structure of the IPs as well as the type of assessment that we have deemed most appropriate. To justify these choices and help future instructors in their own planning, this chapter also offers a brief theoretical discussion of relevant issues that have informed the TC Nurse team.

To draw attention to several pertinent issues that will discussed over the following pages, let's start by taking a not-so-hypothetical example of a poorly designed course that promises more than it can deliver. Such an example can shed light on several common problems and introduce us to some of the big questions that go into the planning of any educational program.

> You have stumbled across a series of seminars that promise to equip you with the skills that you need to become a successful real estate investor and quickly amass considerable wealth. The course consists of two weeks of lectures and workshops given by business leaders and other experts who can help you "take your game to the next level." Attendees will learn "the tricks and tips" that will give them the needed edge in a competitive sector. To show that students have mastered the course's content, all participants will take a written test, containing 30 multiple-choice questions that cover the most important ideas discussed in the seminar. Once passing this test, they will receive a certificate.

While all of this may sound alluring to some, a discerning observer would likely ask some skeptical questions before signing up. Isn't it ambitious for such a short course to promise such large gains? Do learners just need to gain some new important information, or do they actually have to develop new skills, forge new relationships and get access to new resources? How will learners really know whether they have succeeded by the end of the course? Do they have to wait and see whether they get rich quickly or is the course certificate an accurate indicator in and of itself?

While this example may appear like a satire of the notoriously misleading and predatory tactics of some for-profit educational institutions (ANgulo 2016), it does nevertheless draw attention to a real set of fundamental problems that are common to the broader educational landscape. Furthermore, in an increasingly competitive world that not only requires workers to be ever more credentialed but also encourages educational institutions to treat students like customers (Clayson and Haley 2005), there is a growing number of seminars and educational opportunities that follow this sort of model: offering a quick and intensive program that can have a significant impact on learners. In its own way, the educational portion of the TC Nurse project, which introduces students to a series of complex issues surrounding intercultural communication, respect, empathy, cultural desire, self-knowledge and, last but not least, transcultural and safe care, also makes big promises to its students. So our first question should be what can we reasonably expect to accomplish with our students within a week-long intensive course or a 3-credit ETCS module. Next, we should ask ourselves when dealing with

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such important and abstract issues, how can students and instructors gauge progress and what even constitutes success in the first place.

To discuss these issues and avoid a common set of recurring problems, the present chapter reviews some basic concepts from educational research about module design and learner assessment. Our thinking on these questions has been profoundly influenced by thinkers like J. Biggs, whose influential manual, Teaching for Quality Learning at University (now in its fourth edition and co-authored with C. Tang) has popularized the notion of aligned learning, as well as J. McThighe and G. Wiggins, whose 1998 Understanding by Design has led to deeper reflection on the curriculum and championed the idea of "backwards design." The present discussion cannot do full justice to the work of these thinkers and any interested reader is strongly urged to delve into the bibliography more deeply.

2.1. Intended learning outcomes (ILOs)

When preparing a new class, a common first question is "what information do I need to prepare and what tools can I use?" or, a bit more cynically, "how on earth will I fill all that time?". These are certainly reasonable and imminently practical questions to ask, especially when time is short or instructors have to teach outside of their comfort zone. However, beginning with such details is a mistake from an educational point of view. Instead, we should begin with the larger question of what precisely we want learners to know or be able to do after finishing a course. A slightly different way to put it would be to ask what's the point of the course and how it can better prepare learners for their future. Such goals are often called intended learning outcomes (ILOs). These should serve as every teacher's north star and inform all their planning and work in the classroom. This is because ILOs can give a course coherence, make it meaningful and engaging and help teachers plan properly for assessment. If we don't think about ILOs purposefully, we can fall into several common traps, some of which are summarized below:

1. **The meal-ticket problem:** in this scenario, the implicit goal (at least from the learner's point of view) is little more than to finish and pass a course and "move on" to the next thing. This happens when learners are not told what the course can offer them besides a certificate or a step towards a getting a required qualification. Accordingly, this problem is especially common in formal education (whether a secondary school, university or other credentialing institutions), since some learners merely want to "get it over with" and glide on to their future. In practical terms, this attitude often leads students to simply memorize what the instructor says so that they are ready for an exam. This attitude of "going through the motions" is unproductive and arguably a waste of time, even if it can create the illusion of better prepared professionals. To use the real estate example, someone could sign up for the course just to have something else to add to his/her resumé, while not actually expecting to get much out of the learning experience.

2. when ILOs are not realistically calibrated, **the get-rich-quick problem** can arise. Often instructors have lofty pretensions for their courses, believing that they will be utterly transformative and life changing. Ideally, this will be the case. The problem, however, is when what is done in class is not adequate to truly prepare a learner for those lofty goals. If we return to the imagined example above, we can agree that becoming a successful professional is a worthy goal, but it is safe to assume that no one can reasonably achieve this in just a few seminars. In this instance, the ILO is out of students' reach and no learner could honestly achieve it simply on the basis of receiving the training. In other words, even if some students do manage to accomplish a lofty ILO, this may not be due to the received training, but would be better explained by other contributing factors (e.g., former experience, prior knowledge, social/professional connections, etc.).

3. A separate issue can be dubbed **the where-are-we-going problem:** if an instructor does not think carefully about his/her ILOs, there is the real possibility that the students will learn and do things that are valuable but don't actually adhere to a stated goal or lack a desired level of coherence. There are an endless number of useful things to learn, but everything has its place: if students signed up for a class on the real estate acquisition, but then got a lecture on property management, they would probably be frustrated and disoriented. By continually focusing on our ILOs and keeping them as our guiding light, we can make sure that what we do in a course is constructive, relevant and coherent.

4. Perhaps the most prevalent situation arising from the lack of explicit and sustained reflection on ILOs is **how-do-you-know problem:** in this case, a course may have promising ILOs, but by the end, there is no reliable way to measure whether students have actually reached those goals. Going back to the example above, does passing a multiple-choice test mean that a learner has actually achieved the goal of becoming a savvier real estate entrepreneur? Who knows! In this case, the assessment does not give an accurate reflection of student progress towards the goal; instead, it tells us about something much less ambitious (internalizing some ideas and information). As we shall see, a multiple-choice test, can tell us if students can recognize or perhaps analyze information, but it does not tell us whether the student can do something or act in a certain way. As a result, a student can theoretically pass with flying colors but not have achieved the stated goal (more on this problem below).

These issues are not all mutually exclusive. As we shall see later, some of them tend to go hand in hand, such as numbers 2 and 4.

There is one final point that merits mention and has already been hinted at above: not all types of learning are the same. Learning to label all the countries in South America on a map is quite different from learning how to ride a bicycle, which in turn is very different from learning to be a good neighbor. This topic is itself quite complex, but in the present context we can only offer one tripartite framework for distinguishing different types of learning:

COGNITIVE CONTENT: learning new information and ideas

PROCEDURAL CONTENT: learning how to do something new

ATTITUDINAL CONTENT: learning new attitudes and ways of being

This sketch simplifies a rather complicated matter, but let it suffice to say that when planning our ILOs we should distinguish between these three broad categories and the different needs and challenges offered by each of them. In the context of TC Nurse, we want students to work towards all three types of objectives: learning central concepts (e.g., "empathy"), skills (e.g., how to listen actively) as well as attitudes (e.g., how to become more compassionate and empathetic). These example from TC Nurse illustrate how these three types of learning are different but nevertheless related: if a student understands the concept of empathy, he/she will be better prepared to develop skills that foster empathy; finally, through putting that knowledge to use and practicing that skill, students can begin to act differently and develop new values. And yet we would not say that "understanding empathy," "acting empathetically" and "being empathetic" are one and the same. Within the context of a single module, we can reasonably expect students to understand new concepts and start to apply them in realistic settings, though we cannot ask or expect them to become new or different people in such a short span of time. What we can do, however, is ask them to make progress in that direction.

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2.2. TC Nurse's Intended Learning Outcomes

In the case of the TC Nurse module, the issue that we have been most worried about from the list of common short falls is number 2, the "get-rich-quick problem." That is because the skills and attitudes that the course seeks to address require long and sustained work on a student's part. To put it bluntly, one cannot become culturally competent in a week or even a semester. Nor can one learn to give culturally safe care in such a short amount of time. Since learning to do these things and seeing the world through these concepts is a more extended process, a single module can only help students make forward strides in their personal development. After all, Rome wasn't built in a day. Here we have to remember that students will come to program from different backgrounds and with different experiences and skill sets: one student may come to program with a developed awareness about transcultural care, whereas for another student these ideas may be completely new. It would be foolhardy to conclude that the success of the student with pre-existing knowledge can be attributed solely to the course; likewise it would arguably be unfair to unfavorably compare other students to one who already had a headstart.

However, there is also a deeper, more fundamental question: is there even an end point in learning the content central to the TC Nurse project? That is, is it even possible to speak of being "100% culturally competent"? We don't think so, since one can always deepen one's knowledge and develop one's skills further. For that reason, we have had to be careful when thinking about the ILOs for our program and not promising more than we could realistically deliver.

Guided by the CCMEn model developed by Antón-Solanas et al. (2020), the IPs have sought to help students deepen their knowledge of concepts, learn about themselves, start to rehearse/put into action culturally safe practice and find information for knowing about different groups within their own communities. These activities all require time and are part of larger processes. For that reason, we cannot promise that students will achieve all of these things during the module, but rather that they can make and demonstrate meaningful strides in that direction. Just because one cannot "master" the topics addressed in the module in a week or even a semester does not mean that these topics should not be covered or should be traded out for something less ambitious and easily attained. In fact, precisely because these things are hard to achieve it is worthwhile pursuing them in this module. It is not ambitious ideas that need to be left aside, but rather unrealistic notions of definitely mastering something.

Finally in this regard, it is worth mentioning the English language, which is a cornerstone of the TC Nurse project: students had to be evaluated on their language use without rewarding students who came to the project with a high level of proficiency and penalizing those with less experience. Here all ILOs concerning language need to take into account ideas of effort, participation and progress. These issues are discussed in greater depth in the CLIL guide that has been produced as part of the TC Nurse project (Intellectual Output 3) and are discussed further below.

The following table lists the ILOs that were used in the final IP (June-July 2021). They constitute a progressive refining of the ILOs used in the first and second IPs.

1. Reflect on their desire to actively engage in the process of becoming a culturally mindful individual and a culturally safe nursing professional through active participation in teaching and learning, and social activities both inside and outside the classroom.
2. Explain and analyze the detrimental effects of ethnocentrism, cultural stereotyping, prejudice and cultural imposition, which have the potential for decreasing quality of care and generating conflict between culturally diverse clients and health care providers.
3. Critically reflect on their personal identity as individuals and nursing professionals; explain how being in a multicultural environment may influence their behaviour; demonstrate respect for their peers and teachers and self-confidence.
4. Discuss and compare health-related beliefs, practices and behaviours, as well as biological, psychological and socioemotional characteristics, of selected cultural groups; reflect on their impact on patients' health outcomes.
5. Manage their own emotions and behaviour; demonstrate a degree of comfort and self-confidence in the multicultural learning environment through verbal and/or non-verbal language and active engagement with the courses' activities.
6. Discuss and analyze the impact of aspects such as patient empowerment, trust, respect, acceptance and communication on the nurse-patient relationship; explore the risk/benefits of (lack of) adherence to these principles to the patients' health outcomes.
7. Improve their ability to use both verbal and non-verbal language to effectively communicate with each other and with teachers, making clear strides to overcome the language barrier (this may include active listening, giving and receiving feedback, conflict negotiation abilities, relationship building and teamwork).

3. Constructing coherent learning experiences: backwards design and aligned learning

Once we have appreciated the centrality of formulating adequate ILOs that students can realistically accomplish during a module, we can more easily grasp the importance of making sure that learning experiences are actually linked to those objectives. Several educational ideas and best practices can help ensure that this is achieved. Two key concepts are discussed below, before turning to the ways in which TC Nurse organized its IPs so as to help students meet program expectations.

3.1. Backwards design

This approach has been championed by J. McThighe and G. Wiggins (1998) and urges us to think deeply about our objectives before beginning the planning of any particular activities or deciding how we will assess learners. If we compare learning to a journey, we have to decide where we want to go before choosing how to get there: If I leave my house on bicycle and twenty minutes later decide that I want to go to Hong Kong, I'm in trouble! In this way, class assessment and activities should be understood as a means of helping students arrive to a specific ILO and not as stand-alone events that are interesting or fun on their own. In short, the idea of backwards design is meant to guarantee focus and coherence by clearly highlighting what is important and then making sure that everything contributes to meeting the agreed-upon goals.

According to this system of class design, we begin by finalizing our ILOs and then decide how to determine whether or not students have achieved those outcomes by the end of the course. In other words, assessment and evaluation, which in both students and teachers' minds is often the end all be all of a course, are really just a set of tools to see whether students have achieved educational goals. Accordingly, teaching and learning activities ought to be conceived of as opportunities to prepare students directly for assessment, which in turn can truly tell us whether or not a goal has been met.

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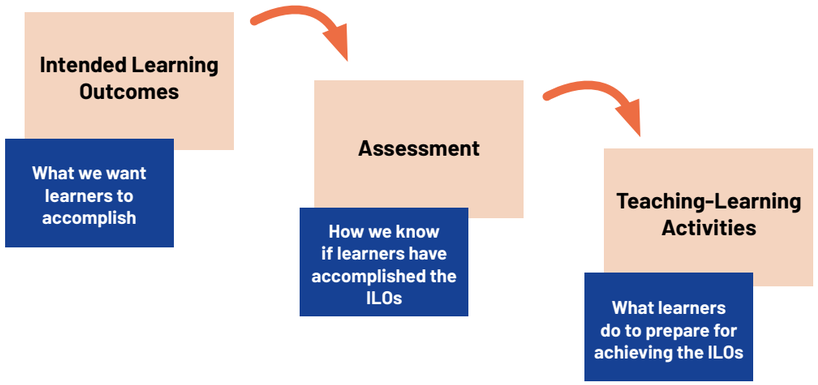

The rationale for doing things backwards is that it can keep us from losing sight of our organizing goals and not getting caught up in the weeds and losing sight of the bigger picture. As we will discuss in the next sections, going backwards helps us put together a coherent vision to which all assessment and teaching-learning activities contribute in one way or another. This is of crucial importance for all educational planning and especially so for projects with multiple instructors: because of various interests, areas of expertise and values, teachers working alongside one another are prone to take things in slightly different directions and, as a result, unintentionally reduce the coherence of a course or module. McThighe and Wiggins (2013) have illustrated this problem well with a construction metaphor: if there is no blueprint for a house, different craftsmen and workers may build and design rooms that are individually beautiful and wonderful but hardly add up to a functioning house. Our ILOs are like that blueprint that can keep workers on track and focused. Without them, we can have many wonderful lessons, but they may not add up to what the TC Nurse module seeks to accomplish.

3.2. Aligned learning

The previous considerations about starting our planning with the big picture before moving on to secondary questions of assessment and activities brings us to perhaps the most central concept for designing coherent and meaningful learning experiences: aligned learning. The topic has long been defended by John Biggs and is perhaps most fully explained and defended in Biggs and Tang's 2011 edition of Teaching for Quality Learning at University, in which many pages are dedicated to the topic. While it cannot be treated in such detail here, we can provide some of the most salient points for the TC Nurse project.

Not only should we plan by starting with our objectives and goals (i.e., through backwards design), but with each step we must ensure that there is a meaningful and logical connection between the ILOs, assessment and activities. Importantly, this is a slightly separate issue from having all the parts of a course connected thematically in terms of content. In fact, and as we shall see, sometimes thematic continuities across a course can obscure a lack of alignment between objectives, activities and assessment.

In short, activities need to prepare students for a certain type of assessment: if students will be assessed on their ability to resolve a case study, for instance, students ought to engage in activities involving case studies and have practice using tools to analyze and resolve these sorts of issues. By doing so, we can ensure that our activities are well targeted and coherent with the demands that we will place on our students. Next, the assessment ought to be aligned with the ILOs, which means that if a student passes the assessment, he or she has demonstrated an adequate mastery of the ILOs. If the student fails the assessment, he or she does not have an adequate grip on the material.

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While this may sound obvious and straightforward, there are slews of examples of unaligned learning across the educational spectrum. The most common problem arises from a lack of alignment between assessment and ILOs, which was hinted at above: many teachers will be familiar with examples of students passing a course (perhaps with good marks) without having truly mastered or internalized the most important concepts; likewise, we have all heard of a student who is constantly engaged in class, leading and helping her peers, who nevertheless performs poorly on evaluated tasks or even fails the course outright. These sorts of situations ought to be avoided and commonly result from unalignment: in such cases the assessment does not get at what is most important or is structured in a way that disadvantages certain types of students who, if evaluated differently, could show an adequate understanding and mastery of the ILOs.

One common reason for this breakdown is that instructors, who are often overworked and have larger numbers of students, opt for types of assessment that are easy to grade. Another parallel problem arises when instructors seek out what they deem to be more "objective" types of assessment, where there are answers that are either right or wrong and which can provide results that allow them to numerically rate (and implicitly rank) student performance. Hence the popularity of certain types of standardized testing like short answers, true/false questions or multiple choice. From the perspective of fairness and efficacy, these often appear to be ideal tools for student assessment. Here it is important to stress that no type of assessment is intrinsically good or bad, and we don't mean to beat up on multiple choice. The fundamental point is that different types of assessment are better suited to evaluating different types of knowledge (i.e., cognitive, procedural or attitudinal) and that instructors often mismatch an assessment strategy with the type of objective that they proposed at the outset of the course.

Let's return to the example of the real estate program discussed at the beginning of this chapter. If the ILO is "to acquire the skills needed to become successful," using a multiple-choice style test that covers the content of the course is clearly unaligned with the objective. At first, this may seem a bit nit-picky, but there is an important underlying distinction. The mastery of information presented by instructor for a multiple-choice test requires what we call lower order thinking skills (e.g., remembering, repeating, regurgitating). In other words, students are asked to recall and reproduce information that has been presented to them. While this is certainly important and provides the foundation for more sophisticated types of learning, it is ultimately a passive process largely based on memorization, association and/or identification. Instead, to better measure the ILO above, a student would have to actively demonstrate those needed skills in a realistic setting, whether that involved engaging with potential business partners, analyzing a potential business deal or showing the kind of creative thinking necessary to innovate. Doing all of these things is clearly more challenging, complex and time consuming than taking a quick quiz. Yet, if an instructor is to confidently say that a learner has meet such an ambitious goal, a more active and ambitious type of assessment is needed. Engaging in the sort of activities described above requires what we call higher order thinking skills. To do these things successfully, one must also have internalized the sort of content that can be tested by a multiple-choice test. Instead of merely regurgitating those ideas, however, now a learner's behavior and way of seeing the world has been affected by those ideas, which now allow the learner to do new things.

In an ambitious project like TC Nurse, it is of vital importance to reflect deeply on learning objectives and then design an assessment scheme and series of activities that are well aligned and give students the opportunity to meet those goals. These issues will all be discussed in the next section about how the project's learning activities have been organized and how we have assessed student performance in that context.

4: The IPs: format, structure and assessment

As mentioned above, problems of coherence and unalignment can arise easily in educational endeavors in which many different instructors collaborate. This is only to be expected. In light of this problem, TC Nurse has been careful in its planning of the IPs in order to construct a coherent series of activities that prepare students for the program's assessment and hence achieving the project's major objectives. The following subsections outline the different IPs and how the TC Nurse team prepared for them.

4.1. The different formats: in-person, online and blended learning

When the TC Nurse project was first envisioned, the plan was to have an in-person IP every year in Portugal, Belgium and Turkey, respectively. While the first summer school was held in person (summer 2019), the others could not be because of the pandemic and resulting travel restrictions. As a result of changing circumstances, each IP had a slightly different organization: IP 1 was completely in person, whereas IP 2 was completely online. IP 3, for its part, was blended, meaning that certain activities were synchronous while others were asynchronous; furthermore, some activities were conducted (when possible) in person, while others were not.

At first, the changes imposed by the global health situation was a serious disappointment since it was thought to negatively impact one of the project's main goals: to offer students a chance to increase their intercultural competence through direct interaction with peer nursing students from other countries. Creating that contact, we thought, was most easily done in person. After some careful reflection and thinking about new trends to promote "internationalization at home" (Beelen and Jones, 2015), however, the curve ball that the pandemic threw us was reimagined as a potential strength: we could better learn to use online tools and platforms to create the desired intercultural interaction and hence work towards a model that could be replicated more easily, because of lower costs and less logistical difficulties. Furthermore, online learning offered the possibility of stretching out the IPs so that not all activities had to be fit within a single week. This was most fully taken advantage of during the third IP (June-July 2021) when students had an introductory session and a hefty series of preparatory tasks to do before the main lesson began. More importantly, the team decided to give students a full week to work on their final projects before presenting them to the class (in C2 students only had several hours in the afternoon for this). Giving students more time to digest ideas, debate and collaborate with their peers led to stronger final projects.

Besides in this document, the team has reflected on the various strengths and needs of the different learning contexts in other outputs: see Intellectual Output 3 for CLIL in relation to in-person, online and blended learning; see Intellectual Output 4 for the ways in which the learning platform can be used to address difficulties of online and blended learning; see Intellectual Output 5 for a module that is prepared for a blended learning environment and spans an even longer period of time.

4.2. Structure and planning

The first IP was modelled on the 4Cs of CLIL (Coyle, 2007) and Papadopoulos, Tilki and Taylor's model for developing cultural competence (Papadopoulos, 2006). However, after the first IP, the team identified difficulties and shortcoming in the model and went back to the drawing board. The fruit of this further reflection is the CCMEn model (Antón-Solanas et al., 2020), which was used during the second and third IPs and described in further detail elsewhere in this manual. For the present purposes, we can say that there are five main areas of study (Cultural desire, Self-awareness + Cultural awareness, Awareness of the other + Cultural knowledge, Social skills + Cultural sensitivity and Culturally mindful behavior + Culturally safe practice) that combine ILOs geared towards the acquisition of interpersonal and professional competencies.

In the TC Nurse project, each partner institution was responsible for preparing the materials for one day of each intensive program, with each day corresponding to a part of the CCMEn model (see previous chapter). Within these larger national groups, different instructors prepared smaller activities that were pertinent to each day's theme. Working within this overall structure proved to be a productive way to stay focused and keep lessons coherent. The program's guiding objectives and principles were integral to this model to ensure coherence, focus and adequate sequencing.

Relying on the CCMEn model alone, however, was not sufficient to guarantee the desired coherence. Accordingly, the team has moved towards a model of organization and a review process that Dr. Antón-Solanas has usefully called "communities of teaching." In the project, there were four communities of teaching, with one corresponding to each partner institution and managed by an instructor with CLIL experience. As lessons were developed, they would be reviewed by the CLIL expert, who would ensure that students were given ample opportunities to participate, have questioned answered and be supported with proper resources and scaffolding; furthermore, in each community of teaching, different instructors worked to ensure that they were covering relevant parts of the CCMEn model. Once each community of teaching had finished their proposed activities, they filled out a lesson plan template that would be reviewed by the larger team (to identify gaps or overlaps in the entire course program) before being finalized. These lesson plans are heart of the present manual and represent to work and collaboration of the entire TC Nurse team.

4.3. Student collaboration

A major premise of the TC Nurse program is that by working with peers from different cultural and linguistic backgrounds, students will find themselves in a more fruitful context for developing and training intercultural competence. For that reason, the TC Nurse team made a concerted effort to make students work with peers from different countries and socialize with the larger group. For this reason during the final IP, students were organized into groups of 8 (with two students from each partner institution) that would be their work groups for the duration of the entire project. During the main sessions relating to the first 4 parts of the CCMEn model, students would work with these peers on the different activities and challenges found in this manual. Finally, they would continue working together on a final group project that corresponds to the fifth part of the CCMEn model.

4.4 Assessment

Assessing students who are in the process of undertaking a career-long journey that involves the development of personal and professional skills is no easy task. As alluded to above, one potential risk is to reward students who happen to be further along in that journey because of their past experience and penalizing those who are just beginning to engage with a new series of issues. A similar issue relates to language: not all students come to the program with the same linguistic skills and hence may have an easier or harder time communicating with others. In this case, it would also be inappropriate to penalize someone based on their previous experience instead of what they actually accomplished during the course.

In an attempt to avoid such problems, we have made a series of choices to help students throughout the process and have also designed an assessment scheme in which students can work collaboratively and pool different team members' knowledge, skills and strengths.

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ASSESSMENT TOOLS:

Case study	40%	group
Student portfolio	30%	individual
Pre/post-language survey	10%	individual
Peer and self-assessment	20%	individual

1. CASE STUDY

The final and most substantial part of the assessment for the TC Nurse program involved the explanation and careful analysis of a case study, all of which are included in this manual. Students were asked to present their case study to their peers and then make suggestions to address problems and improve the situation.

This activity was the culmination of what students learned and experienced during the IP. It required consistent group work that culminated in a presentation. Students were encouraged to be creative and find compelling ways to share their work.

2. PORTFOLIO

Since the team wanted students to work consistently throughout the IP to prepare for each lesson and also to actively reflect on their learning, students were asked to compile a short learning portfolio in which they collected their different tasks and also wrote a daily learning journal in which they reflected on new ideas and concepts as well as their ability to learn and communicate through English.

Yet evaluating students solely on the basis of the case study was not deemed sufficient to assess all the ILOs. For that reason, a peer and self-assessment was added so that learners could reflect on the contributions of all team members to the group project and other activities. Each student was asked to reflect on the general group dynamics as well as score each group member on a series of issues.

3. PRE/POST-LANGUAGE SURVEY

Learning to navigate intercultural situations through English is crucial to TC Nurse. Hence, students also had to be evaluated on language and communicative competency. As mentioned above, no two students came to the program with the exact same knowledge or level of English, which means that many standard forms of language assessment would be inappropriate. Therefore, the team opted to assess students on growth and progress. At the beginning of the program, each participant completed a questionnaire about their language abilities and attitude towards using English. At the end of the course, students would fill out the same questionnaire and results would be compared to judge progress. In many courses conducted in a foreign language, those who already know the most (and have less to learn) have a clear advantage in terms of assessment; the system employed by TC Nurse, however, has turned the tables: students who have a weaker level and hence have the most to learn can demonstrate progress more easily. This dynamic is a useful way to motivate more advanced English users to deepen their knowledge actively, even if they already have a sufficient level: to be assessed favorably in this regard, they too must make the effort to widen their communicative skills.

4. PEER AND SELF-ASSESSMENT

The TC Nurse team wanted learners to reflect on their experiences working in groups. Not only is this good practice generally, but also would provide important information on the completion of different ILOs. For that reason, students were required to assess their contributions to their groups as well as the contribution of each team member. This assessment took place on the final day of the program after students had finished presenting their case studies.

The following table shows the link between the courses ILOs, assessment and activities.

ILO:	Way to assess it	Activities to prepare students
1. **Reflect** on their desire to actively engage in the process of becoming a culturally mindful individual and a culturally safe nursing professional through active participation in teaching and learning, and social activities both inside and outside the classroom.	**Portfolio:** "My roadmap towards transcultural competence" **Self-assessment**	Daily personal reflection Every session should contribute to this ILO, though it should be addressed directly on the day for "Cultural Desire" (led by Belgium)
2. **Explain and analyze** the detrimental effects of ethnocentrism, cultural stereotyping, prejudice and cultural imposition, which have the potential for decreasing quality of care and generating conflict between culturally diverse clients and health care providers.	**Case study**	Every session should contribute to this ILO
3. Critically **reflect** on their personal identity as individuals and nursing professionals; **explain** how being in a multicultural environment may influence their behaviour; **demonstrate** respect for their peers and teachers and self-confidence.	**Portfolio:** learning journal requiring daily reflection **Peer assessment**	This is especially relevant to the topic **"Self-Awareness/Cultural awareness"** (led by Turkey), but other sessions should also address this ILO as well
4. **Discuss and compare** health-related beliefs, practices and behaviours, as well as biological, psychological and socioemotional characteristics, of selected cultural groups; reflect on their impact on patients' health outcomes.	**Case study**	This is especially relevant to the topic **"Awareness of the other/ Cultural Knowledge"** (led by Portugal), but other sessions should also address this ILO as well
5. **Manage** their own emotions and behaviour; **demonstrate** a degree of comfort and self-confidence in the multicultural learning environment through verbal and/or non-verbal language and active engagement with the courses' activities.	**Peer Assessment** **Self-Assessment** **Language before/after questionnaire**	Every session should contribute to this ILO, though it should also be a focus of all the **preparatory materials and activities**
6. **Discuss and analyze** the impact of aspects such as patient empowerment, trust, respect, acceptance and communication on the nurse-patient relationship; **explore** the risk/benefits of (lack of) adherence to these principles to the patients' health outcomes.	**Case study**	Every session should contribute to this ILO, though it should be stressed in **"Social Skills/Cultural Sensitivity"** (led by Spain)

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7. **Improve** their ability to use both verbal and non-verbal language to effectively communicate with each other and with teachers, making clear strides to overcome the language barrier (this may include active listening, giving and receiving feedback, conflict negotiation abilities, relationship building and teamwork).	**Peer assessment** **Self-assessment** **Language before/after questionnaire** **Portfolio:** "Today I was able to…" checklist + short reflection	Every session should contribute to this ILO, though it should also be a focus of all the **preparatory materials and activities**
8. **Put into practice** aspects of culturally mindful behaviour when working together during class sessions, assessment activities and especially group work; **enact** culturally safe nursing practice through the resolution of specific case studies involving patients, families and/or communities from different cultural backgrounds	**Peer assessment** **Self-assessment** **Case study**	Every session should contribute to this ILO, but the guidelines and rules of conduct need to be expressed explicitly as part of the **preparatory materials and activities**

Finally, it is important to assess the design of the project as well as the work of the instructors. For that reason, the TC Nurse team conducted daily surveys with learners about their experiences as well as a series of focus groups with students at the end of the course and instructors. All of this data proved immensely valuable for improving the project and is discussed in detail in Intellectual Output 3.

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04. Teaching Plan and Activities

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Introduction:

This chapter presents the teaching plans and activities which were used during the intensive learning program of the three summer schools of TC-Nurse. Each partner was responsible for one of the four aspects of the CCMEn model.

- Cultural desire
- Cultural Awareness and self-awareness
- Cultural knowledge and awareness of the other
- Cultural sensitivity and social skills

Each year new activities on the same theme were added to the teaching plan. The teaching plan began with introducing the theme using group activities, videos, reflection exercises, short quiz, assessment exercises and so on. Each teaching plan was planned for a day's lesson of 5-6 hours, comprising of multiple sessions of 25-30 minutes each and breaks in between.

The first summer school of TC-Nurse was conducted face to face in a class room with break out rooms for group exercises. The next two summer school was conducted on an online basis due to Covid-19 pandemic. However, the plenary session and break out rooms for group exercises were conducted on an online basis. Group sessions were moderated by instructors, discussions and reflections following group exercises were held in plenary sessions attended by all.

The teaching plans and activities presented in this chapter may be modified based on teaching session and student group. The goal is to give future teachers ideas and resources that explore important and complex themes.

1. Teaching Plan and Activities for working on: Cultural desire

2. Teaching Plan and Activities for working on: Cultural Awareness and self-awareness

- Turkish Team:
- Venue: Portalegre, July 01, 2019
- Start time: 09:00
- Finish: 13:30
- Total time: 3 hours, 30 minutes (+30 min break)

2.1. Session aims

The main aim of the session is to:

- Create an environment to make the students aware of the cultural diversity among them.
- To introduce students to the concept of cultural diversity, awareness, tolerance, cooperation in the work place.
- Provide case studies to understand and acknowledge the beliefs and practices of other cultures/ communities.
- Describe different culture, belief systems, values and religious practices that are specific to identified cultures and how they affect a person's approach to health and illness.

2.2. Learning outcomes

COGNITIVE

By the end of this session the students will be able to:

- C-ILO1: Identify the cultural diversity among students as well as in the population in general.
- C-ILO2: Understand the influence of cultural diversity, belief and practices of individuals on their approach to health care.
- C-ILO3: Recognize the existence of biological variations among ethnic groups and describe specific characteristics of different cultural groups.
- C-ILO4: Explore culturally sensitive verbal and non-verbal communication during class discussions and in relation to different case scenarios.
- C-ILO5: Recognize the detrimental effects of ethnocentrism, cultural stereotyping, prejudice and cultural imposition on health care.

SOCIOEMOTIONAL

By the end of this session the students will be able to:

- SE-ILO1: Develop an awareness of their own values, beliefs and attitudes towards both colleagues and patients who belong to a different culture.
- SE-ILO2: Integrate values as trust, empathy, compassion, respect, acceptance and appropriateness into the nursing plan for specific culturally diverse patient populations.
- SE-ILO3: Demonstrate respect, empathy, acceptance for the opinions of others during class debate.
- SE-ILO4: Discuss culturally sensitive nursing care in specific case studies.

2.3. Language support

LANGUAGE *OF* LEARNING	LANGUAGE *FOR* LEARNING	LANGUAGE *THROUGH* LEARNING
Learning od words/vocabulary Learning of phrases, professional jargon and colloquial language Reading, learning and understanding text	For group assignments and discussion For participating in the class verbally or express comments and opinions through writing.	Through presentation of assignments Through discussion among peers Through reading, understanding the content

2.4. Culture support

Culture Specific perspectives and examples:

- Mixing of students from different countries will be facilitated
- Groups constituting students from all countries will engage into conversation and discussions
- Students will speak about their cultures and health care systems in their countries, problems and scope for improvement
- Portuguese, Spanish, Belgian and Turkish healthcare systems will be discussed. Students will be encouraged to share their perspectives on the matter.

2.5. Description of the teaching and learning activities

ACTIVITY 1

Defining Cultural Awareness

(Video1 – We are all alike) – Don't put people in boxes

1) The activity will help students think about how they are alike and not really different from each other (not to be put in separate boxes)

Assessment: After looking at the video, the students will try to reflect on this point and write on "post it" as to how they are "alike" and how they are "different" from others.

https://www.youtube.com/watch?v=zRwt25M5nGw

ACTIVITY 2

Languages and Cultural Awareness

Handout 1

This activity is designed to help students think about their language learning and cultural awareness as well as their place as a citizen of the world.

Handout 2 &3 Papadopoulos (Visual analogue Scale, Assessment of Cultural Awareness)

Assessment

The students will reflect on their cultural identity and language by means of the activity sheet provided, share with the group and try to assess the similarities and differences.

Every group thinks of an example how his/her attitude/thinking/behaviour may have been affected by his/her cultural background.

Students will assess their cultural awareness using VAS scale.

(Handouts 1,2,3 attached among teaching materials)

ACTIVITY 3, 4

Videos (2) about Refugees in Turkey (Video 1 embedded in the presentation, Video 2 attached in teaching materials.

Assessment

Self Reflection and Open Discussion

ACTIVITY 5

Enhancing Cultural Awareness in Health Professionals

Handout 5

The material contains a list of aspects regarding cultural awareness (Pregnancy Issues), for healthcare professionals.

The students will read the material as group and discuss among themselves

Assessment:

The students will analyse the material and circle the 2 most important recommendations

(Handouts 5 attached among teaching materials)

ACTIVITY 6

This activity consists of a material regarding "cultural issues related to women's health". This activity enables to arouse empathy toward other cultures by being in their shoes.

The students as a group will read the problem statements of refugees regarding language and cultural barriers and reframe the sentences from patient's aspects (as though they were the patient themselves).

Assessment:

The statements will be analysed from the way of expression and language aspects.

ACTIVITY 7

Cultural Awareness in Healthcare: A nurse's checklist: Use an adequate modal verb to write your checklist.

The students will reframe the sentences using an adequate modal verb to re-write the given checklist.

Assessment:

This is an exercise with cultural awareness content stressing on language.

Support for Language

Here is some vocabulary that may help you express your opinion:

WORD	DEFINITION
refugee	Displaced from home
asylum seeker	Seeking refuge in another country
migrant	Same as above
prejudice	Negative belief or preference that is generalized to a group that leads to prejudgment.
judgements	how someone perceives another person based on certain superficial factors like the clothes they wear or the car they drive.
empathy	an understanding gained by putting ourselves in the other's position
challenges	difficulties
discrimination	Different treatment of individuals or groups based on specific characteristics. Denies those individuals rights and opportunities.
embrace	welcome; show warmth towards; accept enthusiastically
ethnocentrism	A tendency to hold one's culture as superior to others. Can be the basis of bias and prejudices.
respect	treat properly
exclusion	not including; leaving something or someone on the outside
impose	force; press
cultural misconceptions	Mistaken thoughts, idea, or notion; misunderstandings about a culture. These are false ideas about a culture resulting from misunderstanding rather than from reality.
cultural stereotypes	A fixed idea (mostly incorrect) that people have about what someone or something is like.

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CASE STUDIES I II III

The students will read the case studies, work as a small group to analyse the situation.

Discuss the cultural aspects of the underlined sections in the materials

ASSESSMENT

Each group will try to come up with ideas as to how they manage (could manage) differently such a situation as a health care provider.

2.6. The teacher's corner (this will be explained further after the session)

ACTIVITY 1

This is an ice-breaker activity where students coming from different backgrounds realize that they are alike and have more in common than they really think.

ACTIVITY 2

Students will reflect on their cultural identity and language by means of the activity sheet provided, share with the group and try to assess the similarities and differences. The Papadopoulos evaluation sheet is for self-reflection in terms of cultural awareness for each person.

ACTIVITY 3

Refugees in Turkey is approximately 3.5 million in number currently and the social, health and economic aspects are very important especially for health care providers. Unfortunately, most of the aspects are not known in the other parts of the world including Europe. This session was planned in a way, to share some of the aspects with students from other countries who would be future nurses so that they would be aware of these issues.

ACTIVITY 4

Same as above.

ACTIVITY 5

The aim was for the students to analyse the situation as a nurse/health care provider and prioritize certain issues as per their thinking

ACTIVITY 6

This activity will help students to empathize with the patients because they will express the problem statement from the patient's perspective.

ACTIVITY 7

This activity has been designed more as a language support in professional area supporting CLIL techniques.

3. Teaching Plan and Activities for working on: Cultural knowledge and awareness of the other

4. Teaching Plan and Activities for working on: Cultural sensitivity and social skills

05. Case Studies and Student Assignments

Nuran Komürcü, Indrani Kalkan, Arzu Kavala, Seda Değirmenci Öz

Introduction:

This chapter presents the different case studies that were analyzed and discussed during the three intensive learning courses. The chapter also contains the pre-session assignments and activities included in the student portfolio which was evaluated as an assessment tool for the participants.

The final and most substantial part of the assessment for the TC Nurse program involved the explanation and careful analysis of case studies based on the different aspects of CCMEn model. Students were assigned to groups such that the groups consisted of students from all participating HEIs. Each group was asked to present their case study to their peers and then make suggestions to address problems and improve the situation.

This activity was the culmination of what students learned and experienced during the IP. It required consistent group work that culminated in a presentation. Students were encouraged to be creative and find compelling ways to share their work.

Apart from that, there were additional activities for preparing for the Ips. As part of the portfolio for assessment, students participated and completed several activities some on group basis and others on individual basis. The assignments included explaining and analyzing their national healthcare system, pre-post language survey, self and peer assessment, taking and presenting videos of their cities stressing on certain cultural issues, reflection after having watched particular movies and documentaries assigned to them by the instructors and so on.

The case studies belonging to each aspect of the model has been listed as follows:

- Cultural desire
- Cultural Awareness and self-awareness
- Cultural knowledge and awareness of the other
- Cultural sensitivity and social skills

1. Case Studies

1.1. Cultural Desire

CASE STUDY " Aba is so precious to us"

CLIENT PROFILE

Identification of the child: Aba Ayaan, F Date of birth: 29/03/2017 (3 years old) Nationality and/or origin: Somalia

Date and reason for current recording: Unscheduled admission on 21/02/2020 due to constipation and severe abdominal pain, no previous history of illnesses.

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Nurse's initial assessment upon admission:

- Emergency admission, coming from home.
- Aba seems to be very constipated and in severe pain. There are no known allergies.
- There is a barrier to make an initial assessment due to the age of the child and the language barrier with the parents. Communication is possible with the mother but only in limited English. The father understands very little English, he only speaks Somali.

The parents have 5 children, all under the age of 6. They came with all the children to the emergency unit as they were unable to find someone to care for the other 4 children. They seem very dedicated and concerned, but are unable to express themselves sufficiently in English.

Setting

Aba is being admitted on the emergency unit from a general hospital. The pediatric unit is fully booked for the moment. Once there is a vacancy, they will inform the emergency ward of the possible transfer.

There is a pediatrician on duty and a pediatric nurse is stand by.

Aba is given a pediatric box, but the two parents and four children cannot be accommodated in this small room. As there is no room on the pediatric ward, they sit in the hall on the floor to wait.

Description Of The Case Study

Aba is still very small and needs a full time caregiver.

- Parameters on admission: Weight 14.2 kg and temperature 36.8 °C
- Pain assessment: Pain present, pain score is between 5-7.

Suspected child abuse: Strange interaction with the father, lying in curves and crying. When she plays with her mother, she seems happy. Mommy doesn't notice any special/weird behavior related to the father.

The staff of the Emergency Unit tries to explain that it would be preferable for the father and the other children to go home, and the mother can then stay with Aba. This is not possible for both the mother and the father. They stay very polite in their communication, but also seated in the hallway. The mother indicates that she cannot stay without her husband and that Aba cannot stay alone. So they all stay. The mother seems to be very subservient towards the father.

Aba shows a good enough general condition. Her weight is 14.2 kg.

At the moment she seems to be a bit behind in the normal development. Mom says she is functioning normally at school. Aba keeps her neck and back stiff, but doesn't seem meningeal stimulated.

She doesn't want to sit or straighten up, she stays completely stiff. She takes steps when we put her down on the floor. According to mummy, walking is more difficult than stretching over. Aba regularly lies in an opisthotonus position, but she is easily distracted and then she laughs. Even in a moment of pain, she stretches fully (in opistothonus).

After administering a painkiller, Aba improves reasonably quickly. According to the father, Aba isn't able to talk. According to mama she seems to understand everything mama says. The brothers indicate that it is mainly sign language and that they rather guess what she wants to say.

Symptoms related to the current disease state: Crying / painful behavior, abdominal pain, vomiting and fever, eats and drinks very little these past days. Nose runny, but little cough. Doesn't want to sit or walk.

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Diagnosis or problem: Adenovirus, pathological bone remodeling L3/transition L2-L3 = spondylitis/discitis. Secondary constipation, abdomen contains a lot of air, is erect but supple.

Treatment: Amoxiclav IV and fluid IV were administered because of inflammatory blood count and antalgic posture.

Glossary of terms

unscheduled admission: without an appointment or planned intervention, the patient is admitted to the hospital.

opisthotonus posture: this is a convulsive backward stretching of the body (Solvo, 2020)

antalgic posture: this is the posture one adopts to reduce pain, in which pain is felt least.

caregiver: a person providing care like a mother or father.

a vacancy: a hospitalbed is not filled so there is a vacancy to admit a new patient.

child abuse: a child is treated cruelly or violently or with a harmful result.

subservient: giving the impression to obey others unquestioningly.

pathological bone remodeling L3/transition L2-L3 = A healthy skeleton must be maintained by constant bone modeling to carry out these crucial functions throughout life. Bone remodeling involves the removal of old or damaged bone by osteoclasts (bone resorption) and the subsequent replacement of new bone formed by osteoblasts (bone formation). This important physiological process can be derailed by a variety of factors, including menopause-associated hormonal changes, age-related factors, changes in physical activity, drugs, and secondary diseases, which lead to the development of various bone disorders in both women and men.

spondylitis: an inflammation of the vertebra

discitis: inflammation that develops between the intervertebral discs of the spine

CASE STUDY "Case Younes: Psychiatry or djinn "

Client Profile

Younes is a 16-year old boy of Moroccan descent who was born in Antwerp,Belgium. He lives with his parents in the center of Antwerp and goes to school in a secondary school nearby. He used to play football, but his engagement has been decreasing the last months. He lost some weight and seems to have difficulties with certain types of food.

He speaks Dutch, French and Arabic.

Setting

The general hospital where Younes stays, treats children ages 3-19 for an array of diagnoses including depression, anxiety, ADD/ADHD, bipolar disorder, and addiction. They also provide special treatment programs focusing on schizophrenia and personality disorders and their accompanying symptoms.

Their full complement of inpatient, outpatient, residential, and partial hospital services helps young people and their families cope with psychiatric illness and the challenges it often brings.

Younes can probably participate in the STAR Program which delivers high- quality outpatient care to teens and young adults ages 14-25 who are at risk of psychotic illnesses. The program offers individual therapy and psychiatric treatment for young people who are experiencing changes that impact thinking, emotions, behavior, and functioning.

Description Of The Case Study

Younes was admitted in the psychiatric urgent care unit from the General Hospital.

He was brought in, after a referral by the family's physician, with aggressive behavior and strange thoughts who were difficult to handle. This behavior had been difficult for some time and the family had been in contact with some local assistance. These difficulties were also present in the school and at his football club.

Observation of the behavior quickly gives cause to think of a psychiatric episode. In addition to observing and handling the behavior, one of the goals of the placement is to maintain a positive relationship with parents. The parents are thus kept explicitly informed of the progress of the placement of Younes.

His mother is a fairly westernized Muslim, working in a school. She visits Younes regularly. She understands the content of psychiatric care and agrees with the advice to have their son urgently examined in a mental health institution.

His father has a different vision. He's convinced that his son's symptoms are present because he's been visited by a jinn. He doesn't support the proposed treatment. His father would like to see Younes being treated by an imam.

Symptoms

Both positive and negative symptoms of schizophrenia are present:

- Positive: agitation, delusions (illusory beliefs), disorganized thinking, hallucinations (illusory perceptions), bizarre behavior
- Negative: lack of interest, flat affect, relational deficit, lack of motivation, reduced social interaction

Nurse: When Younes was admitted, we immediately developed sympathy for him and his family. They were all very kind people, also for one another. Younes' behavior was very worrying, and his parents were desperate to retrieve the son they used to know.

Younes was experiencing a psychotic episode and it was very difficult to communicate with him. He was saying strange things, not adequate, sometimes related to religion or punishment. After two weeks on anti- psychotic medication, he was a lot better. We could communicate with him, he went to the hospital-school two hours a day and behaved adequately.

Then, after some weeks, he had another psychotic episode. He became more isolated, didn't shower and was always mumbling.

One day, it was late in the evening and we were just making the transfer to the nightshift, he acted out. He was in his room and started destroying his cupboard and personal belongings. He started ripping his version of the Koran to pieces and throwing them away.

He was then transferred to the isolation room and was given extra medication. After a few days, he was much better but we had to acknowledge his vulnerability for these psychotic episodes, giving indications for the diagnosis of schizophrenia.

I will never forget the second day after this acting out. He was still in the isolation room and asked for his version of the Koran. I explained to him that it was damaged during his moment of acting out. He was very sad for this. However, we had kept the pieces and together with Younes, I started putting back the pieces and thus reconstructing the Koran book.

We worked for more than two hours, and then my colleague from occupational therapy took over. At the end of the day, he again had his version of the Koran. He was so happy, I will never forget that. While restoring his book, we also restored some of his pain and loss.

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His parents were very involved. However, the father only spoke about going to Morocco and the local healer to drive out the djinn. I thought it was strange that a father, seeing a son that was obvious suffering from psychotic episodes, wanted to involve a local healer. I have very little faith in these practices. The mother of Younes understood our Western approach, but she wanted to resolve things peacefully so she didn't contradict her husband.

Glossary of terms

Djinn: are believed to be powerful, invisible beings, capable of possessing people and even inflicting suffering on them. Stories of human encounters with djinn are very common across cultures and history.

inpatient and outpatient: The difference between an inpatient and outpatient care is how long a patient must remain in the facility. Inpatient care requires overnight hospitalization
Patients receiving outpatient care don't need to spend a night in a hospital

psychotic illnesses: Psychotic disorders are severe mental disorders that cause abnormal thinking and perceptions. People with psychoses lose touch with reality. Two of the main symptoms are delusions and hallucinations

referral by the family's physician: the family got the advice from their GP (general practitioner) to come to the hospital.

proposed treatment: the actions suggested by the physician. To retrieve: to get back

To behave adequately: to do the things you are supposed to do in a good way.

mumbling: talking in a very low voice without good pronunciation

to act out: to behave poorly, often communicating without words but with actions

ripping: to tear to pieces

vulnerability: fragility, you suffer more than other people from that... to contradict: to say the opposite

1.2. Cultural Awareness and self-awareness

1.3. Cultural knowledge and awareness of the other

CASE STUDY "All about dementia - Joana"

Client Profile

Joana is a 68-year-old widow, retired and resident in a small Portuguese town.

She emigrated from Africa 40 years ago with her husband and children, fleeing the war. She left all others relatives in Africa and never returned.

She is a practicing Catholic and very active in her religious community.

She lives alone. The children (a girl with 30 years old and a boy with 35, both married) live in a large city and only visit her on festive occasions like Easter or Christmas.

Setting

A small Portuguese city with about 15,000 inhabitants formed by small and close streets with very strong neighborhood networks.

All people know each other and have easy access to primary health care but difficult access to specialized care.

Description Of The Case Study

On a recent visit, her daughter noticed obvious memory failures especially in memory related to instrumental life activities (difficulty in shopping or reminiscing ingredients of culinary recipes.

She also found great neglect in her daily activities, such as bathing.

However, she writes notes so she does not forget the tasks she has to do during the day.

His mood has also changed. She is no longer gentle and worried and has episodes of anger for no apparent reason. She became stubborn and irritable and occasionally aggressive for no apparent reason.

She lost interest in hobbies, newspapers and television.

She has difficulty finding the right word and sometimes makes nonsense phrases.

There is no relevant somatic or psychiatric history. She doesn't take any relevant medications.

Lately she has found refuge in the church where she spends most of her days just praying.

The daughter, after the last visit, requested an appointment with her family doctor in order to be observed later in a neurology consultation.

Their behaviors were not identified among other members of the religious community or among neighbors since the subject of dementia is still a stigma that is not spoken openly.

The identification of cognitive deficits and memory alterations does not integrate the culture of this community.

Glossary of terms

Religious community: is a community (group of people) who practice the same religion. The term is used in a wider sense and a different narrower sense. People who define themselves as having a particular religion are considered to be members of the religion's community.

In the wider sense, the term is used to refer to members of one religion who may live in groups, or near or intermingled with members of other religions. Community members may mix with others in everyday life, but worship separately, typically in a dedicated temple such as a church or mosque

Memory flaw: It is related with a memory fault, mistake, or weakness, especially one that happens while something is being planned or made. Can be about language or actions

Daily activities: Activities of daily living (ADL) refer to daily activities that individuals normally do, unassisted, to take care of themselves. These activities include: bathing, eating, cooking, walking, dressing, house chores, personal hygiene and walking

Mood: A mood is a feeling or a person's specific state of mind at any particular time. A mood is also the prevailing emotion found not only in people but also in literature, music, and other expressive arts. Moods set the overall tone for speech or writing and are an important element in literature as well as in everyday life.

Stubborn: A stubborn person is determined to do what he wants and refuses to do anything else. It can happen due to memory failures

Relevant facts and figures about the minority culture

The independence of the Portuguese colonies in Africa began in 1973 with the unilateral declaration of the Republic of Guinea-Bissau, which was recognized by the international community but not by the colonizing power. The remaining Portuguese colonies ascended to independence in 1975, following the Cravos Revolution.

Half a million Portuguese were integrated into Portuguese society during the period from the summer of 1974 to the summer of 1975, as a result of the decolonization imposed by the end of the Estado Novo dictatorship. It is a unique population integration movement that brought a qualified human mass that contributed decisively to the construction of the democratic State. For history they became known as the "returnees." In fact, they are the last generation of Portuguese who lived and grew up in Portuguese colonial Africa.

Portuguese decolonization left deep traumatic marks in the Portuguese social environment with more than half a million returnees and many Portuguese assets, public and private, lost forever.

Decolonization should be one of the themes that, even today, more passions light up in Portugal. And it is natural that this should be so. The definitive and late end of the Portuguese Empire implied a radical change in the lives of more than one million Portuguese. Radically changing life from one day to the next is not a small thing. It leaves deep traumas. Add to this a 13-year colonial war whose memories were, until the end of the 80's, lived in silence by many people leaving traumatic marks in memory.

CASE STUDY "At nursing home "

Client Profile

A 63-year-old female patient, married, living in a nursing home.

She attends the family doctor's office accompanied by her son, who reports apathy, psychomotor retardation, of ability to concentrate, anedonia and asthenia of six months of evolution, with progressive worsening.

Prior to symptomatology, it was completely independent for basic and instrumental daily living activities (DLAs).

It presents as comorbidities: controlled hypertension and type 2 diabetes, controlled with non-pharmacological treatment.

Has a history of chronic urge incontinence, which has worsened in the last two months.

Setting

The increase in the average life expectancy has brought with it an increase in the number of elderly people and, with them, a number of social needs, which present themselves as challenges in the modern societies in which we live. To respond to these challenges, a number of social responses have emerged over the years, such as day centers, home support services (SAD), residential structures for the elderly (ERPI), among others.

Description Of The Case Study

Functional Capacity Evaluation

Partial dependency for basic DLAs - help for washing parts of the body. Incomplete dependence for instrumental DLAs - went on to require supervision for home care, she did not cook or went out alone.

First Cognitive evaluation (schooling - 4 years of study): MMSE - 12/30

Clock test: Absolute inability to represent the clock.

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In the assessment of mobility, it was observed the march, with timed up and go test of 22 seconds, extended base and unbalanced gait. The exam showed no changes other than unstable gait, no visual, auditory changes were observed or oral in the patient.

The impairment of cognitive functions with repercussions in DLAs refers to four main basic diagnoses: depression, dementia, delirium, and mental illness. Despite the apathy and disorientation, the absence of fluctuations during the day and the persistence of symptoms for six months weaken the possibility of delirium. The absence of psychotic symptoms, such as delusions and hallucinations, makes it unlikely the hypothesis of mental illness1. They remain as depression and dementia.

This patient, with functional for losses in basic and instrumental DLAs, impairment memory and other cognitive functions,

such as praxia, executive and visuospatial function, fulfill the diagnostic criteria for dementia.

A pseudodementia picture secondary to an episode major depressive disorder would explain apathy, psychomotor retardation, reduction in the ability to concentrate, the anedonia and asthenia, but not the gait disturbance nor the worsening of urge incontinence.

Glossary of terms

anedonia is the loss of the ability to feel pleasure, proper of severely depressive states. It is also found in some types of schizophrenia and personality disorders.

functional capacity evaluation (FCE) is set of tests, practices and observations that are combined to determine the ability of the evaluated person to function in a variety of circumstances, most often employment, in an objective manner.

They are also required by insurers in when an insured person applies for disability payments or a disability pension in the case of permanent disability.

The mini-mental state examination (mmse) or folstein test is a 30-point questionnaire that is used extensively in clinical and research settings to measure cognitive impairment. It is commonly used in medicine and allied health to screen for dementia. It is also used to estimate the severity and progression of cognitive impairment and to follow the course of cognitive changes in an individual over time; thus making it an effective way to document an individual's response to treatment. The MMSE's purpose has been not, on its own, to provide a diagnosis for any particular nosological entity.

the clock-drawing test is a simple tool that is used to screen people for signs of neurological problems, such as Alzheimer's and other dementias. It is often used in combination with other, more thorough screening tests, but even when used by itself, it can provide helpful insight into a person's cognitive ability.

Relevant facts and figures about the minority culture

The changes in the age composition of the resident population in Portugal are revealing of the demographic aging that has occurred in the last years, as has happened in most of the developed countries. As a result of the fall in the birth rate and the increase in longevity in recent years, there has been a decrease in the number of young people (0 to 14 years old) and in the working age population (15 to 64 years of age) in Portugal, of the elderly population (65 and over). By 2015, 2.1 million people, almost 20% of the Portuguese population, were 65 or older. The proportion of older people in the population has been growing and the trend is expected to continue. According to national projections, it is predicted that in 2030, the elderly will represent about 26% of the population and by 2060 will grow to 29%. The number of people aged 80 and over more than doubles between 2015 and 2060, projected to rise from 614 thousand to 1421 thousand individuals.

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The number of elderly people has already surpassed the number of young people in Portugal for a long time. aging rate2, reaching 140 elderly people per 100 young people in 2015. The dependency ratio, which allows us to measure the relationship between the number of elderly people and the number of people of working age, has been steadily increasing in recent years. in 2015, with 31 elderly people per 100 people of working age.

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CASE STUDY "Stroke and English language skills, what is the relationship?"

Client Profile

A couple of English tourists were visiting Portugal. Madeleine is 52 years old and her husband Johnny is 51 years old. Both only speak English and it is the first time that they visit Portugal, they arrived at Faro airport after the Covid 19 pandemic restrictions were lifted. When they arrived at the airport they rented a car, Johnny drives the car when he feels ill with a sharp pain in the head with sudden numbness, weakness and paralysis in his face. Madeleine panicked when she sees her husband in agony. But she remembered that she had received at the airport, a brochure with safety instructions and immediately called the European Emergency Number 112, on the other hand, the agent speaks English correctly, a dialogue is initiated, and the situation described by the English tourist is immediately understood and after, the agent asks for the geographical location where the couple is at this moment. Madeleine manages to identify a signpost and the emergency number operator immediately activates the Via Verde AVC® (Greenway Stroke), giving the information that a medicalized ambulance will immediately meet the English couple, as well as an emergency and resuscitation medical vehicle (VMER) with a doctor and a nurse.

Setting

In a few minutes a medical team and an ambulance arrived.

However, when the first aid teams arrive to Johnny, none of these teams speak English and communication becomes very difficult.

When Johnny is placed in the ambulance, Madeleine also wants to go with her husband to the hospital but is stopped by the emergency team. Madeleine doesn't understand why she cannot accompany her husband in these hard times. The rescuers explain that it is not allowed to accompany family members inside ambulances in situations of acute illness such as this stroke episode.

Madeleine is very nervous and Johnny to see her in this state is even more agitated. Madeleine says that in her country, patients can be accompanied by a family member inside the ambulance and does not understand why they do not allow this here in Portugal.

The staff transported Johnny to the nearest hospital. He was accompanied by a doctor and a nurse who provided him the prehospital first care, activating the greenway stroke line (VIA VERDE AVC®). When he arrived at the hospital, Johnny was immediately treated with fibrinolytic therapy and did a CT scan, because he was already referred by the VMER medical team. But he is completely lost, does not know what tests are being done and does not even know the whereabouts of his wife.

Description Of The Case Study

Stroke remains one of the main causes of death in Europe, and is also the main cause of morbidity and potential years of life lost in all cardiovascular diseases. The first hours after the onset of stroke symptoms are essential for the victim's help, as this is the time window that guarantees the effectiveness of the main treatments.

The INEM advises citizens, therefore, to call 112 whenever a victim of a sudden illness presents the signs and symptoms of stroke, in order to reduce the number of patients with this pathology who go to hospitals by their own means, a situation that, in most cases, it delays the start of treatment of the disease, reducing its effectiveness.

To obtain a faster screening, with an assessment and orientation of stroke patients, allowing the diagnosis and treatment to be more adequate, faster and with effective therapy, reducing mortality.

Whenever a case of stroke is detected, Medical Emergency triggers an emergency team that immediately moves to the patient's home and the protocol is activated. In the emergency teams there is always a nurse.

In Portugal, most of the episodes of stroke were accompanied in an ambulance with medical and nursing care, with this protocol, mortality has decreased and quality of care has increased.

Conclusions:

In this case, it was very important, both the operator of the emergency call center to speak English, as well as the VMER team (medical emergency vehicle) learning a second language, and is essential English language skills, especially in countries with a lot of tourist flow. If not, communication was almost impossible and there would be a chance that Johnny would not be saved. Remember, Stroke is a major cause of mortality worldwide, hence the importance of competent and committed professionals in the treatment of this pathology.

By the way, these ambulance rescuers are only complying with the rules in force, but in this case will the separation of this couple be correct?

Could they break the rules and let Madeleine to be with her husband Johnny? And at the hospital? How will the urgency welcome be?

Will there someone at the admission who speaks fluent English well to understand Johnny's complaints?

What would be your way of proceeding in this situation?

Glossary of terms

Stroke: Stroke is a major cause of mortality worldwide with rapidly developing clinical symptoms and/or signs of focal, and at times global (applied to patients in deep coma and to those with subarachnoid hemorrhage), loss of cerebral function, with symptoms lasting more than 24 hours or leading to death, with no apparent cause other than of vascular origin.

VIA VERDE AVC ®: The Via Verde AVC® is efficient, safe and effective, and brings health gains. The speedy access to the emergency department and speedy examinations allow the identification of the type of stroke, which is a decisive factor for the treatment and patient safety.

National Institute of Medical Emergency (INEM): Is the body of the Ministry of Health responsible for defining, organizing, coordinating, participating and evaluating the activities and functioning of an Integrated Medical Emergency System (SIEM) in order to guarantee victims or victims of sudden illness the prompt and correct provision of health care.

112: phone number for emergency medical service in the Europe wide. When someone dials "1-1-2", the call is directed to a Police dispatch center. The Police dispatch center redirects the call accordingly for the type of emergency to the appropriate emergency services.

VMER: Emergency Medical and Resuscitation Vehicles (VMER), are pre-hospital intervention vehicles intended for the rapid transport of a medical team, consisting of a Doctor and a Nurse, who move quickly to the place where the patient is.

CT scan or computed tomography scan: is a medical imaging procedure that uses computer-processed combinations of many X-ray measurements taken from different angles to produce cross-sectional (tomographic) images (virtual "slices") of specific areas of a scanned object, allowing the user to see inside the object without cutting. CT scanning of the head is typically used to detect infarction, tumors, calcifications, hemorrhages, and bone trauma.

Fibrinolytic therapy: also known as thrombolytic therapy, is used to lyse acute blood clots by activating plasminogen, resulting in the formation of plasmin, which cleaves the fibrin cross-links causing thrombus breakdown. Is used in the treatment of a ST segment elevation myocardial infarction (STEMI), acute stroke and other less common indications such as pulmonary embolism and acute deep venous thrombosis. A variety of agents have been used to effect thrombolysis, including urokinase plasminogen activator (uPA) and streptokinase.

Signs and symptoms of stroke:

Trouble speaking and understanding what others are saying. You may experience confusion, slur your words or have difficulty understanding speech.

Paralysis or numbness of the face, arm or leg. You may develop sudden numbness, weakness or paralysis in your face, arm or leg. This often affects just one side of your body. Try to raise both your arms over your head at the same time. If one arm begins to fall, you may be having a stroke. Also, one side of your mouth may droop when you try to smile.

Problems seeing in one or both eyes. You may suddenly have blurred or blackened vision in one or both eyes, or you may see double.

Headache. A sudden, severe headache, which may be accompanied by vomiting, dizziness or altered consciousness, may indicate that you're having a stroke.

Trouble walking. You may stumble or lose your balance. You may also have sudden dizziness or a loss of coordination.

1.4. Cultural sensitivity and social skills

CASE STUDY "Death and mourning in Gypsy society and culture"

Client Profile

PATIENT: Male, aged 30, Spanish, Gypsy Roma, single, practising Evangelical Christian, admitted to ICU following a road accident.

RELATIVES: Large group (around 50) of men, women and children including babies and elderly men and women, Spanish, Gypsy Roma, practising Evangelical Christians, some residing in the local area and some coming from distant regions in the country.

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Setting

HOSPITAL LA PAZ: Public, tertiary care hospital, managed by the government of the Community of Madrid (Spain). It comprises 17 buildings and is divided into 4 blocks, namely the General Hospital, Maternity Hospital, Children's Hospital and Traumatology and Rehabilitation Hospital. Approximately 50.500 patients are admitted each year, and over 220.000 receive emergency care. The Hospital La Paz employs 7.000 workers and covers an area of 180.000 square meters.

Description Of The Case Study

(News published in Diario ABC (Madrid), 22/01/2004, p.32)

Brawl in La Paz following the passing of a young man

Almost 50 members of the same family, who were Gypsies, attempted to take the body

Antiriot police were obliged to intervene. A brother of the deceased pulled out a knife and suffered a skull fracture in the struggle.

MADRID. The ICU (Intensive Care Unit) of Madrid's La Paz Hospital became, last Tuesday, the scenario of a pitched battle between the relatives of the deceased young man and antiriot police.

It all began on Tuesday afternoon, with the passing – due to natural causes – of a young Gypsy man who was admitted to ICU. After learning of the passing of the patient, aged 30, the relatives, who were all gathering inside the hospital building – around 50 of them according to the police – insisted in taking the body with them. At one point they became so worked up that the physicians called security, who were unable to contain the "fury" displayed by the large Gypsy family.

In fact, not only police officers from the local police station of Fuencarral- El Pardo but also antiriot police were obliged to intervene.

Broken windows and threats

Among screaming and crying, the 50 or so relatives broke windows and equipment, and insulted the doctors and nurses who crossed their path. According to the police, one of the relatives, Ramón M.L., aged 45 and brother to the deceased, pulled out a knife aiming at the abdomen of one of the police officers.

As a consequence of the struggle between the two, the alleged attacker fell to the ground hitting his head against a piece of furniture of the lobby of the hospital and suffered a skull fracture. He remains under observation in the same hospital under constant police watch, accused of damaging public property and assaulting a police officer.

It seems that this was not the first time that this family's behavior ends up in a quarrel. In fact, hospital security had been reinforced about two weeks ago due to the potential for conflict displayed by some members of this family.

According to the Medical Director of La Paz hospital, Joaquín Díaz Domínguez, the difficulties started on the 7th, when the patient was admitted to ICU. "The relatives brought blankets with them and lay down on the floor of the hospital's lobby, and did their business outside in the main entrance", said the Medical Director, who confirmed that a porter had been threatened in the past.

Ramón M.L. has a record of criminal activity including assault, thievery and illegal possession of weapons. In addition, he has a prison sentence issued against him by a criminal court in Palma de Mallorca.

A new security plan

The local Healthcare Counselor, Manuel Lamela, described the events as "deplorable" and added that this sort of violent and aggressive behaviour towards healthcare professionals and a public hospital, "that belongs to all of Madrid's citizens", cannot be justified even if motivated by" affective factors".

Lamela confirmed that a new security plan, financed with 9 million euro, was being developed in order to guarantee the safety of all patients and healthcare professionals in the local healthcare services.

REACTIONS

SAE (Nurse Auxiliaries' Union)

The union demanded yesterday the implementation of a security plan to guarantee the security and safety of all healthcare professionals, and the creation of a specialised unit to support and provide legal advice to healthcare workers who are victims of aggression. According to the SAE, these aggressions should no longer be permitted.

CESM (Doctors' Union)

The CESM made a call for "sense and respect" in the relationship between society and the healthcare workforce. In their opinion, conflict is emerging far too frequently lately. For this reason, they "beg" all service users to understand that doctors will always act in the best interest of their patients.

Glossary of terms

Evangelical: Branch of Protestant Christianity emphasizing the authority of the Bible, personal conversion, and the doctrine of salvation by faith in the Atonement (the reconciliation of God and mankind through Jesus Christ's sacrifice).

Brawl: A rough or noisy fight or quarrel.

Passing: Dying.

Antiriot police: Branch or division of the police forces specialised in preventing and dealing with public violence, tumult or disorder.

Deceased: Dead.

*Struggle: B*attle, fight, a violent effort or exertion.

Pitched battle: An intensely fought battle in which the opposing forces are locked in close combat.

Worked up: Excited, emotionally aroused.

Threat: An expression of intention to inflict evil, injury, or damage.

Alleged: Accused but not proven or convicted.

Lobby: A large hall serving as foyer.

Assault: A violent physical or verbal attack.

To do one's business: To urinate.

Thievery: The act or practice of stealing.

Deplorable: Lamentable; deserving censure or contempt.

Professional union: A professional association or organisation concerned with protecting the interests of individuals engaged in that profession, as well as the public interest.

To beg: To ask earnestly; to implore.

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RELEVANT FACTS AND FIGURES ABOUT THE MINORITY CULTURE

Population

Largest cultural minority in Europe (approximately 7-9 million); there are more than 650.000 Gypsies living in Spain (1).

Education

In terms of education, according to several authors,(1,2) educational segregation is a reality within Spanish schools. This means that, in some classrooms, the majority of the students are Gypsies, while in others there are very few or none. This results in high levels of absenteeism and school failure, lack of motivation, low level of education and social exclusion. As a result, the educational level of Gypsies in Spain is significantly lower than the rest of the population; around 70% of the Gypsy population is Spain do not finish primary school (1).

Housing and employment

The rate of employment in the Gypsy community is very low. In addition, those who are employed or self-employed usually suffer job insecurity and low salaries. As a consequence, Gypsy families tend to live in sub- standard/poor housing conditions, usually in ghettos. Frequently, these areas have poor or inadequate services and infrastructure, and there is a higher incidence of disease and risk of being evicted (1).

Gender

Gypsy women frequently suffer a double discrimination, which leads them to suffer lower levels of access to healthcare, education, employment, etc. This has an impact on childrearing and education as women are frequently responsible for their children's education (1).

Average age for marriage for Gypsy women is 16-20, and for Gypsy men 18-22, which is significantly lower than the non-Gypsy population.

Religion

In Spain, most Gypsies are Christian Catholic or Evangelists, although Evangelism is on the raise in this community. It is important to highlight that the influence of the Evangelist Church on its parishioners frequently affects not only religion-related behaviour, but also other behaviours and conducts, some related to health. For example, Gypsies may seek the help of their pastor in terms of conflict resolution and conduct modification (i.e. smoking cessation, rehabilitation, etc.).

Health

Poverty, poor housing and low level of education have contributed to health inequalities, resulting in poorer health and a low life expectancy;(1) Gypsies live approximately 10 years less than the non- Gypsy population (3).

There is a strong relationship between education level and health. That is, the higher the level of education, the more likely the person in to engage in health promotion and disease prevention,(1) and adhere to treatment.

Intercultural mediation

Intercultural mediation is an accessible resource designed to bridge cultures, promote mutual understanding and solve conflict. There are three types of intercultural mediation:

- Preventative, with the aim of closing the gap and aiding in the communication process between individuals and groups from different cultural backgrounds.
- Rehabilitative, with the aim of gradually reducing intercultural conflict.
- Transformative, with the aim of overcoming individual rules, norms and traditions, and finding new ways of relating to each other.

In the Gypsy population, intercultural mediators are usually highly respected individuals, usually elderly men who are Gypsy (1,4).

Cultural identity

There is an intense sense of pride and belonging in being Gypsy, from which a perception of safety, security and protection emanates. In the Gypsy culture, the community, and especially the family (understood as the extended family with a patriarchal head), plays a very important role in the lives of its members. If necessary, the family will offer support, material resources, physical and emotional care to its members. As a result, when a member of the family becomes ill, the whole family (not only the closest relatives) will unite to support and physically accompany the patient throughout the episode (1).

Other cultural aspects in relation to health include:

- The interest of the family/group prevails over the interests of the individual.
- Great value is given to the spoken word.
- The elderly are respected and play a key role in the community. When a Gypsy becomes old and infirm, they are looked after in the home by their family, usually the women.
- Older Gypsies can exert a strong influence over younger ones. It is important to address those individuals with the power and capacity to influence the group.
- Religious pastors can be very influential on the behaviour of their parishioners.
- Women taken responsibility for the health and treatment of the family.
- Girls and young women and overprotected in preparation for marriage. Sex is frequently taboo in the Gypsy culture.
- Mourning is an extremely intense and important period for Gypsies. When someone dies in their community, Gypsies will stop all social and professional activities, and will frequently modify their personal appearance (i.e. women wear black and men grow a beard). Furthermore, they would be deeply offended that they did not have the chance to bid a proper goodbye to their relative or friend.
- When someone dies, Gypsies are likely to express their pain, grief and sorrow in a loud and expressive way, especially during external examination and autopsy, involving screaming, pulling out their hair, and flinging themselves against walls or the floor. Other practices include lighting a candle under the patient's bed, moving the body next to a window, and encircling the bed and asking the deceased to forgive them for their mistakes. If these practices are stopped, some Gypsies believe that the person could return as an evil spirit and harm family members.
- Gypsies do not believe in autopsies or organ donation upon their deaths; when a patient dies, asking the family if the organs may be donated will offend them during their time of grief. They also believe that the body of a dead person is sacred and needs to be properly prepared for the journey into the next world (1,5).

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CASE STUDY "Conspiracy of Silence"

Client Profile

PATIENT: 70-year-old Chinese woman (who only speaks Chinese language) with a medical history of hypertension and dyslipemia, was admited to the hospital with a 3 days history of fever, nausea, vomiting and intermittent abdominal pain.

Setting

Hospital Miguel Servet: Public and tertiary referral hospital, located in Zaragoza (Spain). It comprises 3 centres including General Hospital, Pediatric Hospital and Traumatology, Rehabilitation and Burns Hospital.

Actually, the hospital has 1343 beds and 28 operating theatres. Around 83000 patients are admitted each year.

Description Of The Case Study

Chéng Lì is a Chinese woman in her 70s.

She has been admitted to the hospital with a recurrent abdominal pain, but it soon became apparent that she had advanced stage pancreatic cancer.

She was unaware of her diagnosis, due to her son and husband's insistance. Both conspired to avoid using the word "cancer" in front of Chéng LÌ or to even acknowledge her fatal prognosis. Instead, they referred to her condition as "abdominal pain".

During the time she was in the hospital, Chéng LÌ became close to the nursing staff. However they were felt that the patient was in distress and aimed to treat this symptomatically. The family, however, chose treated her symptoms with some traditional chinese medicine such as tea remedies and coin rubbing.

One day Anna was administering her pain medication and she was uncomfortable with having to withhold the truth about the diagnosis. Sudenly, she asked her whether she wanted to know her diagnosis and why she was receiving chemotherapy medication. Her answer was no.

Se said "Tell my son and housband; they will make al of the decisions".

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Glossary of terms

Conspiracy: The activity of secretly planning with other people to do something bad or illegal.

Conspiracy of silence: A general agreement to keep silent about a subject for the purpose of keeping it secret.

Chemotherapy: The treatment of diseases using chemicals.

Distress: A feeling of extreme worry, sadness, or pain. A situation in which you are suffering or are in great danger and therefore in urgent need of help.

Coin rubbing: Chinese medical technique performed by taking a coin and rubbing it along the skin in linear.

Rub: To press or be pressed against something with a circular or up-and- down repeated movement.

Alternative medicine: A range of treatments for medical conditions that people use of or with western medicine.

Relevant facts and figures about the minority culture

Language barrier

Many Asian-born patients have some difficulties with language. Moreover, in a medical context is even more difficult to speak and understand than everyday conversation language.

Language barriers often make families unable to be well informed of the severity of the disease or to get reasonable advice in making treatment decision (1).

Traditional Chinese culture

Chinese Bioethics

In China, only the patient's family members or surrogates can make the decision to limit treatment. In fact, is a legal obligation of physicians to considerer the opinions of family members (2).

Based on this, the decision to communicate the truth about the diagnosis or prognosis to the patient depends on considerations of the patient's condition and the family's wishes in the matter (2).

End-of-life care cultural beliefs and attitudes

Despite dying peacefully is important to Chinese people the personal autonomy is not highly valued in this culture. Because of that, in Chinese culture, familial relationships are stressed more than an individual rights and is the family who will assume responsability, including medical decision-making, for an individual's care (3).

Moreover, family plays an important role in the end-of-life decision- making process.

The special status of the elderly in Asian culture includes a value that they should not be burdened unnecessarily when they are ill (4).

Alternative chinese medication

Is the most common of healthcare among Chinese population. Developed over thousands of years, is mainly guided by holistic concept of health that emphasizes achieving balance and harmony throughout bodily systems. There are several examples of TCM such as herbal medicine, acupuncture, sking scraping, coin rubbing, cupping, among others (1).

Communicating bad news (5)

In many Asian cultures, it is perceived as unnecessarily cruel to directly inform a patient of cancer diagnosis. Also emotional reaction to news of serious illness is considered directly harmful to health. This negative emotional impact on health apperars to be one of the primary reasons that Chinese patients are less likely to sign their own do-not- resuscitate orders.

Religion (4)

Confucianism "Willing to die to preserve virtue". Paternalism philosophy that support the idea that illness is taken to be an occasion involving the entire family and not just for the individual, given cuch familial decisions have repercussions for all family members.

Filial Piety. Is a central value in traditional Chinese culture and has a strong influence in decision making in Asian societies. It places an obligatory duty on children to care for their elders, driven in part an appreciation of the care they had previously received.

Taoism "Life and death unfied". Life and death are natural processes. One becomes part of nature upon death, and does not need to grieve when facing death.

Buddhism "Belief in new life after death"

Death is part of the process of the Wheel of rebirht. Death is a way to enlightenment.

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CASE STUDY "I pray to God every day"

Client Profile

Maria is a 4-day old female neonate who is admitted to the Local Neonatal Unit (LNU) with trembling, drowsiness and lethargy. She was born 4 days ago following normal vaginal delivery in week 39+5. Apgar score 9 one minute after birth and 10 ten minutes after birth. Weight at birth: 3.280 kgs; weight on admission: 3.150 kgs. Exclusive breastfeeding well tolerated; the mother mentions that she is not producing much milk.

Family history – mother: Alejandra is a 32-year old first-time mother with no previous relevant medical history; no illnesses during pregnancy; good physical appearance; displays a cooperative attitude during the admission interview; born in Colombia.

Family history – father: Vasile was born in Rumania; not present during the admission interview; no more information available.

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Given Maria's symptoms, Alejandra is questioned repeatedly about substance consumption during pregnancy. She vehemently denies having taken any drugs.

Setting

Local Neonatal Unit (LNU) within a large tertiary hospital in Spain. Babies who need a higher level of medical and nursing support are cared for in this unit.

Care on an LNU may include:

- Breathing support given through their windpipe (ventilation)
- Short-term intensive care
- Continuous positive airway pressure (CPAP) or high flow therapy for breathing support
- Feeding through a drip in their vein (parenteral nutrition)
- Cooling treatment for babies who have had difficult births or are unwell soon after birth
- Helping babies who become unwell soon after birth

The LNU is always open. The patients' parents can visit at any time during the day or night, and they can stay with their baby 24 hours a day if they wish.

Description Of The Case Study

MARIA

Baby Maria is admitted to LNU; Alejandra accompanies her, never leaving her side and looking sad and concerned. Once they are both settled, the nurse responsible for Maria's care asks her once again about substance consumption during her pregnancy. After much insistence on the nurse's part, Alejandra finally admits that she has taken drugs in the past and that she used some about 20 days ago.

This information is passed on to the rest of the team and a urine drug screen test is done on baby Maria, which is positive to cocaine. Maria is diagnosed with

neonatal abstinence syndrome (NAS) and is subsequently moved to a special area within LNU for further monitoring and assessment. In addition, her case is referred to the hospital's social worker for evaluation by social services.

Interventions after diagnosis include:

- Maintain a peaceful environment, low intensity light, etc.
- Exclusive artificial feeding; Alejandra must not breastfeed Maria. 50cc / 8 times / day.
- 8-hourly assessment of Maria's NAS through the Finnegan Scale, designed to quantify the severity of NAS and to guide treatment.
- Urine output and fluid balance (weigh nappies).
- Daily weight.

Maria scores 6 on the Finnegan Scale and does not require medication (if 3 consecutive scores are equal to or greater than 8, treatment for withdrawal is started). She presents a light trembling episode and degree of hypertonia on day 2, which ceases spontaneously. By day 5 of her admission, Maria is feeding and resting adequately, and she is steadily gaining weight.

ALEJANDRA AND VASILE

Alejandra visits arrives every day at 6 am and stays with her daughter until 3 pm approximately; she then leaves to go to work and returns at 12 am in time for her feed. Her attitude towards Maria is always loving and caring; she picks her up and asks frequently about her health. She tells the nurses that her whole family is terribly worried, and insists that she "prays to God for Maria's recovery". Vasile visits Maria every day at 6 pm. He feeds Maria but rarely interacts with her nor the staff.

Alejandra frequently verbalizes her feelings and her concerns, especially at night. She does not want to lose her daughter and she tells the nurses that she fears Maria is going to be taken from her. She explains that her whole family is Colombia and that she has not family in Spain that can look after the baby. More than anything, she does not want Vasile to have the custody of Maria.

THE NURSING STAFF

The nursing staff are kind to her, but they disapprove of her behavior. They are not surprised that she has been taking drugs; at the end of the day, she is from Colombia. They comment that, although she looks genuinely worried about her daughter, she should not have been taking drugs during her pregnancy in the first place: "less praying to God and more taking care of her daughter".

SOCIAL SERVICES AND DISCHARGE

After evaluation by social services, Maria's custody was temporarily retired from Alejandra. This was not communicated to Alejandra nor to Vasile. The day that Maria was due to be discharged, two police officers, a social worker from the local government's Child Protection Service, Maria's foster parents and the hospital's social worker turned up at the LNU.

Alejandra was taken to a private interview room, where she was informed about the temporary withdrawal of Maria's custody. In the meantime, Maria was given to her foster family, who dressed and prepared her to leave the unit and take her home.

When Alejandra came out from the interview room and saw that her child was no longer in her cot, she became very angry and cried, pleading with the staff not to take Maria away from her. The nursing staff and the social worker try to calm her down and kindly invite her to leave the LNU immediately.

Alejandra left the LNU without María.

Glossary of terms

Neonate: A newborn child; an infant less than four weeks old.

Trembling: Shaking or quivering involuntarily and uncontrollably.

Drowsiness: A feeling of being sleepy.

Lethargy: A lack of energy; a state of sleepiness or unresponsiveness and inactivity.

Apgar: The Apgar score is a test given to newborns soon after birth to see if extra medical care or emergency care is needed.

Breastfeeding: The action of feeding a baby with milk from the mother's breast.

Substance (consumption): (toxic) drug abuse.

Windpipe: Colloquial way of referring to the trachea.

Ventilation: The supply of air to the lungs, especially by artificial means.

Drip: An apparatus which passes fluid, nutrients, or drugs drop by drop into a patient's body on a continuous basis, usually intravenously.

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Parenteral nutrition: Administered or occurring elsewhere in the body than the mouth and alimentary canal.

Neonatal abstinence syndrome: Group of conditions or symptoms caused when a baby withdraws from certain drugs he or she is exposed to in the womb before birth; it is most often caused when a woman takes drugs during pregnancy.

Monitoring: Observing and checking the progress or quality of something or someone over a period of time.

Nappy: A piece of absorbent material wrapped round a baby's bottom and between its legs to absorb and retain urine and feces.

Withdrawal (symptoms): The unpleasant physical reaction that accompanies the process of ceasing to take an addictive drug.

Hypertonia: An abnormally high level of muscle tone or tension.

Custody: The protective care or guardianship of someone or something.

Foster: (Of a parent or authority) assign a child to be brought up by someone other than its parents.

CASE STUDY "Lost in anatomy"

Client Profile

Sheeja is a 25-year-old woman from Pakistan who attends the Endoscopy Unit in a large UK hospital. She has recently moved to the UK from Pakistan with her mother following her engagement. Her mother tongue is Punjabi. Neither Sheeja nor her mother, who accompanies her, speak English.

Setting

The admission interview takes place in a private interview room within a large hospital's endoscopy unit. Sheeja has been referred to the endoscopy department by her GP due to her recent history of colorectal bleeding and change in bowel habit. These symptoms may be due to a number of conditions including colorectal cancer and inflammatory bowel disease, and it is extremely important that a diagnosis is established today. As Sheeja is unable to communicate in English, a medical interpreter has been booked to help with the interview process.

Description Of The Case Study

THE NURSE

The nurse must complete the endoscopy pre-assessment checklist (Doc 1. Endoscopy pre-assessment checklist) and ensure that the patient understands the procedure and agrees to sign the consent form (Doc 2. Patient information sheet and consent form). She has over 5 years' experience of working in endoscopy and has worked with interpreters in the past. She is used to working with patients from different cultures. Nevertheless, she sometimes shows a lack of understanding of cultural differences and usually tries to impose her own point of view and her rules of conduct.

SHEEJA

Sheeja does not take any medications, has no known allergies and has no relevant previous medical history. She has no learning or other disabilities, but she cannot read or write; as a child, she left school at a young age to start working in the family business.

Her symptoms began about 6 weeks ago; some days she was constipated and then others she had diarrhoea. She has seen blood in her stool and her stomach hurts sometimes in the lower part.

Before being referred to the endoscopy department, Sheeja was given a patient information sheet by her GP including a description of the procedure and instructions to prepare for the test, which she has followed to the letter. Her fiancé's 10-year old nephew translated the information for her at home.

Sheeja appears worried and uneasy; she talks nervously with her mother in her own language throughout the interview. Frequently, she seeks her mother approval before answering a question. As the nurse goes over the procedure with her, Sheeja becomes confused and frustrated. She does not understand why it is necessary to pass the "camera" (endoscope) up her back passage instead of down her mouth.

THE MOTHER

Sheeja's mother and next of kin is a 45-year-old lady who, like her daughter, speaks Punjabi and does not speak English. She is concerned about her daughter's symptoms and wants her to get better. However, she wants to preserve her daughter's modesty. She is not comfortable with the idea of the procedure and would prefer a female doctor, but she would be prepared to support her daughter if she decided to have the test done by a male doctor.

THE INTERVIEW

The nurse calls Sheeja, who is sitting in the waiting room with her mother, by her name and surname. They all walk into the interview room with the nurse and take a seat. The nurse introduces herself and begins the admission process.

Sheeja shows her lack of knowledge regarding some basic parts of the human anatomy and seeks clarification with the interpreter when difficult or more technical terms are used in the conversation. She has never heard of any medication called warfarin or clopidogrel, but she takes no tablets so she can answer more or less confidently. Sheeja does not know what a pacemaker is. She knows she is not a diabetic, but does not understand some of the other pathologies, such as epilepsy, glaucoma and haemophilia. After some dialogue between her and her mother, she confirms that she is in good health and does not have any of the conditions mentioned by the nurse. She has no known allergies.

When she hears the word sedation, she becomes slightly agitated and empathically confirms that she definitely wants sedation. She has never had a blood transfusion; has never had surgery and does not know what CJD and MRSA mean.

Towards the end of the pre-assessment checklist, the patient confirms that her fiancé's 10-year-old nephew has translated all the information for her. However, she is not comfortable with the test and appears both worried and embarrassed. At this point, after some conversation between the patient and her mother, the patient finds the courage to suggest that the camera is passed through her mouth and not through her back passage. The nurse tries to hide her surprise when she realises that the patient believes that the large bowel can be accessed through the upper gastrointestinal system, but her face is evidently showing mockery of the patient's request and she makes this comment to the interpreter: "How ignorant these people are! They are worse than children!".

The nurse impatiently explains that a colonoscopy is the only option available and proceeds to explain the procedure using the Patient information sheet and consent form document. After some discussion between Sheeja, her mother and the interpreter in Punjabi, she accepts to have the test done but before she presents a last request. She wants the test to be performed by a female doctor. Once again, the nurse seems not to understand the cause of this request and rejects making any attempt to adapt to the patient's preferences. After some small talk with her mother, the patient refuses to have the test done unless she has an all-female endoscopy team in the room.

GLOSSARY OF TERMS

Endoscopy: A procedure in which an instrument is introduced into the body to give a view of its internal parts.

Engagement: A formal agreement to be married.

Colorectal bleeding: Passing blood from the bottom or the back passage.

Bowel habit: Term used to refer to the frequency of bowel movements and quality of the stool or feces.

Interpreter: A person who interprets, especially one who translates speech orally or into sign language.

Constipated: Affected with constipation; person that has difficulty emptying their bowels, usually associated with hardened feces.

Diarrhea: A condition in which feces are discharged from the bowels frequently and in a liquid form.

Fiancé: A man to whom someone is engaged to be married.

Stool: A piece of feces.

Uneasy: Causing or feeling anxiety; troubled or uncomfortable.

Endoscope: An instrument which can be introduced into the body to give a view of its internal parts.

Next of kin: A person's closest living relative or relatives.

Modesty: Behavior, manner, or appearance intended to avoid impropriety or indecency.

Warfarin and clopidogrel: Blood-thinning medication.

Pacemaker: A device for stimulating the heart muscle and regulating its contractions.

Epilepsy: A neurological disorder marked by sudden recurrent episodes of sensory disturbance, loss of consciousness, or convulsions, associated with abnormal electrical activity in the brain.

Glaucoma: A condition of increased pressure within the eyeball, causing gradual loss of sight.

Hemophilia: A medical condition in which the ability of the blood to clot is severely reduced, causing the sufferer to bleed severely from even a slight injury.

Sedation: The action of administering a sedative drug to produce a state of calm or sleep.

CJD: Creutzfeldt-Jakob disease (CJD) is a rare, degenerative, fatal brain disorder also known as mad cow disease.

MRSA: Methicillin-resistant Staphylococcus aureus is a bacterium that causes infections in different parts of the body. It is resistant to some commonly used antibiotics.

Embarrassed: Feeling or showing embarrassment; feeling awkward, self-conscious, or ashamed.

Mockery: Teasing and contemptuous language or behaviour directed at a particular person or thing.

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