Palliative Care
VICTORIA
Specialist health care and practical support

Culturally Responsive
Palliative Care

State wide cultural responsiveness training for the palliative care sector
2014-2015

Caring for patients and families from culturally diverse backgrounds

Participant manual

JM&A

JudithMiralles&Associates Pty Ltd

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Notes

The team

Caroline Bouten Pinto is passionate about enabling people to work effectively with cultural diversity. She has over 25 years combined experience in cultural diversity for profit, government and health sectors, in Canada, Europe, Asia and Australia. In collaboration with colleagues and clients, her 'Culturewise Practice'® approach to management and leadership emerged. This has enabled hundreds of people, from frontline staff to senior managers across the health, community services and disability sectors work effectively with cultural differences in their everyday work practice and relationships. She is currently completing a PhD to develop this approach further into a relational framework for leadership in culturally diverse organisations.

Susan Lee has been involved in community and inpatient palliative care since 1990. She is currently a member of the Palliative Care Research Team and the Director of Research Degrees in the School of Nursing and Midwifery at Monash University.

Susan has worked in palliative care education and research for the past 20 years. She has been instrumental in the development of undergraduate, postgraduate and capacity building community courses in palliative care. She is co-editor of the most recent edition of the popular Ausmed text "Palliative Care Nursing Practice: A guide to practice" and has numerous publications in journals and texts.

Susan has engaged in research exploring cultural and ethical issues related to palliative care, skill development of health professionals and care decision making and advance care planning.

Judith Miralles has over 30 years' experience in the area of culturally inclusive service delivery. The company's work spans the community sector, local and state governments, across a number of portfolios.

Over the past ten years Judith has worked in the health sector to increase cultural competence. She has worked to support Australia and overseas trained health professionals to work effectively in culturally diverse teams and ensure safe practice with culturally diverse patients. Judith has been also been involved in research and development projects; for example *Cultural competency in health: A guide for policy, partnerships and participation* for the National Health and Medical Research Council.

Dr Hung The Nguyen is a general practitioner and educator. He works in private general practice in Glen Waverley and at an Aboriginal Community Controlled Health Service in Dandenong. He is a Teaching Associate at Monash University and Inaugural Censor for the National Faculty of Aboriginal and Torres Strait Islander Health, Royal Australian College of General Practitioners. He has a deep interest in cross-cultural health practice, education, training and assessment.

Emeritus Professor Margaret O'Connor AM held the Vivian Bullwinkel Chair in Palliative Care Nursing at Monash University from 2003-14, a successful partnership with 3 clinical services in the south of Melbourne. She established the Palliative Care Research Team and during that time, the Team was involved in a number of projects on aspects of culture and palliative care.

Margaret has contributed to the development of palliative care in Australia at many levels. In recognition of this, she received the national honour of an Order of Australia in 2005 and was made Life Member of Palliative Care Victoria in 2012. Since stepping out of her academic role Margaret has established her own consultancy, works in a clinical service and sits on a number of boards and committees.

Notes

Introduction

Mapping / consolidation of relevant policy frameworks:

Mapped standards		**NSQHS Standards (10)**	**Victoria CR F/wk (6)**	**Palliative Care National Standards (13)**
Governance & Systems **Whole-of-organisation** **Leadership** **Mechanisms** **Values**		1. Governance for safety and quality	1. Whole of-organisation approach 2. Demonstrated leadership	7. Values, culture, structure for competence and compassionate care 8. Formal mechanisms for care, information and services 10. Access and equity 11. Quality improvement & research
Partnering		2. Partnering with consumers	5. Community involvement	9. Collaboration & partnerships 11. Quality improvement & research
Client focussed practices **Client focused** **Working with interpreters**		3. Preventing & controlling infections 4. Medication safety 5. Patient identification and procedure matching 6 Clinical handover 7. Blood & blood products 8. Preventing and managing pressure points 9. Recognising & responding to deterioration 10. Preventing falls & harm from falls	3. Accredited interpreters 4. Inclusive care planning	1. Inclusive care planning 2. holistic approach 3. Ongoing assessment 4. Minimise burden 5. information, support & guidance for primary care giver 6. Consider unique needs, preserve dignity 11. Quality improvement & research
Staff focused practices **Quality staff** **PD & training**		1.10 Workforce performance & skills management Staff training & development	6. Staff training & PD	11. Quality improvement & research 12. Qualified staff & ongoing development & training 13. Reflective practice & care

Notes

Focus of workshop - knowledge, awareness, skills:

Understand how cultural values and world view, including spiritual beliefs, affect experience and expectations. Increased:

- Awareness of difference and identity as complex rather than absolute notions.
- Awareness of the complexity of factors which affect world view and ways in which this is reflected in expectations and areas of comfort/discomfort.
- Ability to plan for the culturally relevant needs of clients, family and friends.
- Awareness of circumstances that may give rise to errors of communication.
- Ability to detect signals that a communication problem is occurring and act to resolve it.
- Ability to elicit culturally significant information for positive impact on client encounters.
- Ability to sensitively ask culturally significant questions including about alternate therapies that may put clients at risk.
- Ability to engage client in managing well-being.
- Understanding of culture-bound nature of health beliefs and decision making processes.
- Knowledge of relevant policies and professional norms.
- Reduced client and agency risk due to miscommunication
- Ability to apply appropriate communication options in emergency situations

Activity - Clarifying objectives

We held a pre-workshop consultation with your agency. These are the skills we were told staff wanted to cover. Spend a few minutes reflecting on what they mean to you.

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Let's discuss how we will cover them.

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Notes

How do I become more effective?

• Information • Self-awareness • Reflection • **Risk-taking**	• Knowledge • Skills • Attitude

What approach will we use?

Information is one component underpinning effective practice. https://www.pcvlibrary.asn.au/display/wel/Palliative+Care+Victoria+Resource+Library is a key clearinghouse.

It's the application of information to build self-awareness, reflection and risk taking which lead to effective practice.

Dr Robert Arnold MD, Director of the Institute for Doctor-Patient Communication at the University of Pittsburgh spoke at the Palliative Care Victoria conference. Dr Arnold's presentation stepped conference participants through a template of skills to deal with difficult conversations.

These skills can be applied in a cross cultural communication setting:
- 'Tell me more'- Explore the person's world
- Check expectations – Share information, enquire about person's view
- Respond to emotion – Understand own and other person's perspective

Emotional response
Responding to emotions turn off ' fact processing'

Cognitive response
Responding to facts turns off 'emotion tracking'

Integrated response - Using emotional and cognitive cues

For further reading:
Educational Modules for the Critical Care Communication (C3) Course - A Communication Skills Training Program for Intensive Care Fellows. Written by the C3 investigators (Robert Arnold, Judith Nelson, Thomas Prendergast, Lillian Emlet, Elizabeth Weinstein, Amber Barnato, and Anthony Back). Based on modules from Oncotalk (by Anthony Back, Robert Arnold, Walter Baile, James Tulsky, and Kelly Fryer-Edwards) (PDF can be downloaded from CultureMate® website)

Notes

Difficult conversations in a palliative care and cross cultural setting

Why are they difficult?

What am I thinking?	What am I feeling	What am I doing?

Notes

Activity- Personal identity

✓ **The three you think have influenced you most:**

☐ Family relationships – daughter/son, mother/father, brother/sister....
☐ Gender
☐ Ethnicity
☐ Religion
☐ Nationality
☐ Profession
☐ Economic status
☐ Social rank
☐ Hobbies
☐ Other

Our multiple & shifting identities

- We are all diverse. In fact there are 22.7 million people of diverse backgrounds in Australia.
- Some identities are at times more important than others –if we feel that aspect of our personality is being attacked.
- Some may be more important to others than they are to us at a given time.
- Some may be difficult to reconcile e.g.: parent / worker.
- We may share common roles across cultural differences.

Notes

A home visit

Activity - Personal self-reflection

Step 1 – Watch the film clip.

Step 2 – You are the palliative care nurse. How did you feel?

Step 3 – Choose one other protagonist. How did you feel?

Please write some thoughts below

Nurse : I felt…..	**……………….: I felt**

Notes

Activity - Small group work (Work with two others)

Step 1 – **WHY** might the nurse have behaved as she did? What was her objective?

Step 2 – **WHY** might the protagonist you chose have behaved as she/he did? What was her/his objective?

Nurse – I behaved this way because… ..	**…………… – I behaved this way because…**

This is what I would have done differently………The reason why is……….

Notes

Family	**PCN**
Children taking responsibility for their parents - They do the talking, protective role. Extended family networks limited thus even more important family rallies around. Communication style strong focus on future and building relationships. Each member has an obligation to others. Filial piety is important. Clearly defined roles – Mother's is food and traditional remedies. Father's changed role as the most powerful to the least powerful. Family will accept outside help if outside their expertise - Pain control but not household chores, care for father - This is their responsibility and obligation (What would the neighbours say if the children did nothing and strangers helped.) Victor's concept of pain – Stoic acceptance needs to be gently explored to give him a way to accept pain relief. Using family is a way in. Victor doesn't expect definitive answers and takes a long-term view – again the benefits of palliative care need to be framed keeping this world view in mind. Communication style is indirect and values 'delicate' treatment of sensitive topics.	What do they know? / Number of strategies / Explores information they want and emphasises need for all to be informed by providing bilingual information. Listening and considering long-term strategy. PCN getting a 'list' of the issues faced by Victor and family. Applies a 'blended communication style' relationship and information; present and future; process and outcome focuses. • Models her preferred communication style while including family's. Sets ground rules. 'Everyone allowed to speak, no one is interrupted'. While Alan does most of talking, PCN directly encourages Victor and Bernice to speak. • Mirroring the family's indirect style while also letting Victor know he is her primary concern. • Indirect style used to show her preference for use of interpreter. Alan hears the implied message. • PCN talks about death and other sensitive issues 'delicately'. Responds to tangential questions by Victor. Exploring family's resilience and how cultural background affects it – How strong are its networks; coherence; communication; is there conflict?

Dr Robert Arnold MD:
- Tell me more
- Ask/Tell/Ask
- Respond to emotion

Dr David Kissane MD In a family meeting assess: • Cohesion –Teamwork • Communication • Conflict	We suggest as an overlay: • Culture – Migration history; family networks – how extensive etc…

Bereavement care for families, Editors D. W. Kissane & F Parnes, Routledge, NY 2014

Notes

Talking cultural diversity: Unconscious bias / Generalising vs. Stereotyping

What are my unconscious biases? Is it OK to generalise? Am I stereotyping?

Generalising

Generalisations simplify the complexity of the social world, making it easier to communicate. When we apply generalisations, we use previously stored information about other people. For example, when observing different cultures we make general observations based on our knowledge and experience. We use these as guides to determine how to communicate. We then look out for situations in which we may have to amend these generalisations.   For example, we can generalise that:

- Australian culture tends to be individualistic.
- U.S. Americans readily praise personal achievement.
- Japanese society values discretion.In this sense, generalising about group traits or tendencies is in itself benign, a way of making sense of the world.

Stereotyping

The danger lies when we take these categorisations of factual observation and apply them in a judgemental way.

The stereotypical views of the above generalisations could be:

- Australians are selfish.
- US Americans are show-offs.
- Japanese never say what they really think.

Generalisations	**Stereotypes**
Retained consciously	Retained unconsciously
Descriptive, not judgemental	Judgemental, not descriptive
Modified by subsequent experience and information	Not modified by experience or information

See also ***Unconscious bias*** pdf in CultureMate®

Notes

A model to explore cultural values

Cultural dimensions

Based on the body of work of Geert Hofstede and his colleagues.

INDIVIDUALISTIC

White English speaking Australian culture is among the most individualistic cultures on earth, second only to the USA. (English speaking nations exhibit individualistic characteristics but the USA and Australia have been found to be the most individualistic of the English speaking cultures).

In individualistic cultures, the interests of the individual are more important than the needs of the group. Individuals are expected to be highly independent and self-sufficient.

Key role of parents is to foster independence.

Society tends to have a ‘rights-based’ social system.

What does this mean for the palliative care setting?

- Internal locus of control
- Privacy and confidentiality are extremely important
- Family is not automatically involved or informed
- Informed consent means patient must fully understand medical procedure
- Advance care/end-of-life care plans may involve ‘unusual’/individual requests (e.g. personalised funerals)

What are some assumptions?

- In home-care settings, expectation is each person is treated as an individual with unique needs
- Strong focus on patient rights
- Personal freedom is to be protected
- Making group decisions as individuals
- Individuals should speak out, offer solutions

What creates discomfort?

Notes

COLLECTIVIST

In collectivist cultures, each person has a strong connection and sense of obligation to the extended family or kinship group. The needs of the group are more important than the wishes of each individual member.

While white English speaking Australian culture is among the most individualistic cultures on earth, Indigenous Australians' cultural values are collectivist.

Key role of parents is to foster strong sense of obligation to group.

Society tends to have a 'duties-based' social system.

What does this mean for the palliative care setting?

- External locus of control
- 'Informed' consent by family - Family is involved in decision making
- Decision happens following discussion among the group and not by a single person at the moment when the question is asked
- Decision, appears to be made but following group discussion, the decision may change
- Some decisions such as place of care, treatment and other care options may be driven by needs other than those of the patient
- The needs of the patient may not be central when considering decisions about treatment (involving expensive medication or travel for example)
- Family 'protects' patient
- 'Face' of family is irrevocably bound with patient's care
- Many, many people involved in care – patient rooms will be full, the home will also be full. Palliative care nurses need to work out the relationships, who is important, who is the person with whom to liaise
- Interpreting privacy – how to address the needs of the patient among a crowd of people

What are some assumptions?

- Private interests are vested in group
- Social harmony and the well-being of the group take precedence over the exercise of individual rights
- A person's identity is largely a function of his/her membership and role in a group (e.g. the family, the work team)
- Making individual decision as a group

What creates discomfort?

Notes

LOW POWER DISTANCE

This cultural characteristic measures how people behave with each other in social and professional settings. It does not compare the economic prosperity among citizens nor their access to decision making. There are some very rich and powerful people in Australia and some very poor and disenfranchised groups in our society. Nonetheless, at work and in social settings, Australians minimise differences in power and status.

What does this mean for the palliative care setting?

- Patients and carers are encouraged to ask questions medical staff accepts patients may refuse treatment
- Patient and carer feedback whether positive or negative is encouraged and avenues for doing so are freely provided
- Palliative care teams have a flat structure with collaborative decision-making
- Individuals are encouraged to speak out and take the initiative to identify and solve problems
- Titles are rarely used; there is a strong preference to use first names to minimise power differences and encourage participation
- Less formality and less deferring to people in higher positions
- Managers take a more strategic approach and leave daily operational matters to staff

What are some assumptions?

- Status is earned, not conferred through family, class or connections
- The individuals involved in a disagreement are expected to work together to find a solution
- Questions are ‘neutral’ – Seeking clarification
- Direct communication is valued

What creates discomfort?

Notes

HIGH POWER DISTANCE

This cultural characteristic measures how people behave with each other in social and professional settings. It does not compare the economic prosperity among citizens nor their access to decision making. There are cultures where society is comfortable with marked differences in status and through language and social practice mark these differences.

What does this mean for the palliative care setting?

- In families, final decision-making may be the responsibility of some designated members - Decision-maker in family needs to be identified
- Patients may be reluctant to speak to the health care team directly and may only talk through the designated member
- Feedback is given privately or indirectly to 'save face'
- Greater formality and more structured ways to acknowledge power and status
- The workplace is mostly organised along rank, not work tasks and the type of decisions made by staff reflect rank
- Managers are operational - involved in day-to-day activity
- It is sometimes difficult for palliative care clinicians to ascertain the wishes of the patient
- Some may find it difficult to talk to clinicians, holding them in esteem or feel intimidated by them - Patients may be loath to express a view

What are some assumptions?

- Superiors / third party resolve conflict
- People tend to accept externally imposed codes of personal behaviour
- Feedback is given privately or indirectly to 'save face'
- Less directness in communication
- Questions may be confronting / challenging

What creates discomfort?

Notes

COMFORTABLE WITH UNCERTAINTY

This cultural value measures how people react to uncertainty. Consider whether your birth culture sees interpersonal communication and relationships in ‘black and white’ with clearly defined rules. Other cultures more accepting of uncertainty see the world as ‘grey’ and individuals are expected to be flexible and amend workplace protocols if required. Australian mainstream culture is comfortable with a degree of uncertainty.

What does this mean for the *palliative care setting*?

- Palliative care team develops individualised responses to patient needs
- Patient and family involved in negotiating care plan
- Accept guidelines (instead of preference for rules, protocols)

What are some assumptions?

- Expectation to disclose lack of knowledge. The next step is to take personal responsibility to overcome the gap in knowledge. *‘I don’t’ know but I’ll find out’*
- Encourage risk-taking in safe environment
- Social roles tend to be more flexible

What creates discomfort?

Notes

UNCOMFORTABLE WITH UNCERTAINTY

The uncertainty intrinsic in life is culturally framed as a threat to be controlled. A way of avoiding uncertainty and managing the high stress it causes is to establish detailed instructions, codes of practice and rituals both in the workplace and in social life. These provide structure and eliminate the chaos of the unexpected, including personal interaction.

What does this mean for the *palliative care setting*?

- Patients and carers need to be aware that decisions can be changed in relation to care planning etc.
- Patients and families prefer clear instructions rather than negotiated care plans.
- Waiting for results creates anxiety
- May ask many questions difficult to answer: what is my prognosis, or what is causing this?
- May find the lack of curative treatment options difficult to accept. They may ‘shop around’ for more definitive opinions as to prognosis and treatment options
- Workers may not disclose mistakes or lack of knowledge

What are some assumptions?

- Decisions tend to be binding once made
- Strong tendency to seek definite answers

What creates discomfort?

Notes

PROCESS FOCUS

Some cultures, Australia being one of these, are interested in the process of completing the task as well as the outcome.

What does this mean for the *palliative care setting*?

- Staff take a holistic approach to patient care operating in a team-based environment rather than each health worker having a specific task
- Patients and families see care as a process or 'journey'
- Communication with client and carer all along the way
- Teams work collaboratively through consensus

What are some assumptions?

- Interpersonal and communication skills are important
- Greater ambiguity of what is expected of each gender
- Culture emphasises quality of work life
- Sharing the process is seen to achieve the best for the patient and carer

What creates discomfort?

Notes

TASK FOCUS

Some cultures focus on outcomes and only value the completion of the task.

What does this mean for the *palliative care setting*?

- Value clinicians' and health team members' operational skills above their communication skills
- Workers are given specific responsibilities and are not encouraged to work outside those
- Patients and carers focus on diagnosis

What are some assumptions?

- Distinct expectations of male and female roles in society and the workplace
- Achievement is valued above all else

What creates discomfort?

Notes

FUTURE / PRAGMATISM FOCUS

This cultural dimension helps explain how a culture deals with time and the unknown. Some cultures are pragmatic, focussing on the future. The term, 'short-term pain for long-term gain' captures how people from these cultures see the world and individual endeavour.

In societies with a future or pragmatic orientation, people show an ability to adapt traditions easily to changed conditions, a strong propensity to save and invest, thriftiness, and perseverance in achieving results.

What does this mean for the *palliative care setting*?

- Decisions are taken with a view to the long-term impact – patients may accept less than optimal situation if they see future benefits.
- A fatalistic view of death – 'Pain is part of life'
- Suffering has a purpose and a patient may be encouraged to endure pain that may otherwise be relieved

What are some assumptions?

- Values long-term commitments
- Thrift and perseverance valued

What creates discomfort?

Notes

PRESENT / PRAGMATISM FOCUS
Some cultures have a strong focus on immediate results.

What does this mean for the palliative care setting?
- Use of medical technology for immediate diagnosis
- Address current problem directly

What are some assumptions?
- Traditions and commitments are not impediments to change
- Workers more willing to adopt new workplace practices
- Change can occur more rapidly

What creates discomfort?

PAST / PRAGMATISM FOCUS

For some cultures, the past is a tangible part of the present. People in such societies have a strong concern with establishing the absolute Truth and a need for personal stability. They exhibit great respect for social conventions and traditions.

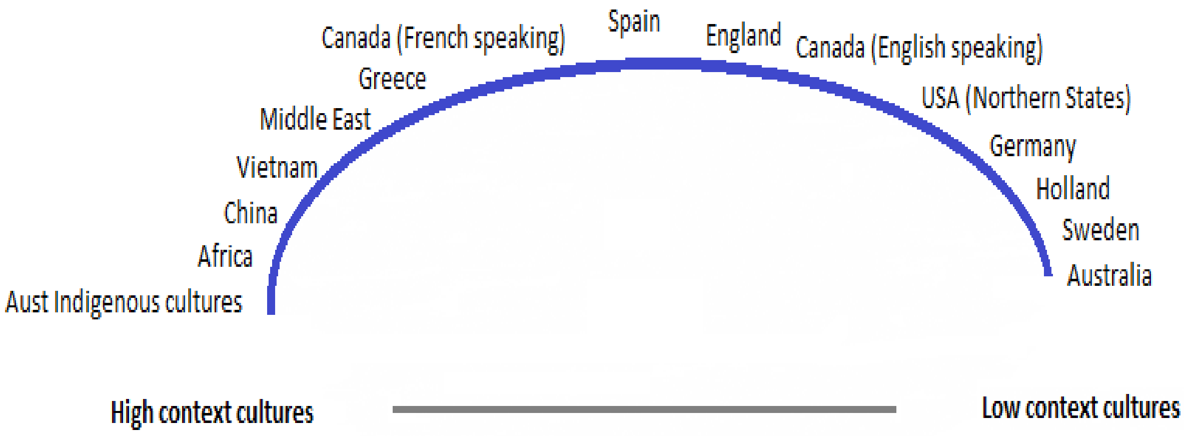
What does this mean for the palliative care setting?
- Concern for continuity of traditional approaches
- Fear of change

What are some assumptions?
- Wisdom from the past - *'We have always done it this way'*

What creates discomfort?

Notes

Direct / Indirect (E.T. Hall)



(E. T. Hall)

INDIRECT (High Context)	DIRECT (Low Context)
Our shared experience is the basis of cooperation. In interpersonal communication much can be left unsaid. What matters is what is not said (Indirect)	We need less shared knowledge as a basis for cooperation. What matters is what is said. (Direct)

High context cultures - High context cultures align with the 'Collectivist' dimension defined by Hofstede. Communication between in-group members:

- **Indirect / implicit communication**
- **Shared, complex body of experience (Much can be left unsaid)**
- **Goal of exchange is to maintain harmonious relationship**
- **Topic of communication as intrinsic to the person**

Low Context cultures – Low context cultures align with the 'Individualistic' dimension defined by Hofstede. There are no in/out groups and communication:

- **Direct / explicit communication**
- **Relationships are fluid and less opportunity for shared experience (Much needs to be stated)**
- **Goal of exchange is to effectively relay information**
- **Topic of communication separate from the person. "Don't take it personally."**

Notes

Activity - How I see you…..

What do direct and indirect communicators think of each other?

DIRECT communicators think indirect communicators are:

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INDIRECT communicators think direct communicators are:

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Notes

Know my patients and their carers

Activity - Small group work

Think of your agency's catchment area. What is the cultural make-up of your potential clients?

What are the top 10 culturally diverse communities?

What are the top 10 emerging communities?

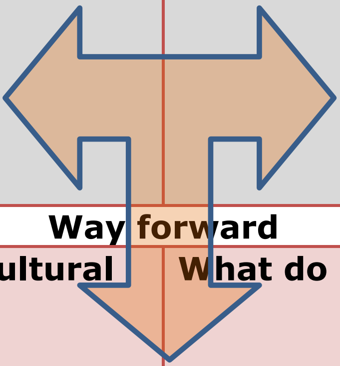
Choose a community. What are some demographic characteristics which would help you to provide improved culturally responsive care?

Notes

Practical strategies

Apply Robert Arnold’s and team’s three step strategies:

- Tell me more
- Ask/Tell/Ask
- Respond to emotion



Situation / case study **(Document salient points)**	
What am I thinking?	**What am I feeling?**
Way forward	
What do I know? (Any cultural blind spots?)	**What do I need to find out?**
New approach to communication	

Notes

After workshop activities

Here are a number of activities to enable you to further explore and reflect on the content we covered today.

1. Complete the online *Cultural competence checklist* and once you've generated your individual learning plan, implement a personal professional development program for the coming 12 months.

2. Use the *Communication toolkit* and *Community profiles* as well as some of the information found in the *Online learning resource* to compile a plan to improve communication with culturally diverse communities. (A Communication plan template is found in CultureMate®)

    - Your agency might wish to hold an information session for a particular cultural group. Information about the community will give you an insight about how best to communicate with its members.

    - Your agency could organise some information and cultural sharing activities to coincide with Harmony week (usually held in March every year) or Palliative Care week (in May). Culturally diverse community members value the opportunity to establish networks with mainstream organisations. They see it as a way of gaining vital information for their members as well as sharing information about themselves with the broader community. It's a win-win situation.

3. Use the resources related to overcoming unconscious bias and dealing with racism to hold a small group discussion. You might review policies or practices or develop some personal strategies to improve your confidence in dealing with these issues.

4. Continue to practice Robert Arnold's and colleagues' *Three step strategies* in intercultural palliative care communication situations. Keep a journal.

Notes

Role plays

The role plays are structured to give everyone the opportunity to apply the communication strategies discussed during the workshop.

Participants will take a turn to act in one of the role play scenarios with an actor.

1. Arrange you chair so you are part of a large circle.
2. Read the case study or story that will be the basis for the role play with one of the actors who have joined us.
3. Think about the key communication and cultural issues to be addressed.
4. Discuss with others.
5. Each participant interacts with the actor to illustrate how he/she would communicate in an appropriate way.
6. You can call time-out if you are stuck or find it too difficult to proceed, or you have a question to ask the group.
7. At the end of each case study there will be feedback.

We will follow this order for feedback
- Participant first (To reflect on what happened and why, learnings from role play)
- Facilitator
- Actors
- Observers next (Questions are encouraged).

This approach provides a 360° perspective on the role play.

How will we provide feedback?
- Describe specific things seen and heard, relevant to the exercise and to the person(s) doing the role playing – something that the role player can use.

- No subjective judgements. Role play feedback is not helpful if it suggests that the role player should 'be nicer' or if s/he was 'good'.

Notes

Role play 1

You have a meeting with the spouse of a patient. This patient has had surgery for cancer of the colon in the past and was recently admitted with abdominal pain and a partial bowel obstruction. This has resolved with conservative treatment. The patient has been told that the cause of the problem is a recurrence of the cancer but the patient seems not to realise how serious this is and is talking to the family about getting home before the next lot of treatment.

You will try to explain to the spouse that the cancer is inoperable, no further curative treatment will be delivered, and that palliative care is the approach that is needed. You will try to organise a referral to the palliative care team in the hospital, who will come to see the patient and explain how palliative care works.

Extension – You and the interpreter arrive. **OR** you have arranged a telephone interpreter.

Role play 2

You arrive for your first meeting at the home of a new patient; an elderly man who you understand is a widower and lives alone.

You are met at the door by someone you do not know who is blocking your way – You're not coming in here'………You're going to try to accomplish your visit.

Role play 3

Mr & Ms XX have a 3 month old baby, born prematurely with a congenital condition; she is not expected to live beyond 6 months. They are international students and she is their only child. The baby has been in the RCH since soon after birth and in accordance with the parents' wishes the paediatric palliative care team at the hospital is working to bring her home to die. They have enlisted the local palliative care service and the hospital paediatric palliative care team will continue their involvement. The baby requires naso/gastric feeds and pain control, but mainly sleeps and the parents have said they can cope with support and backup.

One of the parents asks to speak to you…..

Extension

Even though they are international students, and seemed to understand English very well, they have asked for an interpreter to meet with you again, to make sure that they understand the decisions they need to make. You make the necessary arrangements: You and interpreter arrive. **OR** You arrange a telephone interpreter.

Role play 3a

As a volunteer you have been asked to support the family – Help with transport as they do not have a car; visit during the day to relieve their isolation. This is your first meeting…..

Notes

Role play 4

The patient arrived in Australia as a refugee. The family with 6 children live in a small 2 storied unit. The patient was diagnosed with advanced lung cancer last year and recently was diagnosed with cerebral secondaries. The patient has been told that the treatment is no longer working. The patient has been receiving home-based palliative care for about 6 months, but had a fall 2 weeks ago and was admitted to hospital. The hospital palliative care service visited to assess the patient's ability to go home. It was revealed that the fall was due to loss of balance and doctors consider it unsafe to return home, so have recommended the patient be admitted to the palliative care unit near the home.

You will be communicating all this to the spouse and seeking to have the care plan accepted.

Role play 5

The patient is elderly and lives in a nursing home, which is specifically for the patient's ethnic group. The patient had a mastectomy 20 years ago and has recently been diagnosed with spinal and lung secondaries. The home has been very helpful in facilitating the doctor and hospital appointments and keeping the family (mainly her oldest son) informed about developments. The patient has been happy in the home, as she has plenty of friends and company, but she has become increasingly bed-bound with lessening ability to walk and because of increasing pain. This means she misses her outings and has not been able to visit her son's house and grandchildren. She is a very religious person, and often tells the nursing home staff it is 'God's will' that she is suffering. They don't know how to respond to this and after a particularly difficult day with pain, the manager calls in the palliative care nurse from the local service for assistance with both these issues.

You arrive on the scene…..

Notes

Role play 6

The patient is elderly and arrived in Australia with a spouse many years ago. They both experienced torture and trauma in their country of birth. They established a new life in Australia and raised their family of 3 children. The patient developed bowel cancer 3 years ago, had surgery, radiotherapy and chemotherapy, but 2 months ago was diagnosed with further bowel and liver metastases. Further treatment had become too burdensome in terms of side effects and the patient wants to go home to be with spouse.

The palliative care nurse visits for an assessment. The patient is reluctant to accept palliative care, believing that 'I am not going to die; I have lived through worse and felt worse.' And anyway the spouse can assist.

The patient refuses to speak you, but agrees to let you speak to the spouse.

Role play 6 - Extension

Although the patient refused to see the palliative care nurse, the patient agreed that the spouse can be supported to provide care to the patient. A volunteer comes and provides the spouse with a couple of hours respite once a week, as part of the palliative care plan.

The palliative care volunteer arrives for the first time…..

Notes

EVALUATION

Thanks for your feedback!

Time & Date: …………………………………………….
Agency: ……………………………………………………..
Venue: ……………………………………………………

1. How relevant was the training program to your work?

Excellent ☐ Very Good ☐ Neutral ☐ Fair ☐ Poor ☐

2. How effective was the design of the program?

Excellent ☐ Very Good ☐ Neutral ☐ Fair ☐ Poor ☐

3. How effective was the style of the facilitator?

Excellent ☐ Very Good ☐ Neutral ☐ Fair ☐ Poor ☐

4. How well did the facilitators encourage interaction between the participants?

Excellent ☐ Very Good ☐ Neutral ☐ Fair ☐ Poor ☐

5. How much did the program increase your knowledge of cross-cultural communication?

Excellent ☐ Very Good ☐ Neutral ☐ Fair ☐ Poor ☐

6. How much did the program increase your confidence in your ability to communicate across cultures?

Excellent ☐ Very Good ☐ Neutral ☐ Fair ☐ Poor ☐

7. Overall, how satisfied are you with this training program?

Excellent ☐ Very Good ☐ Neutral ☐ Fair ☐ Poor ☐

8. How confident are you that you will be able to transfer what you have learned to your work?

Excellent ☐ Very Good ☐ Neutral ☐ Fair ☐ Poor ☐

9. What aspects of the workshop could be improved?

____

____

10. Were there other topics you would like to see included?

____

____

11. Tell us one thing you learnt today that you will use.

____

____

Notes

Attachment

Excerpted from: Using Interpreting Services: Victorian Government Guidelines on Policy and Procedures (p.18).

Preparing for the session

- Brief the interpreter by providing general background information, such as the reason for the session, specific terms to be used and what needs to be achieved.
- For onsite interpreting, ensure the room is set up appropriately. Ideally, seats will be arranged in a triangle with the service provider facing the client.
- For Auslan interpreting it is normally best if the interpreter is seated or stands next to the service provider and opposite the client.
- For long sessions, a break for the interpreter should be considered.
- Avoid leaving the interpreter alone with the client, either in the room where the interview will take place or a waiting room.
- For a telephone interpreting interview, ensure you have access to the appropriate telephone technology, and understand how to work the telephone system.

Beginning the interview

- Introduce yourself and the interpreter to the client.
- Explain the interpreter's role, noting that the interpreter's role is not to add to the communication, but only to interpret what is being said.
- Explain the purpose of the session and what you hope to achieve.
- Do not assume that the client knows what the interview is about.
- Explain to the client that questions or concerns can be raised at any time during the interview

During the interview

- Talk directly to the client (not the interpreter) and maintain eye contact with the client.
- Use the first person when speaking to your client. For example, say "What time did you arrive today?" instead of "What time did she arrive today?"
- Use clear language and avoid using slang, colloquialisms and metaphors.
- Make one point at a time. Pause until the end of a full sentence. Keep questions, statements and comments short. This allows the interpreter to understand and remember what is being said and to interpret in stages.
- Allow the interpreter to clarify information with you. If there is a need to clarify, ask the interpreter to explain this to the client first.
- Allow the client to ask questions or raise issues at any time in the interview.

- If you have any questions about the client’s cultural background, ask the client directly and not the interpreter.
- Summarise the discussion occasionally to ensure the client understands the information.
- Do not ask the interpreter to edit your information to suit the client’s background.

At the end of the interview

- Summarise key points for the client.
- Check that the client understands any information you have conveyed.
- Allow the interpreter to leave separately to the client.

After the interview

- Debrief the interpreter and discuss any issues experienced in the interview that related to the role of the interviewer or the interpreter.
- Do not to ask the interpreter to express an opinion about the client or what they have said.
- Provide any positive feedback about the interpreting session and the ways in which the interpreter assisted the interview to run smoothly.
- Raise any unprofessional or unsatisfactory practices directly with the interpreter at the end of the interview

Office of Multicultural Affairs and Citizenship (OMAC) entry point Standards and guidelines

http://www.multicultural.vic.gov.au/projects-and-initiatives/improving-language-services/standards-and-guidelines

Interpreters –

http://www.multicultural.vic.gov.au/images/stories/documents/2014/omac%20using%20interpreting%20services%20guidelines%20on%20policy%20and%20procedures%20online.pdf

Translations –

http://www.multicultural.vic.gov.au/images/stories/documents/2014/omac%20effective%20translations%20guidelines%20on%20policy%20and%20procedures%20%20online.pdf