Los Angeles Harbor College

Associate Degree Nursing Program

Nursing 311

COMMUNICATION IN NURSING

2018-2019 Edition
E. Moore

LOS ANGELES HARBOR COLLEGE
ASSOCIATE DEGREE NURSING PROGRAM
COURSE OUTLINE

Nursing 311: Communication in Nursing

FACULTY CONTACT INFORMATION:

Edie Moore, RN, MSN, FNP
Office Location – Nursing 111
Office hours posted outside office
mooreev@lahc.edu
Mailbox 471
(310) 233-4377 – messages retrieved only on teaching days
(310) 408-3431 – texting welcome

COURSE DESCRIPTION: This course provides theoretical knowledge and practical experience needed by the nursing student to understand and effectively use basic communication skills to interact therapeutically with patients, communicate in groups, institute a teaching-learning plan, and begin the journey to cultural competence. This course consists of four units: A) Communication, B), Patient Education C) Cultural Awareness and D) Group Concepts.

CREDIT/CONTACT HOURS: This one (1) semester unit course has 18 hours of lecture over a six-week period. In addition to three lecture hours per week, anticipated study and clinical practice time for this course is nine (9) hours per week.

TRANSFERABLITY: CSU

PREREQUISITES: Category 1: Students enrolled in Nursing 313/315 will complete this course as a component of the first semester course load. Category 2: Students admitted to the RN program beyond the 1st semester or pending acceptance to the program by special permission. Eligible students include LVN, transfer, and special admission students.

STUDENT LEARNING OUTCOMES/COMPETENCIES:

At this level, which comprises courses in the first semester of the nursing program, the students are expected to integrate and synthesize knowledge obtained in prerequisite courses.The students are introduced to nursing concepts and professional behaviors that they are to adhere to and practice under the guidance of experts in the clinical setting. They are expected to carry out the nursing process, perform basic nursing skills, and complete patient's care plan of care utilizing a set of rules and resources in their decision-making.

Program Learning Outcomes for level one are:

1. Relate the components of the nursing process using the Roy Adaptation Model.
2. Develop professional behaviors for nursing practice.
3. Identify assessment data with which to formulate clinical decisions.
4. Provide safe, patient-centered care.
5. Describe roles of health care team members and develop effective strategies for communication.
6. Identify evidence-based practices to support clinical reasoning.
7. Implement a personal quality improvement project.
8. Identify the impact of information technology in the clinical setting and guidelines for protected health information.

COURSE OUTCOMES/COMPETENCIES:

At the end of this course, with appropriate study and practice in the classroom and clinical setting, the first semester student will be able to apply therapeutic communication techniques; increase knowledge related to cultural awareness and steps to providing culturally congruent care; demonstrate teaching and evaluation of a learning experience; and explain the dynamics of the group process. The student will be able to:

1. Establish and demonstrate a theory base for understanding and implementing the basic concepts of interpersonal communication (2,4,5).
2. Define and differentiate intimate communication, social communication, therapeutic communication and assessment interviews (2,5).
3. Describe the elements and significance of verbal and non-verbal communication (5).
4. Identify and utilize basic techniques of therapeutic communication (2,4,5).
    a. State facilitators to communication, their purpose and examples of each.
    b. State blocks to communication, their effects and examples of each
5. Recognize the appropriate time to utilize closed-ended versus open-ended questioning (5).
6. Describe growth and development factors that guide assessment and planning for patient interaction (1,3,4,5,6).
7. Relate growth and development theories to communication guidelines for patient interaction (2,3,4,5,6).
8. Discuss growth and development factors as they relate to the communication process (2,3,4,5,6).

9. Utilize the process recording to improve therapeutic communication skill (2,4,5,6).
10. Develop and demonstrate a theory base for understanding and implementing a teaching-learning process between the nurse and patient (2,3,4,5,6,8).
11. Identify environmental factors conducive to and effective learning (4, 6).
12. Compare the elements of the communication process to their use for the teaching-learning process (4,5).
13. Research and conduct an evidence-based stress reduction learning activity. (3,4,6,7).
14. Conduct a peer review of the teaching learning process (3,7).
15. Identify the components of three conditions necessary for learning to occur: patient readiness, ability to learn, and a facilitative learning environment (1,3,4,6).
16. State the three domains of learning and examples teaching techniques in each domain (3,4,5,6).
17. Describe key concepts related to cultural awareness (1,3,4,5).
18. Explore sociocultural statistics specific to Los Angeles County (3,4).
19. Identify communication patterns and cultural concepts that affect healthcare to diverse populations (3,4,5,6).
20. State five cultural factors that place populations at risk for health care disparity (3,4,6).
21. Define transcultural nursing and culturally congruent care (2,3,4,6,7).
22. Demonstrate the ability to perform a cultural assessment (1,3,4,).
23. State the steps in developing cultural competence (2,4,6,7).
24. Relate the National Standards for Culturally and Linguistically Appropriate Services in health care.
25. Describe linguistic competence and related health care laws (4,5,6,8).
26. Explore the role of spirituality and religion in the healthcare environment (3,4,5,6).
27. Relate the role of core measures and quality improvement in healthcare (3,4,5,6).
28. Develop and demonstrate a theory base for understanding and implementing selected basic concepts of group dynamics (2,5,6).
29. Define a group and give examples of at least five different types of groups and how they differentiate from one another (2,5).
30. Define and describe behaviors of group members assuming dominative roles versus democratic roles (2,5).
31. Define and differentiate behaviors of a sick versus healthy group (2,5).
32. Identify principles that contribute to group satisfaction and productivity (2,5).
33. Relate the components of the five stages of group development [forming, storming, norming, performing, adjourning]. (2,5).
34. Explore the concept of incivility in the workplace (2,4,5,7).
35. Practice Pre-licensure communication skills to maintain civility in the clinical and classroom setting (2,4,5,7).
36. Demonstrate patient safety communication techniques: ISBAR, the two-challenge rule and check-back (2,4,5,7).

METHOD OF INSTRUCTION:

Lecture, discussion, games, video presentations, role-play in practice scenarios, process recordings, develop and implement a teaching-learning activity, cultural awareness project/presentation.

REQUIRED TEXTS:

Potter, P. A., Perry, A. G., Stockert, P. A., & Hall, A. M. (Eds.). (2017). *Fundamentals of nursing* (9th ed.). St. Louis, MO: Mosby Elsevier.
ISBN 978-0-323-32740-4

ATTENDANCE POLICY:

Class absences are not to exceed **one** lecture. **There are no unexcused absences.** Students are expected to contact the lead instructor via text, phone message or email for any absence prior to the class session or as soon as possible if absence is unexpected. Reasons for excused absences are limited to personal illness, death of an immediate family member, or personal emergency. A written statement from a physician or other person involved in helping the student resolve the personal emergency must validate any absence during the final week. Nursing students are urged NOT to be absent, and are reminded that the student is responsible for ALL information, announcements, and learning materials given during class time. Two (2) tardies (greater than 15 minutes late) will be counted as one absence in this six (6) week course. Absence that exceeds the specified maximum of one class session is considered excessive and may result in exclusion from the course or receiving an "F" grade.

ACADEMIC DISHONESTY:

The District Academic Dishonesty Policy 9803.28 describes academic dishonesty violations as follows: "Violations of Academic Integrity include, but are not limited to, the following actions: cheating on an exam, plagiarism, working together on an assignment, paper or project when the instructor has specifically stated students should not do so, submitting the same term paper to more than one instructor, or allowing another individual to assume ones identity for the purpose of enhancing ones grade."

Academic dishonesty will not be tolerated in the Nursing Division. For further clarification, the nursing faculty has addressed definitions for the four major forms of academic dishonesty.

- Plagiarism- presenting the work of another as if it were student's own work. Each time a source is utilized, a citation for the source must be included in the text of the paper.
- Cheating- engaging in an act of deception whenever by misrepresenting mastery of information on an academic exercise that has not been mastered.
- Fabrication- falsifying research or invents information with the intent to deceive.
- Academic misconduct- violation of college policies, tampering with grades.

CHALLENGE/CREDIT BY EXAMINATION PROCEDURE:

Students requesting credit by examination for courses in the Registered Nursing Program must meet the Los Angeles Harbor College "Credit by Examination" policy prior to requesting credit by examination in place of enrolling in and completing any nursing course. As stated in the catalogue, the policy requirements include, but are not limited to, the following:

- Be currently registered and have a minimum cumulative grade point average of 2.0
- Have completed 12 units within the Los Angeles Community College District
- Not to be currently enrolled in, or have completed a more advanced course in this discipline
- Meet all other criteria listed in the college catalogue for "Credit by Examination"

After fulfilling the above criteria, the student may request the necessary materials for demonstrating competency in both the clinical and theory course content. For credit in this nursing course, the student must meet all prerequisite courses to Nursing 311. These prerequisites include, but are not limited to, the following General Education courses: Psychology 1, Psychology 41, Sociology 1, Speech 101 or 121, Microbiology 1 or 20, Anatomy 1, Physiology 1, and English 101.

COLLEGE AND DEPARTMENT POLICIES:

See **Los Angeles Harbor College Catalog** and **Nursing Student Handbook available online at www.lahc.edu.**

BOARD POLICIES/ACCOMODATIONS:

1. Disability Accommodation Statement: Nursing students with a verified disability who may need a reasonable accommodation(s) for this class are encouraged to notify the instructor and contact the DSPS Office or the Office for Special Services as soon as possible. All information will remain confidential.
2. Board Rule 9803.28. Academic Dishonesty. Violations of Academic Integrity include, but are not limited to, the following actions: cheating on an exam, plagiarism, working together on an assignment, paper or project when the instructor has specifically stated students should not do so, submitting the same term paper to more than one instructor, or allowing another individual to assume one's identity for the purpose of enhancing one's grade.
3. Board Rule 9803.14. Obstruction or disruption of classes, administration, disciplinary procedures, or authorized College activities.
4. Board Rule 9803.19. Alcohol and Drugs. Any possession of controlled substances which would constitute a violation of Health and Safety Code section 11350 or Business and Professional Code section 4230, any use of controlled substance the possession of which are prohibited by the same, or any possession or use of alcoholic beverages.

5. Title IX (of the 1972 Education Amendments) protects students and staff alike from discrimination based on sex, including Sexual Harassment and Sexual Assault, which are forms of Sexual Misconduct. Under Title IX, all people in the educational environment must be treated equitably, regardless of sex, sexual orientation or expression, and/or transgender identity. If you have experienced or learned of a possible violation of Title IX and/or would like to know about options, resources (including confidential services), the law, or District policy, please do not hesitate to contact a Title IX Coordinator.

   LAHC Campus Title IX Coordinators : Peggy Loewy Wellisch (310) 233-4321 loewywp@lahc.edu & Dawn Reid (310)233-4237 reidd@lahc.edu

   District Title IX Office: Office for Diversity, Equity, and Inclusion (213) 891-2315 TitleIX@email.laccd.edu

Please see the LAHC **College Catalog** for a listing of all District Board Rules. Also, refer to the Student Discipline Procedure for due process for disciplinary issues, grievances and the student appeal process. All students are required to read the **Student Nurse Handbook**. If you do not have a copy, you may obtain a copy from the Nursing Learning Lab desk.

GRADING POLICY:

Criteria for successful completion of this course are as follows:

- Satisfactory academic performance as evidenced by attainment of 75% or better average overall for the unit examinations, final examinations, process recordings and teaching care plan.
- Satisfactory classroom performance as evidenced by participation in all role-playing scenarios and cultural exercise.
- Late assignments can only be given a maximum grade of 75%.

Course Assignments

Unit AB Exam	**50 points**
Unit CD Exam/Final Exam	60 points
Process Recordings (x 3)	40 points (best 2 out of 3)
Teaching Exercise	20 points
Therapeutic Communication Exercise	10 points
Culture Group Exercise	20 points
Group Process Exercise	10 points
Total Points	210

Grade Assignment

Letter Grade	*Percentage*	*Points*
A	90-100%	188-210
B	81-89%	170-187
C	75-80%	157-169
D	60-74%	125-168
F	Below 60%	124 or less

MAKE UP EXAMINATIONS:

There are no scheduled make up exams. Students are urged to contact instructor if major illness requires missing an exam. The grade obtainable for an exam taken after the scheduled testing day is 75%. Make-up exams may be multiple choice, fill-in, essay, or assessment and/or nursing care plans, or a combination of all the above. To receive a grade of "W" (withdrawal) for the class, the student must officially drop the course in admissions by the end of the 4th week of the course.

N311 Reading Assignment

Unit	Title	Resource
A	**Communication** **Developmental Theories**	***Potter & Perry*** Chapter 24 -pages 316-335 Chapter 11 – pages 132-140 **Review Syllabus material**
B	**Patient Education**	***Potter & Perry*** Chapter 25 – pages 337-355 **Review Syllabus material**
C	**Cultural Awareness**	***Potter & Perry*** Chapter 9 – pages 101-115 **Review Syllabus material** ***Online or library cultural resources as assigned***
D	**Group Process**	**Review Syllabus material**

Unit A/B OBJECTIVES

Description:

Unit A is an introduction to basic concepts in communication and outlines principles for therapeutic communication in the nurse-patient relationship. The student is introduced to self-evaluation of the therapeutic communication process through the evidence-based tool called the process recording. Specific techniques that enhance therapeutic communication are presented as well as blocks to the therapeutic process. Unit B presents an introduction to basic concepts and principles in the teaching-learning process. Students plan a teaching session and work collaboratively to practice a teaching-learning experience.
Estimated time of achievement: Two weeks.

Objectives	Course Content	Learning Activities
After appropriate study of the assigned resources, and assigned practice of the psychomotor and communication skills, the nursing student will be able to: 1. **Identify ways to apply critical thinking in the communication process.** 2. **Describe five levels of communication and their uses in nursing practice.** 3. **Define and differentiate social, intimate and therapeutic communication.** 4. **Describe the basic elements of the circular transactional communication process.**	**Unit A** **Communication and Nursing Practice** Communication and interpersonal relationships Developing communication skills **Levels of communication** Intrapersonal, interpersonal, small group, public and electronic **Circular Transactional Communication Process** Referent, sender/receiver, message, channel, message, feedback, interpersonal variables, environment **Forms of Communication**	**Potter & Perry** Communication: Chapter 24 - pages 316-335 Developmental Theories: Chapter 11 – pages 132-140 Patient Education: Chapter 25 – pages 337-355 Film: Therapeutic Communication in Nursing Review Syllabus material

5. Relate the elements of verbal, non-verbal and metacommunication. **6. Identify significant features and therapeutic outcomes of nurse-patient helping relationships.** **7. Identify a nurse's communication approaches within the four phases of a nurse-patient helping relationship.** **8. Identify significant features and desired outcomes of nurse-healthcare team member relationships.** **9. Describe qualities, behaviors, and communication techniques that affect professional communication.** **10. Differentiate communication techniques that facilitate and those that block therapeutic communication.** **11. Assess verbal and nonverbal messages communicated by the patient.** **12. Apply and describe these techniques from the clinical setting on the process recording form.** **13. Discuss effective communication techniques for older patients.** **14. Identify patient health states that contribute to impaired communication.** **15. Discuss nursing care measures for patients with special communication needs.** **16. Discuss factors influencing growth and development.** **17. Describe biophysical developmental theories.** **18. Discuss how developmental theories help predict human responses in communication.** **19. Apply developmental theories when planning interventions and therapeutic communication in the clinical setting.** **20. Explore health informatics and Telehealth technologies.** **<u>Unit B</u>** **1. Compare the nursing process to the teaching/learning process.** **2. Identify appropriate topics that address a patient's health education needs.** **3. Describe the similarities and differences between teaching and learning.** **4. Identify the role of the nursing in**	Verbal, nonverbal, metacommunication **Professional Nursing Relationships** Nurse-patient caring relationships, nurse-family relationships, motivational interviewing, nurse-healthcare team relationships, nurse-community relationships **Elements of Professional Communication** Courtesy, titles, trustworthiness, autonomy, responsibility, assertiveness **Assessment: Factors influencing communication** Physical factors, emotional factors, developmental factors (Erikson's Developmental Theory), sociocultural factors, gender **Therapeutic Communication Techniques** Active listening (SOLER), sharing observations, empathy, hope, humor, sharing feelings, using touch, using silence, giving information, clarification, focusing, exploring, paraphrasing, validation, asking relevant questions, summarizing, self-disclosure, confrontation BATHE/NURS techniques **Nontherapeutic communication Techniques** Probing/asking personal questions, giving personal opinions/advice, changing the subject, automatic responses, false reassurance, sympathy, asking for an explanation, approval or disproval, defensive responses, passive or aggressive responses, arguing **Communication Techniques for Patients with Special Needs** Aphasia, cognitive impairments, hearing impaired, visual impairment, unresponsive patients, non-English speaking patients **Health Informatics** E-Health, Telehealth Health Apps **Developmental Theories**	Discussion/Lecture Group participation –Therapeutic communication group exercise Therapeutic communication game Process recordings Teaching Learning Assignment

patient education. **5. Identify the purposes of patient education.** **6. Utilize appropriate communication principles when providing patient education.** **7. Describe the three domains of learning.** **8. Identify basic learning principles.** **9. Discuss how to integrate into patient-centered care.** **10. Differentiate factors that determine readiness to learn from those that determine ability to learn.** **11. Identify elements of the environment that are conducive to learning.** **12. Develop a teaching plan including assessment, diagnosis, learning objective, intervention, documentation, evaluation and peer feedback.** **13. Practice one-on-one teaching of an evidence-based relaxation technique.** **14. Practice the teach-back method.** **15. Use appropriate methods to evaluate whether learning has occurred.**	Biophysical development Freud's psychoanalytical theory of personality development Erikson's developmental theory of psychosocial development Maslow's hierarchy of needs Havinghurst's stage-crisis Theory Piaget's theory of cognitive development Kohlberg's moral development theory Gesell's theory of development **<u>Unit B</u>** **Patient Education** The Joint Commission standards for patient education Purposes of patient education Role of the nurse in teaching and learning Principles of teaching and learning Domains of Learning (cognitive, affective and psychomotor) Teaching methods based on domains of learning Principles in motivation to learn Principles in ability to learn Developmental capacities as they relate to teaching and learning Physical capabilities as they relate to teaching and learning Factors relevant to the learning environment Health literacy and learning disabilities Incorporating teaching with nursing care Setting teaching goals and priorities Organization of teaching materials Teamwork and collaboration in patient education Speak Up Initiatives Instructional methods: one on one, group instruction, demonstration, analogy, role play, simulation Evaluation methods for learning Teach back method, return demonstration	

Unit A: COMMUNICATION

DIFFERENTIATION BETWEEN
SOCIAL *versus* THERAPEUTIC COMMUNICATION *versus* PATIENT ASSESSMENT

	SOCIAL (INTIMATE) COMMUNICATION	THERAPEUTIC COMMUNICATION
FOCUS/GOAL	None, me, you, another, the situation, etc.; no analysis or meaning, may or may not have a goal; past, present, or future oriented Free to meet one's personal/emotional needs or make decisions on own needs, feelings, wants, values, etc.	On patient (client) needs and goals; ***EMOTIONAL/FEELING*** oriented; focus on NOW; ANALYSIS of meeting can be done via the process recording. Communications is always PURPOSFUL
SETTING	Anywhere, causal, unstructured, may be public or private	Hospital or office setting, can be mutually agreed upon place, private, structured, attention to distracters (noise, clutter, environment)
RELATIONSHIP	Friend, acquaintance, accidental contact; no concern about posture/distance/eye contact/relative positions/blocks	Roles of helper/helpee attention to details of verbal/nonverbal/distance/posture/eye contact/ relative positions/blocks/dress
GENERAL CHARACTERISTICS	Movement is free, in or out. May leave situation temporarily or permanently. Free to offer help or keep distance. Help may be given on an intuitive basis.	Professional is responsible to stay and help. Professional is responsible for being aware of personal motivations, actions, consequences. Uses learned therapeutic communication techniques. Professional examines personal judgment and biases and works toward acceptance of views other than own
TIME	Indefinite in duration	Professional responsibility to stay; time is limited

PATIENT ASSESSMENT

Structured, fulfills specific purpose, uses specialized or structured format (admission/discharge interview, pain assessment). Data collected and usually recorded in presence of patient. Usually in a private environment with distracters eliminated or minimized. Focus is on gathering data and information to meet the patient's *PHYSICAL* needs or assess condition. Communication is question oriented with answers recorded but non -verbal behaviors may be recorded to supplement verbal information.

THERAPEUTIC COMMUNICATION

Open versus Closed Questions (both can be therapeutic)

Closed Questions

Advantages

- Time efficient
- Elicit specific information with minimum interaction
- Stimulate client to share precise information (helps patient focus)
- Easy to ask
- When used properly, closed-questioning can supplement other types of questioning/communication techniques.

Disadvantages

1) Limits information to one word responses (often yes or no)
2) Information gained is limited in nature
3) May obscure patient's true perception
4) Can lend to implied or expected responses
5) May challenge the patient's integrity, capability or self-esteem

Examples

- Do you feel you are being helped here in the hospital?
- Are you comfortable?

Open-ended Questions

Advantages

- Well suited for starting a therapeutic interaction
- Does not limit responses
- Provides opportunity for observing patient's frame of reference, knowledge base and vocabulary
- Therapeutic person conveys caring feelings about the patient
- Allows patient to verbalize in their own way and to express fears, concerns and anxiety
- Allows patient to answer own questions and make own decisions
- Increases patient willingness to respond in a contributing manner

Disadvantages

- Time consuming
- Requires ability to listen to tone and intent as well a precise words
- May cause interview to be side tracked by irrelevant topics
- Without skilled intervention, it can be difficult for the nurse to refocus on the original topic

Examples

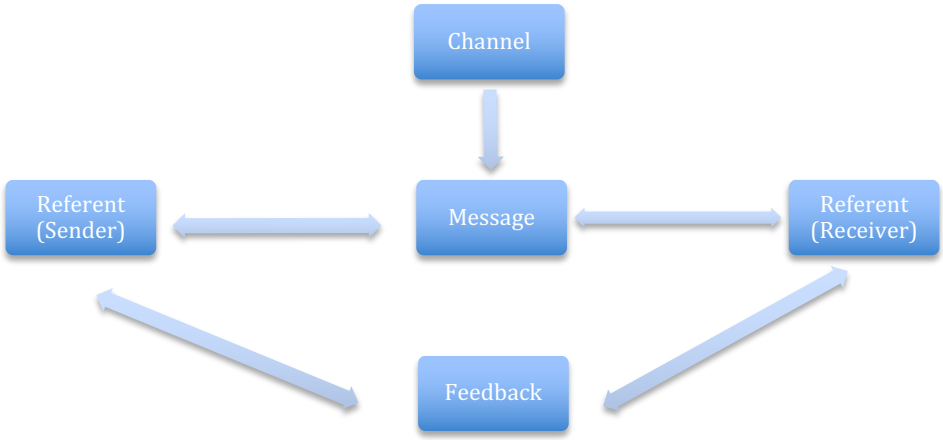
- How has your stay in the hospital been so far?
- Tell me about your comfort level?

“Do’s” in Therapeutic Communication

- ✓ Do provide/select a private, quiet, safe environment in which to hold interactions.
- ✓ Do listen twice as much as you speak. Leading questions set up expectations.
- ✓ Do think of the unique situation you face before responding and consider alternatives.
- ✓ Do acknowledge and build a positive self-regard.
- ✓ Do be simple, clear and direct in communication.
- ✓ Do be congruent in communication.
- ✓ Do be alert and responsive to small changes in communication.
- ✓ Do observe all non-verbal cues in communication.
- ✓ Do be non-judgmental in interactions.
- ✓ Do allow the client to proceed at his/her pace.
- ✓ Do accept people as they present themselves with their strengths and weaknesses.
- ✓ Do provide an atmosphere for the exploration of thoughts and feelings through silence.
- ✓ Do remember that there is always the potential for growth and healthy living. There are no "hopeless' or "hardcore" individuals.

Unit B: PATIENT EDUCATION

VARIABLES & FACTORS AFFECTING EACH ELEMENT IN THE TEACHING - LEARNING PROCESS



Element	Communication Process	Teaching Learning Process
Referent	An idea that initiates the reason for communication	Perceived need to provide the person with information; teacher establishes relevant learning objectives
Sender	Person who conveys the message to another	Teacher who performs activities aimed at assisting the other person to learn
Intrapersonal variables (sender)	Knowledge, values, emotions, sociocultural influences that affect the sender's thoughts, communication experience level, past experience	Teacher's philosophy of education, which stems from learning theory, knowledge of teaching content, experiences in teaching, the teachers own emotions and values
Message	That which is expressed or transmitted by the sender	Content or information to be taught
Channels	Methods used to transmit a message (visual, auditory, touch)	Methods used to present content (involve as many as possible: visual, auditory, touch, taste, smell)
Receiver	Person to whom the message is transmitted	The learner
Intrapersonal variables (receiver)	Knowledge, values, physical and emotional health , sociocultural influences, developmental level, that affect the receiver's perception	Willing and capability to learn; expressed desire; attitudes, physical and emotional health, educational level, previous knowledge and skills, reading level, developmental level, sociocultural influences
Feedback	Information revealing the at the true meaning of the message was received	Determination of whether learning objectives were achieved

TOPICS FOR HEALTH TEACHING

Health Promotion & Illness Prevention

Exercise
Stress Management
Immunizations
Nutrition
Safety (home and hospital)
First aid
Growth and development
Hygiene
Normal childbearing
Avoidance of risk factors: smoking and alcohol
Genetic influences on development of disease processes

Restoration of Health

Client's disease or condition: Anatomy and physiology of body system affected
Cause of disease
Origin of symptoms
Expected effects on other body systems
Prognosis
Expected duration of care
Methods of client participation in care
Rationale for treatment: Medications Tests and therapies Nursing measures Surgical intervention
Diet and activity changes
Hospital/ clinic environment
Hospital / clinic staff
Hospital / clinic policies and procedures
Community Referrals

Coping with Impaired Function

Home care: Medications, Diet, Activity, use of equipment/devices
Prevention of complications: Knowledge of risk factors
Implications of nonadherence with therapy/medications
Implications with adherence to therapy
Rehabilitation of remaining function: Physical therapy Occupational therapy
Support groups, self-help groups
Internet resources

NURSING PROCESS AND THE TEACHING - LEARNING PROCESS

A. **First level assessment:** Assess client's behaviors indicating unmet learning needs
   a. Assess behaviors indicating needs related to deficits in knowledge, skills, or attitudes/ values/ feelings
   b. Assess factors affecting client's ability and willingness to learn and content to be taught (health beliefs, cultural factors, desire to learn, attitudes about health care provider and patient roles, physical strength, sensory deficits, prior knowledge, reading level, developmental level, cognitive function, pain, anxiety, depression, grief).
   c. Assess available resources for instruction (apps, brochures, audiovisual materials, online resources)
   d. Assess the learning environment (noise, ventilation, room temperature, lighting, available equipment)
   e. Assess health literacy (the cognitive and social skills that determine the motivation and ability of individuals to gain access to, understand, and use information in ways that promote and maintain good health
   f. Assess for functional illiteracy (functional illiteracy is the inability to read above a fifth grade level)

B. **Second level stimuli**: Identify stimuli and factors that are related to the cognitive, affective and psychomotor knowledge and skill deficits
   a. Demographic variables: age, sex, race, socio-economic status, culture, education, geographic location, and community resources.
   b. Client's responses: beliefs, attitudes, abilities/ lack of abilities
   c. Illness variables: Severity, relief of symptoms, stage of illness
   d. Psycho-social variables: Intelligence, attitudes toward health, acceptance or denial of illness, threat to health, usual coping strategies, feelings, grieving

C. Nursing Diagnosis
   a. Identify and state nursing diagnoses that related to client learning needs
      i. Ineffective health maintenance
      ii. Impaired home maintenance
      iii. Ineffective family therapeutic regimen management
      iv. Ineffective self-health management
      v. Noncompliance (with medications)
   b. Specify content of knowledge, skill or coping deficits
   c. Specify the three domains of learning to classify the diagnosis
      i. Deficient knowledge (affective, cognitive, psychomotor)

D. Goal setting and planning (learning objectives)
   a. Actively involve client and/or family (when appropriate), identify and state goals related to stated diagnosis
   b. Specify expected client outcome behaviors, content, conditions, criteria and critical times for achievement of goal(s)
   c. Prioritize goals according to client needs, develop a deliberate plan for achieving goals
   d. Identify and specify content from simple to complex, concrete to abstract, familiar to unfamiliar
   e. Specify schedule for initial presentation and repetition of content
   f. Specify teaching strategies and methods for nurse and client
   g. Specify optimal learning environment conditions to meet goals
   h. Specify methods for evaluating the learning process and behavior change

E. Interventions

a. Active participation is key to learning. Persons learn better when more than one of the senses is stimulated. When conducting a discussion with a learner, an educator stays active by changing the tone and intensity of his or her voice, making eye contact, and using gestures that accentuate key points of discussion.
b. A teacher is more effective when presenting information that builds on a learner's existing knowledge. A patient quickly loses interest if a nurse begins with familiar information.
c. Incorporate teaching with nursing care – every action done by a nurse presents the opportunity to teach and is cost effective
d. Offer positive feedback, reinforcement and repetition
e. Match teaching methods to learner needs and style of learning
    i. In the participating approach, a nurse and patient set objectives and become involved in the learning process together.
    ii. The entrusting approach provides a patient the opportunity to manage self-care. The patient accepts responsibilities and performs tasks correctly and consistently.
f. Use the following guidelines for giving preparatory explanations:
    i. Describe physical sensations during a procedure.
    ii. Describe the cause of the sensation, preventing misinterpretation of the experience.
    iii. Prepare patients only for aspects of the experience that others have commonly noticed.
    iv. Be sure the patients know when the results will be available and who will give them the results of their tests and/or procedures.
g. Instructional methods:
    Demonstrations are most effective when learners first observe the teacher and then, during a return demonstration, have the chance to practice the skill.
    i. Be sure that the learner can see each step of the demonstration easily.
    ii. Assemble and organize the equipment.
    iii. Perform each step slowly and accurately in sequence while analyzing the knowledge and skills involved and allow the patient to handle the equipment.
    iv. Review the rationale and steps of the procedure.
    v. Encourage the patient to ask questions so he or she understands each step.
    vi. Judge proper speed and timing of the demonstration on the basis of the patient's cognitive abilities and anxiety level.
    vii. To demonstrate mastery of the skill, have the patient perform a return demonstration under the same conditions that will be experienced at home or in the place where the skill is to be performed.

    Analogies supplement verbal instruction with familiar images that make complex information more real and understandable. Follow these general principles when using analogies:
    i. Be familiar with the concept.
    ii. Know the patient's background, experience, and culture.
    iii. Keep the analogy simple and clear.

    Simulation is a useful technique for teaching problem solving, application, and independent thinking. During individual or group discussion you pose a pertinent problem or situation for patients to solve.
h. A learner who receives reinforcement before or after a desired learning behavior is likely to repeat the behavior. Effective teachers use positive reinforcement
i. Document teaching plan, client responses and behavior change

F. Evaluation

a. Evaluate by comparing client behaviors to goals and outcome criteria
    i. Teach back method
    ii. Return demonstration
b. Revise plan reflecting current needs, institute new strategies
c. Record revised plan and communicate to staff, client and family

DEFINE & DIFFERENTIATE COMPLIANCE & ADHERENCE

Compliance
Definition:
The act or process of completing or performing what is expected, desired, demanded, or proposed by another. To comply with coercion. A disposition to yield to others.

Synonyms:
Consent, conform, yield, submit, obey, obedience
Client attitudes / values: Client follows, performs as directed to behaviors

Adherence
The act, action or quality of adhering; to be consistent; to hold fast or stick by; to bind oneself to an observance.
An adherent is one who is a believer or advocate - who believes in the value of new behavior

Follower, believer, partisan, disciple

Client assumes an active role in altering health beliefs

GUIDE TO CLIENT TEACHING - LEARNING PROCESS

Assessment:

- Assess the client's readiness for health education
- What are his health beliefs and behaviors?
- What psychosocial adaptation is he making?
- Is he ready to learn?
    - Is he able to learn new/-changed behaviors?
    - What additional information about him is needed?
    - What are his expectations?

Nursing Diagnosis:

- Formulate the nursing diagnosis that related to the client's learning needs
    - Organize, analyze, synthesize, and summarize collected data.
    - Identify the client's learning problems, their characteristics and etiology
    - State nursing diagnosis concisely and precisely

Planning:

- Assign priority to the nursing diagnosis that relate to the client's learning needs
- Specify the nurse - client established learning goals
- Identify teaching strategies appropriate for goal attainment
- Establish outcome criteria
- Develop the written teaching - learning plan
    - Include diagnoses, goals, teaching strategies and outcome criteria
    - Put the information to be taught in logical sequence
    - Write down the key points
    - Select appropriate teaching aids and materials
    - Keep the plan current and flexible to meet the client's changing learning needs
- Involve the client, his family/ significant others and multidisciplinary health care team members in all aspects of planning

Implementation:

- Put the teaching plan into action
- Know the material to be presented
- Use language the client can understand
- Use appropriate teaching aids and materials
- Use the same equipment that the client will utilize after discharge
- Encourage the client to actively participate in learning
- Record the client's responses to the teaching - learning process

Evaluation:

- Collect objective data
- Observe the client/ family / significant others
- Ask questions to determine if understanding has occurred – Teach back method
- Use rating scales, checklists, anecdotal notes and written tests when appropriate
- Compare the client's behavioral outcomes to the outcome criteria
- Determine the extent to which the goals were achieved
- Include the client, family, significant others, and multidisciplinary health care team members in the evaluation
- Identify alterations that need to be made in the teaching - learning plan
- Make referrals to appropriate sources or agencies for reinforcement of learning after discharge
- Continue all steps of the teaching - learning process: assessment, planning, implementing, evaluating.

TEACHING - LEARNING PRINCIPLES

Timing:

- Teaching coincides with learner readiness, attentiveness and receptiveness
- Length and frequency of teaching- learning sessions related to learner's abilities, learning styles and complexity of material.
- Reinforcement- repetition experiences are part of the process

Organizing Teaching Materials:

- Begin with essential materials
- Develop written outline of teaching plan
- Go from simple to complex, familiar to unfamiliar, concrete to abstract, and part to whole

Maintaining Learner Attention and Participation:

- Use multiple senses for input of new knowledge, skills and attitudes
- Actively involve learner in the process as an active participant and doer
- Vary teaching behavior, gestures, voice and word patterns

Build on Existing Knowledge:

- Assess learner's knowledge, skills, attitudes, and build on preexisting conditions andbehaviors

Reinforce Learning with Rewards:

- Use positive rewards to stimulate desired behaviors and increase their probability of occurring
- Rewards can be material, social or action – activity

Match Teaching Methods with Learner Needs:

- Match type of learning deficit to teaching strategy
- Match by domain:
    - Cognitive /intellectual: discussion, questioning, lecture, etc.
    - Psychomotor: demonstration and skill practice
    - Affective: sharing, group discussion, interpersonal therapy

COMPARISON OF NURSING PROCESS & TEACHING - LEARNING PROCESS

Steps	Nursing Process	Teaching-Learning Process
Assessment	Identify client's physical, psychological, social, socio cultural, developmental and spiritual needs. Sources of data are the client, family, diagnostic tests, medical record, nursing history and literature.	Identify the client's learning needs, willingness to learn, ability to learn and teaching resources. Sources of data are the client, family, learning environment, medical record, nursing history and literature.
Diagnosis	Identify appropriate nursing diagnosis.	Identify client's learning needs on the bases of the three domains of learning.
Planning	Develop an individualized plan of care. Set diagnosis priorities on the basis of client's immediate needs. Nurse and client collaborate on plan of care.	Establish learning objective, stated in behavioral terms. Identify priorities regarding client's learning needs. Nurse and client collaborate on teaching plan. Identify type of teaching method to use.
Implementation	Performa nursing care therapies. Include client as active participant in care. Involve family in client's care as appropriate.	Implement teaching - learning methods. Actively involve client in learning activities. Include family participation as appropriate.
Evaluation	Identify success in meeting desired outcomes of nursing care.	Determine outcomes of teaching - learning process. Measure client's ability to achieve learning objective.

DOMAINS OF LEARNING

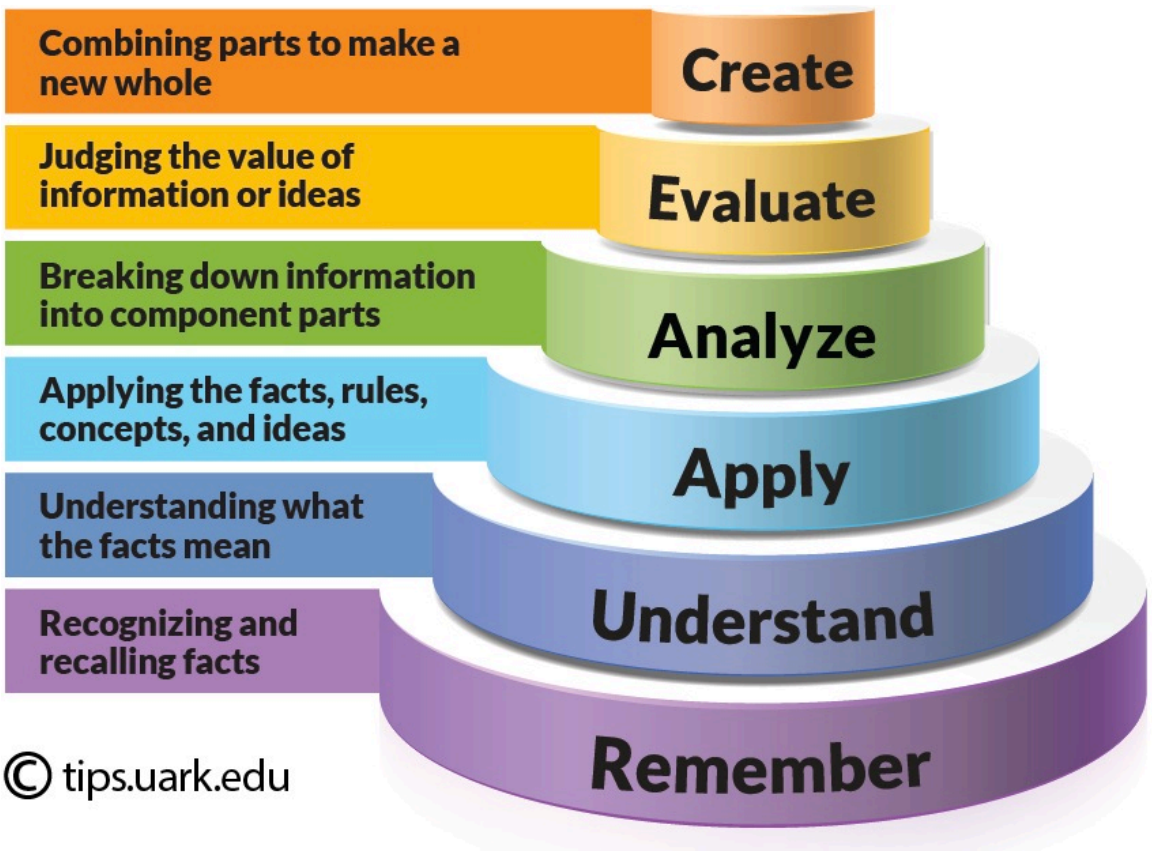
Cognitive Domain	Includes all intellectual behaviors and requires thinking
Affective Domain	Deals with expression of feelings and acceptance of attitudes, opinions, or values
Psychomotor Domain	Involves acquiring skills that require coordination and integration of mental and physical movements

COGNITIVE LEARNING

Bloom's Taxonomy

Bloom's Taxonomy is a classification of the different objectives and skills that educators set for their students (learning objectives). Benjamin Bloom, an educational psychologist at the University of Chicago, proposed the taxonomy in 1956. The terminology has been recently updated to include the following six levels of learning. These 6 levels can be used to structure your learning objectives for the in class assignment.

a. **Remembering**: Learning new facts or information and being able to recall them.
b. **Understanding**: Ability to understand the meaning of learned material.
c. **Applying**: Using abstract, newly learned ideas in an actual situation.
d. **Analyzing**: Breaking down information into organized parts.
e. Evaluating: Ability to judge the value of something for a given purpose.
f. **Creating**: Ability to apply knowledge and skills to create something new.



AFFECTIVE LEARNING

Affective learning deals with expression of feelings and development of values, attitudes, and beliefs. Affective learning includes the following:

a. **Receiving**: Learner is passive and needs only to pay attention and receive information.
b. **Responding**: Requires active participation through listening and reacting verbally and nonverbally.
c. **Valuing**: Attaching worth and value to the acquired knowledge as demonstrated by the learner's behavior.
d. **Organizing**: Developing a value system by identifying and organizing values according to their worth.
e. **Characterizing**: Acting and responding with a consistent value system; requires introspection and self-examination of one's own values in relation to an ethical issue or particular experience.

PSYCHOMOTOR LEARNING

Psychomotor learning involves acquiring motor skills that require coordination and the integration of mental and physical movements such as the ability to walk or use an eating utensil. Psychomotor learning includes the following:

a. **Perception**: Being aware of objects or qualities through the use of sensory stimulation.
b. **Set**: Readiness to take a particular action; there are three sets: mental, physical, and emotional.
c. **Guided response**: Early stages of learning a particular skill under the guidance of an instructor that involves imitation and practice of a demonstrated act.
d. **Mechanism**: Higher level of behavior in which a person gains confidence and proficiency in performing a skill that is more complex or involves several more steps than a guided response.
e. **Complex overt response**: Smoothly and accurately performing a motor skill that requires complex movement patterns.
f. **Adaptation**: Motor skills are well developed and movements can be modified when unexpected problems occur.
g. **Origination**: Using existing psychomotor skills to create new movement patterns and perform them as needed in response to a particular situation or problem.

Teaching Methods Based on Domains of Learning	
Cognitive Domain	Discussion (one on one or group) Active participation, peer support, application/ analysis Lecture More formal, educator controlled Question and answer session Helps patient apply/analyze new knowledge Role play (discovery) Active knowledge, problem solving, insight Independent project (computer assisted, field experience) Can acquire at own pace
Affective Domain	Role play Allows expression of emotions (values, feelings, attitudes) Discussion Peer emotional support Helps patient learn from another patient's experience Promotes responding, valuing, internalizing
Psychomotor Domain	Demonstration of skill by expert Step by step guidance Practice involving repetition and guidance Return demonstration with observation and feedback Independent project (games)

TEACHING-LEARNING ASSIGNMENT
(20 points)

1. The health care provider has ordered teaching on relaxation techniques/stress reduction for your patient twice daily.

2. Research an evidence-based relaxation or stress management technique.

3. Prepare a 10-15 minute teaching/learning experience. Practice your teaching of the selected relaxation/stress-management technique and prepare to teach your peer this technique in class.
   Research and teach:
   a.) The potential physiologic negative health effects of stress on the body
   b.) Physiology of relaxation techniques (how relaxation techniques physiologically affect the nervous system)
   c). The evidence-based relaxation technique

4. Review the form "Patient Teaching Flow Sheet" above and be prepared to complete this form in class on the day of teaching. Fill in what you can from the preparation phase before class. You can make up the assessment data with your partner with the goal of familiarizing yourself with the document.

5. You will be responsible to complete a focus note on your teaching. Please research the definition of a focus note and samples if you are not familiar with this documentation style (DAR, AIE, etc.).

6. Prepare for a peer evaluation. You will need to describe strengths in the teaching process as well as suggestions for improvement. Remember this is a learning process. You do not need to be perfect. Gentle and helpful constructive criticism can be of great benefit during this process.

7. Submit your "Patient Teaching Documentation" for credit. You are the "teacher" and your partner is the "learner".

Unit C/D OBJECTIVES

Description:

In Unit C, material is presented to assist the student in developing cultural awareness. Elements related to transcultural nursing are explored in order to promote skills needed to provide culturally congruent care. Unit D presents the basic concepts of group dynamics. Factors that enhance and factors that inhibit group processes are explored. Nursing communication in the group setting is emphasized.

Estimated time of achievement: Two weeks.

Objectives	Course Content	Learning Activities
1. Define and differentiate culture, ethnicity, race, emic worldview, etic worldview, enculturation, acculturation, assimilation, multiculturalism. 2. Define health disparities and factors that contribute to health disparity. 3. Explore population, ethnic and cultural statistics of Los Angeles County. 4. Describe how health disparities affect quality of care for patients of diverse backgrounds. 5. Explore considerations in communication and culture (patterns or communication, personal space, social organization, cultural healers) 6. Describe steps toward cultural competence. 7. Differentiate between culturally congruent care and cultural competence. 8. Describe the CLAS standards and why they were developed. 9. Explore the effects of immigration, acculturation and language barriers on health status and quality of care. 10. Describe the impact of culture on health care decisions. 11. Explore cultural healers and healing modalities. 12. Utilize cultural assessment to identify significant values, beliefs, and practices. 13. Discuss the difference between spirituality and religion.	**Cultural Awareness** Cultural concepts Intersectionality Oppression Health disparities Cultural competence Culturally congruent care Communication and culture Transcultural nursing World View Cultural healing modalities and healers Culture-Bound syndromes Culture and Life Transitions (pregnancy, childbirth, newborn, postpartum, grief and loss) Cultural Assessment (Ethnic heritage and ethnohistory, social organization, bicultural effects on health, social organization socioeconomic status, religious and spiritual beliefs, bicultural ecology and health risks, language and communication patterns, time orientation, caring beliefs and practices) CLAS standards Linguistic competence Health literacy Core Measures Quality Improvement Spiritual Assessment Spirituality vs. Religion Spiritual Distress	**Potter & Perry** Chapter 9 – pages 101-115 Group Process- read syllabus material Discussion/Lecture Cultural Awareness Group Presentation Group participation – Group Dynamics Group Exercise

14. Identify how one's own cultural and spiritual heritage can affect attitudes in providing nursing care. 15. Define core measures and quality improvement. 16. Describe how core measures affect health care disparities and quality improvement in healthcare. 17. Differentiate spirituality and religion. 18. Identify 4 stimuli and 4 interventions used to treat spiritual distress. **Unit D** 1. Define a group, group goal, group task, and group dynamics. 2. Give examples of at least 5 types of groups and differentiate one from another. 3. Identify 8 examples of dominative roles. 4. Identify 15 examples of democratic roles. 5. Define and differentiate a "Healthy" group from a "Sick" group. 6. Identify specific behaviors of a healthy group. 7. Identify specific behaviors of a sick group. 8. Identify conditions that contribute to group productivity. 9. State behaviors that add to a group's productivity. 10. State behaviors that detract from a group's productivity. 11. Identify principles that contribute to establishment and maintenance of a satisfying group. 12. State behaviors that would add to member satisfaction. 13. State behaviors that would detract from member satisfaction. 14. State behaviors that characterize an effective group and that facilitate the performance of members. 15. Identify stages of team development 16. Practice ISBAR and CUS team communication techniques.	**Unit D** **Group Process** Group definitions and types work group, educational group, governing group, religious group, treatment group, support group, community group, self-help group Dominative roles Aggressor, blocker, recognition-seeker, dodger, dominator, help-seeker, special interest pleader, blamer Democratic Roles Initiator, orientor, facilitator, encourager, harmonizer, summarizer, fact seeker, fact giver, compromiser, expeditor, spokesman, status role, recorder, evaluator, analyzer Behaviors of healthy groups Behaviors of sick groups Conditions contributing to group productivity Principles that contribute to group satisfaction Tuckman's Five Stages in Group Development: Forming, Storming, Norming, Performing, and Adjourning ISBAR multidisciplinary communication technique CUS multidisciplinary communication technique	

Unit C: CULTURAL AWARENESS

Understanding Cultural Concepts

Culture: Thoughts, communications, actions, customs, beliefs, and institution of racial, ethnic, religious, or social groups.	**Ethnicity:** A shared identity related to social and cultural heritage such as values, language, geographical space	**Race:** is limited to the common biological attributes shared by a group such as skin color.
Emic Worldview: The insider, or native, perspective.	**Etic Worldview:** An outsider's perspective.	**Enculturation:** Socialization into one's primary culture as a child.
Acculturation: The process of adapting to and adopting a new culture.	**Assimilation:** Results in varying degrees of affiliation with the dominant culture.	**Multiculturalism:** occurs when an individual identifies equally with two or more cultures.

Self-Assessment Tools

Completing the activities below is an essential part of your learning. It is designed to assist you in identifying your own cultural and spiritual heritage and beliefs.

This section is for YOUR USE ONLY.

It is NOT to be turned in.

Assessing Your Own Cultural Heritage

The culture in which we are raised greatly influences our attitudes, beliefs, values, and behaviors. Our families taught us how to believe about and treat people who were different that we are. In order to provide sensitive and effective care to persons from cultures that are different from our own, two things must occur:

1. An awareness of one's own cultural values and beliefs and recognition of how they influence our attitudes and behaviors.
2. An understanding of the cultural beliefs and values of others and how they are influenced by them.

There are NO right or wrong answers to these questions; however it is important to answer them honestly and completely to facilitate self-awareness. These exercises are for your personal use. They are NOT to be shared with or turned into anyone else. The following exercises will help you clarify your attitudes and beliefs and how these influence your ability to work with people from diverse cultural backgrounds.

Getting in Touch with Your Own Social Identity

Identifying Your Social Roles
1. Circle the items in each of the four columns that best describe you.
2. Place a check mark by the items you circled that seem to be the most important or significant for any reason to you at this time in your life.

A	B	C	D	E
Lower socioeconomic class Middle socioeconomic class Upper socioeconomic class Militant Radical Liberal Moderate Conservative Reactionary Indifferent Apathetic Republican Democrat Independent Other: _____	American Asian European Black African-American Hispanic Latino Caucasian Latin-American Asian-American Middle Eastern Multiracial or mixed Native American Pacific Islander White Other: _____	Female Male Other_____ Married In a relationship Single Separated Divorced Wife Husband Partner Significant Other Mother Father Step-parent Son Daughter Godparent Grandmother Grandfather Aunt Uncle Brother Sister Other: _____	Business person White-collar Professional Technical Blue-collar Skilled Student Service provider Laborer Other:_____	Christian Jewish Buddhist Baha'i Confucians Muslim Hindu Shintoism Sikh Agnostic Atheist Other: _____

How Do You Relate to Various Groups of People in the Society?

Described below are different levels of response you might have toward a person.

Levels of Response:

1. **Greet:** I feel I can greet this person warmly and welcome him or her sincerely.
2. **Advocate:** I feel I could honestly be an advocate for this person that he or she be treated with dignity and respect by the whole healthcare team.
3. **Accept:** I feel I can honestly accept this person as he or she is and be comfortable enough to listen to his or her problems.

The following is a list of individuals. Read down the list and place a check mark by anyone you believe you would be able to "greet". Then move to response level 2 and place a check mark by those who believe you could be an "advocate" for. Then move to response level 3 and place a check mark by those you believe you could "accept." Try to respond honestly, not as you think might be socially or professionally desirable. Your answers are only for your personal use in clarifying your initial reactions to different people.

Individual who is a:	Greet	Advocate	Accept
Child abuser			
White American			
White supremacist			
Street drug user			
Hispanic/Latino person			
Senile, elderly person			
Native American			
Capital punishment supporter			
Jehovah's Witness			
Blind person			
Asian American			
Abortion provider			
Lesbian/Gay/Bisexual			
Transgender			
Atheist			
Person with AIDS			
Rapist			
Unmarried pregnant teenager			
Murderer			
Black/African American			
Christian			
Jewish person			
Political refugee			
Person with cancer			
Pro-life advocate			
Muslim person			
Gun rights advocate			
Person in wheelchair			
Arab American			
Person with mental illness			

Scoring Guide: Now, transfer your checks from the above activity to the form below. The thirty types of individuals can be grouped into five categories as listed. If you have a lot of checks within one specific category, this may indicate a difficulty you may have in being sensitive to these types of individuals.

Level of Response	Greet	Advocate	Accept
Ethnic/Racial Issues			
Hispanic/Latino			
Native American			
Asian American			
Black/African American			
White American			
White supremacist			
Arab American			
Social Issues			
Child abuser			
Lesbian/Gay/Bisexual			
Transgender			
Street drug user			
Rapist			
Unmarried pregnant teenager			
Murderer			
Religious Issues			
Atheist			
Jehovah's Witness			
Christian person			
Muslim person			
Jewish person			
Disability Issues			
Senile, elderly person			
Person with cancer			
Person with AIDS			
Person in wheelchair			
Blind person			
Person with mental illness			
Political Issues			
Abortion provider			
Pro-life advocate			
Gun rights advocate			
Capital punishment supporter			
Political refugee			

Hopefully in completing these exercises, you've given some thought to your beliefs and the traditions that are important to you. Remember, there are NO right or wrong answers. Recognizing and acknowledging your personal cultural and spiritual background is an essential first step to sharpening your sensitivity skills in working with others.

Broad Comparison of Cultural Aspects

Aspects of Culture Mainstream American	Aspects of Culture Mainstream American	Other Cultures
Sense of self and space	Informal, handshake	Formal, bows, handshakes
Communication and language	Explicit, direct. Emphasis on content – meaning found in words	Implicit, indirect. Emphasis on context --- meaning found around words
Dress and appearance	"Dress for success" ideal. Wide range in accepted dress	Dress seen as a sign of position, wealth, prestige. Religious rules
Food and eating habits	Eating as a necessity – fast food	Dining as a social experience. Religious rules
Time and time consciousness	Linear and exact time consciousness. Value on promptness. Time = money	Elastic and relative time consciousness. Time spent on enjoyment of relationships
Relationships, family, friends	Focus on nuclear family. Responsibility for self. Value on youth, age seen as handicap	Focus on extended family. Loyalty and responsibility to family. Age given status and respect
Values and norms	Individual orientation. Independence preference for direct confrontation of conflict	Group orientation. Conformity. Preference for harmony.
Beliefs and attitudes	Egalitarian. Challenging of authority. Individuals control their destiny. Gender equality.	Hierarchical. Respect for authority and social order. Individuals accept their destiny. Different roles for men and women.
Mental processes and learning	Linear, logical, sequential, problem-solving focus.	Lateral, holistic, simultaneous. Accepting of life's difficulties.
Work habits and practices	Emphasis on task. Reward based on individual achievement. Work has intrinsic value.	Emphasis on relationships. Rewards based on seniority, relationships. Work is a necessity of life.

"Ask not what disease the person has, but rather what person the disease has."
- William Osler

CROSS-CULTURAL HOOKS

Another way to help get beyond irritations you may feel when encountering cultural differences is to identify the specific behaviors that bother you and then look deeper to understand the cultural programming that underlies them. Using the following cross-cultural hook list will help you do that.

- ❒ Discounting or refusing to deal with women
- ❒ Speaking in a language other than English
- ❒ Bringing whole family/children to appointments
- ❒ Refusal to shake hands with women
- ❒ No nonverbal feedback (lack of facial expression, nodding, etc.)
- ❒ No eye contact
- ❒ Soft "dead fish" handshake
- ❒ Standing too close when talking
- ❒ Heavy accent or limited English facility
- ❒ Coming late to appointments
- ❒ Withholding or not volunteering necessary information
- ❒ Not taking initiative to ask questions
- ❒ Calling/not calling you by your first name
- ❒ Emphasizing formal tittles in addressing people
- ❒ Other _____

Cultural insensitivity is usually not intentional. It is, rather, caused by not having the knowledge we need to understand another person's frame of reference. Sometimes our insensitivity is a result of our fear of the unknown or of something new, or we try to deny that there are differences by viewing everyone as the same. At other times, our insensitivity is simply due to time constraints: we have too much to do and feel pressured to complete our tasks and move on to the next patient who is waiting. When we are culturally insensitive, misunderstandings can result between the patient and/or family's expectations and ours. Miscommunication can occur. It becomes difficult for us to provide the best and most appropriate care.

Cultures vary in their beliefs of the prevention, cause, and treatment of illness as well as in their understandings of the processes of life and death. These beliefs dictate the practices used to maintain health and to prepare for and experience the processes of life, including pregnancy, birth, postpartum, infant care, illness and death.

Too often we interpret the behaviors of others as negative because we don't understand the underlying value system of their culture. It is a natural tendency for us to assume that our own values and customs are more sensible and right. It is necessary, then, for us to become aware of the cultural assumptions from which we develop our judgments. This is the first step to becoming more culturally sensitive.

Providers of health care and patients often begin their relationship separated by a huge cultural gap. As providers, we are socialized into the atmosphere of the medical profession, with a set of beliefs, practices, habits, likes, norms and rituals. These are all factors that comprise a given culture. We speak a different language filled with medical terminology, and our understanding and beliefs regarding health and illness can differ greatly from the population we serve.

Beliefs	a) Standardize definitions of health and illness b) The omnipotence of technology
Practices	a) Maintenance of health and prevention of disease via mechanisms such as the avoidance of stress and the use of immunizations b) Annual physical examinations and diagnostic procedures such as Pap smears, colonoscopies, mammograms
Habits	a) Documentation b) Constant use of medical jargon c) Use of a systematic approach and problem solving methodology
Likes	a) Promptness b) Neatness and organization c) Compliance
Dislikes	a) Tardiness b) Disorderliness and disorganization
Customs	a) Professional deference and adherence to the "pecking order" found in autocratic and bureaucratic systems b) Hand washing c) Employment of certain procedures attending birth and death
Rituals	a) Physical examination b) Surgical procedure c) Limiting visitors and visiting hours

Western medicine, by its very nature, often treats patients as though they were objects or machines to be put back into "proper working order" or which fail. Patients who are hospitalized, as well as their families, are removed from their own lives and life stories and taken from their familiar homes into the strange and often fearful world of the hospital. Numerous different people come into their rooms uninvited to treat them.

We don't become culturally sensitive or competent overnight. It is a process that takes time, attention and self-awareness. Unless we can identify and then step outside our own framework, it can be difficult for us to understand another's point of view.

Cultural competence can and should occur in both individuals and organizations. It is the state of being capable of functioning effectively in the midst of cultural differences. It is being sensitive not to impose our personal values on someone else because they are different. It is the ability to establish relationships with people in the midst of diversity. It is celebrating differences, the recognition of similarities, and a clear commitment to seeing differences as differences and not deficits.

Being culturally competent does not mean knowing everything about every culture. It is instead a respect for differences, eagerness to learn, and a willingness to accept that there are many ways of viewing the world.

Foundations of Cross Cultural Understanding

All people are more alike than different. Though the human brain notices differences more quickly than it recognizes similarities, the nature of the human experience guarantees that all people have a vast store of common qualities, experiences, attributes, and beliefs.

The largest variable that affects society is that of individual variance. Within any designated group, the full spectrum of possible expressions and experience exists.

Within any identifiable group of people there is more diversity than between all groups of people. We tend to obscure the vast degree of diversity that exists between members of a group to which we can give a label. Generalizations can lead to stereotyping, which can greatly hinder understanding.

Our own cultural identity filters our perceptions of the world. The integral nature of culture affects all our observations and expressions. The first phase of understanding is recognition of our own cultural identity, and assessment of the unconscious effects of culture that constantly influence our behaviors and attitudes.

We must search for descriptive words that do not communicate value judgments. Words like *strange*, *weird*, *unclean*, *primitive*, *underdeveloped*, *savage* suggest inferior value, status, and a lack of respect. Because group or individual differences do not mean on is better that the other we must avoid using words that communicate any sense of net worth.

It is important to use precise language, rather than general or vague words that may cause miscommunications. Often conditional statements are more accurate than absolute ones. Phrases like "some people of this culture," or "in the past" can clarify examples and guard against the construction of stereotypes.

Our beliefs, behaviors, and attitudes are greatly influenced by faulty historical "truths." Scientists, theologians, historians, and philosophers have at times delivered interpretations as "fact" to establish the superiority of one group of people over all others. We must evaluate our beliefs with open minds to remove any vestiges of these prejudices.

Multicultural Health Care Tips

- Don’t treat others as YOU would want to be treated.
- Try to learn how THEY want to be treated. What is viewed as polite, caring, quality health care in one culture may be considered rude, uncaring, or even evidence of poor standards of care in another.
- Address all adult patients from other cultures by their last name (surname) unless specifically asked to use a first name.
- Most other cultures are more formal than American culture and many people who were born and brought up in another cultural environment consider it a lack of respect to address others (or be addressed) by their first names.
- Mind your tone of voice.
- When speaking to a patient who seems to have a limited knowledge of English, don’t shout! Remember the patient is hard of understanding, not hearing. Speak slowly and softly. Try to avoid words and expressions that are dependent upon one’s knowledge and familiarity with American life and culture.
- You can help improve a person’s comprehension of what you are saying by repeating it several times in different ways and using gestures, pictures and other non-verbal forms of communication.
- Every culture has its own rules for touching and distance. When either you or the

other person breaks any of these rules, the other will feel uncomfortable. For example: Americans often feel uncomfortable when someone stands less than three feet away from them, while most people from the Middle East need to stand almost nose to nose with the person to whom they are speaking. Traditional Koreans believe that the soul rests in the head and may become uncomfortable, even fearful if a provider or staff member pats their child on the head or ruffles his or her hair.

- Don't ask a limited English-speaking patient or family member: "Do you understand?" If the patient nods his or her head or answers "yes" to your question, it only means that the patient has heard you, not that he/she has understood your question and agrees with your diagnosis or plan of treatment. Try to ask questions beginning with the words "when, where, why, how". Then listen carefully to the answer for clues to the patient's degree of understanding or real agreement. You can also check understanding by and agreement by asking the patient to repeat to you, step by step, exactly what you have said.
- Patient and family compliance with treatment is heavily dependent upon the 'fit' of the treatment plan with the patient's lifestyle and eating habits.
- Informed consent forms and regulations can be extremely upsetting and frightening. For patients and families who believe that talking about an event may make the event take place or for those whose conceptual framework does not include the concept of "what if..." Anyone administering the consent form should patiently and completely explain each procedure and each form as well as the likelihood of a negative outcome.

SPIRITUALITY

- Can be both religious and non-religious
- Expresses a source of meaning, connectedness and hope
- Beliefs, values, and situations all play an important role in forming one's spirituality
- Each person's spirituality is important

Spirituality involves finding meaning and purpose in one's life and experiences. It encompasses a person's philosophy of life and worldview. Spirituality is expressed through concepts and ideas about God/the Deity/Higher Power, one's sacred beliefs, and one's religious rituals or practices. There is a significant difference between spirituality and religion:

SPIRITUALITY refers to our inner belief system. It is a delicate 'spirit-to-spirit' relationship to oneself, others, and the God of one's understanding.
Everyone is a SPIRITUAL being.

R**ELIGION** refers to the externals of our belief system: church, prayers, traditions, rites, rituals, etc.
Not everyone is RELIGIOUS.

Sensitivity to spiritual issues and the inclusion of spiritual care is an essential and necessary component in patient care and family support.

FICA Spiritual Assessment

The acronym "FICA" can help structure questions when taking a spiritual history.
F: Faith, Belief, Meaning *"Do you consider yourself spiritual or religious?"* *"Do you have spiritual beliefs that help you cope with stress?"* *If the patient responds, "no," ask, "What gives your life meaning?"*
I: Importance and Influence "*What importance does your faith or belief have in your life?"* *"Have your beliefs influenced you in how you handle stress?"* *"Do you have specific beliefs that might influence your healthcare decisions?"*
C: Community *"Are you a part of a spiritual or religious community?"* *"Is this of support to you and how?"* *"Is there a group of people you really love or who are important to you?"* Communities such as churches, temples, and mosques can serve as strong support systems for some patients.
A: Address/Action in Care *"How should the healthcare provider address these issues in your healthcare?"* Referral to chaplains, clergy, and other spiritual care providers.

FICA Spiritual Assessment provided courtesy of Christina Puchalski MD, George Washington Institute for Spirituality in Health

UNIT D

GROUP: Defined

- "A number of individuals assembled together or having common interests" (Webster)

- A group has been defined as a number of persons engaged in interaction with one another in a single face-to-face meeting or a series of meetings, in which each member receives some impression or perception of each other.
    - Each member is distinct enough so that he can, either at the time or in later questioning, give some reaction to each of the others as an individual person.
    - Each person must also hold that every other person's presence and interaction were necessary for the satisfaction of the individual needs of each member.
    - There must be some collective perceptions of unity in the group and it must have some ability to act in some collective manner toward its perceived needs and goals.
- A group may be broadly defined as two or more people coming together to interact and influence each other and recognized in some special way because of the interaction. With such a broad definition a large number of different types of groups could be listed. Some examples include:
    - Work Group: where individuals come together to work on a project or produce a product, such as factory workers, office worker, research team, decoration committee, etc.
    - Social Group: where individuals are organized and oriented toward social activities, such as bowling club, bridge club, tennis club, etc.
    - Educational Group: where educational material is presented and discussed, such as school classes, seminars, science clubs, etc.
    - Religious Group: where individuals have the same system of beliefs, practices, ethical values, etc., such as community of monks, community of nuns, church clubs, etc.
    - Treatment Group: where individuals come together to obtain help for a physical, social, or emotional problem, such as, physical therapy group, counseling group, group therapy, etc.
    - Support or Self-Help Group: where individuals who share a common problem come together to ventilate feelings, reflect on actions and evaluate possible future actions to maintain their integrity, such as Al-Anon, Alcoholics Anonymous, National Alliance on Mental Illness, Cancer survivor groups, grief groups, care-taker support groups, etc.
    - Community Group: where individuals come together to plan community activities, resolve community issues, and establish community regulations.
    - Governing Group: where elected or appointed individuals come together to gather data, listen to testimony, consult with authorities, and formulate public policy and establish rules and laws.

Roles Assumed by Group Participants

1. **DOMINATIVE ROLES** (Person takes power from group members; self-interests are prime)
   a) **Aggressor:** The person who threatens or attacks the status of others; who disapproves the acts, feelings or values of others. He controls by fear. An aggressor exhibits negative behaviors such as putting others' ideas down, attacking others personally when they feel confronted or insecure, competing unnecessarily to "win" at the expense of others within the group, and being outspoken to the point of distraction. An aggressor's behaviors can quickly cross the fine line between being abrasive or dominant and being unethical. For example, a person vigorously defending a position that is relevant and valid is different from a person who claims others' ideas are stupid but has nothing to contribute. As with most behaviors, the aggressor's fall into a continuum based on their intensity. On the more benign end of the continuum is assertive behavior, toward the middle is aggressive behavior, and on the unethical side is bullying behavior. At their worst, an aggressor's behaviors can lead to shouting matches or even physical violence within a group. Establishing group rules and norms that set up a safe climate for discussion and include mechanisms for temporarily or permanently removing a group member who violates that safe space may proactively prevent such behaviors. "Playing desert survival is the dumbest idea I've ever heard."

   b) **Blocker:** The negativistic person who opposes beyond reason or attempts to block any action the group desires to take. He attempts to set groups against each other. The blocker intentionally or unintentionally keeps things from getting done in the group. Intentionally, a person may suggest that the group look into a matter further or explore another option before making a final decision even though the group has already thoroughly considered the matter. They may cite a procedural rule or suggest that input be sought from additional people in order to delay progress. Behaviors that lead to more information gathering can be good for the group, but when they are unnecessary they are blocking behaviors. Unintentionally, a group member may set blocking behaviors into motion by missing a meeting or not getting his or her work done on time. People can also block progress by playing the airhead role. An airhead skirts his or her responsibilities by claiming ignorance when he or she actually understands or intentionally performs poorly on a task so the other group members question his or her intellectual abilities to handle other tasks. "I refuse to play Desert Survival."

   c) **Recognition-seeker:** The person who attempts to direct attention toward himself by boasting or claiming long experience of great accomplishments. He or she answer, repeats, or relays statements of others. The recognition-seeker maintains social barriers and class distinctions. This person remains aloof and expects special considerations.

   d) **Dodger/Playboy/Playgirl:** This person displays a lack of involvement in the group process by horseplay, cynicism, or lack of interest. He or she refuses to do their part and attempts to get others to do the work.

   e) **Dominator:** The person who attempts to show authority or superior judgment or who tries to manipulate certain members by flattery, threats, or conditional promises. The dominator seeks control of the group by giving directions authoritatively, interrupting the

contributions of others and may demand that requests flow through his or her hands. "I'm going to tell you the six reasons why this is a bad idea."

f) **Help-seeker:** The person who plays for sympathy and uses the group to meet his own needs only. He or she comes to the group with requests for help and refuses to participate or leaves the group when the group is focused on other activities or persons. Acts helpless to avoid work "I don't think I can put together a bibliography. Why don't you do it for me?"

g) **Special interest Pleader:** The person who pleads for some special interest, often offering to "let you get yours later if you let me get mine now." The special interest pleader is someone who always has a secondary agenda within a group. A special interest pleader pleads on behalf of a specific group (e.g., small businesses, labor, gender, race, etc.…), but is "usually cloaking his or her own prejudices or biases in the stereotype which best fits their individual need"

h) **Blamer:** The person who blames himself for his difficulties and shortcomings and always excuses himself.

i) **Monopolizer:** The monopolizer is a group member who makes excessive verbal contributions, preventing equal participation by other group members. In short, monopolizers like to hear the sound of their own voice and do not follow typical norms for conversational turn taking. There are some people who are well informed, charismatic, and competent communicators who can get away with impromptu lectures and long stories, but monopolizers do not possess the magnetic qualities of such people. A group member's excessive verbal contributions are more likely to be labeled as monopolizing when they are not related to the task or when they provide unnecessary or redundant elaboration. Some monopolizers do not intentionally speak for longer than they should. Instead, they think they are making a genuine contribution to the group. These folks likely lack sensitivity to nonverbal cues, or they would see that other group members are tired of listening or annoyed. Other monopolizers just like to talk and don't care what others think. Some may be trying to make up for a lack of knowledge or experience. This type of monopolizer is best described as a dilettante, or an amateur who tries to pass himself or herself off as an expert.

2. **DEMOCRATIC ROLES** (Person who facilitates member's / group's functioning).

1. **Initiator:** The person who suggests new activities, new ideas, changing direction, suggesting procedures and even discussion of new problems. This person understands the values, attitudes and needs of the group and is able to outline objectives based upon them. Accepting the role of "change- agent", the initiator provides new energy and ideas. "How would it work if…..? What would happen if……?

2. **Orientor:** The person who seeks to have the group define its goals, outline its activities, and determine the direction the discussion is taking with respect to its goals. The orientor verifies the facts, actions and interprets the experiences of others. This person may call the group to return to the subject at hand.

3. **Facilitator:** The person who keeps communication channels open by asking for a restatement, a definition of terms or a summary. The facilitator sets out to determine the abilities and experiences of each member, and sees that everyone in the group knows about these particular skills. This person realizes that mere introductions seldom furnish enough information. He or she knows that a permissive atmosphere encourages participation and hinders filibustering. The facilitator asks that action proceed promptly.

4. **Encourager:** The person who stimulates others to greater activity by giving them approval, encouragement and recognition for the part they play. The encourager often invites individuals to participate and offers to help those who are slow. He or she provides positive feedback "I think what Heather was saying was totally right."

5. **Harmonizer:** Group members who help manage the various types of group conflict that emerges during group communication play the harmonizer role. They keep their eyes and ears open for signs of conflict among group members and ideally intervene before it escalates. For example, the harmonizer may sense that one group member's critique of another member's idea wasn't received positively, and he or she may be able to rephrase the critique in a more constructive way, which can help diminish the other group member's defensiveness. Harmonizers also deescalate conflict once it has already started—for example, by suggesting that the group take a break and then mediating between group members in a side conversation. These actions can help prevent conflict from spilling over into other group interactions. In cases where the whole group experiences conflict, the harmonizer may help lead the group in perception-checking discussions that help members see an issue from multiple perspectives. For a harmonizer to be effective, it's important that he or she be viewed as impartial and committed to the group as a whole rather than to one side of an issue or one person or faction within the larger group. A special kind of harmonizer that helps manage cultural differences within the group is the interpreter.

6. **Gatekeeper:** The gatekeeper manages the flow of conversation in a group in order to achieve an appropriate balance so that all group members get to participate in a meaningful way. The gatekeeper may prompt others to provide information by saying something like "Let's each share one idea we have for a movie to show during Black History Month." He or she may also help correct an imbalance between members who have provided much information already and members who have been quiet by saying something like "Aretha, we've heard a lot from you today. Let's hear from someone else. Beau, what are your thoughts on Aretha's suggestion?" Gatekeepers should be cautious about "calling people out" or at least making them feel that way. Instead of scolding someone for not participating, they should be invitational and ask a member to contribute to something specific instead of just asking if they have anything to add. Since gatekeepers make group members feel included, they also service the relational aspects of the group.

7. **Summarizer:** The person who pulls the ideas together in order to show the relationships and who suggests how they might work out in practice. Puts contributions into a pattern without adding any information. This role is particularly important if the group gets stuck. "If we take all these pieces and put them together…. Here are our areas of disagreement….Here's what we have agreed upon thus far…"

8. **Fact seeker:** The fact seeker asks for more information, elaboration, or clarification on items relevant to the group's task. The information sought may include factual information or group member opinions. In general, information seekers ask questions for clarification, but they can also ask questions that help provide an important evaluative function. Most groups could benefit from more critically oriented information-seeking behaviors. Critical questioning helps increase the quality of ideas and group outcomes. By asking for more information, people have to defend (in a non-adversarial way) and/or support their claims, which can help ensure that the information being discussed is credible, relevant, and thoroughly considered. When information seeking or questioning occurs as a result of poor

listening skills, it risks negatively impacting the group. Skilled information providers and seekers are also good active listeners. They increase all group members' knowledge when they paraphrase and ask clarifying questions about the information presented. "Could you say a little more about…..? What other facts do we have to consider? What action are we going to take with this new information?"

9. **Fact giver:** The role of fact giver includes behaviors that are more evenly shared than in other roles, as ideally, all group members present new ideas, initiate discussions of new topics, and contribute their own relevant knowledge and experiences. When group members are brought together because they each have different types of information, early group meetings may consist of group members taking turns briefing each other on their area of expertise. In other situations, only one person in the group may be chosen because of his or her specialized knowledge and this person may be expected to be the primary information provider for all other group members. For example, a person was asked to serve on a university committee that is reviewing the undergraduate learning goals. Since the professor's official role was to serve as the "faculty expert" on the subcommittee due to extensive training and experience n curriculum development, the professor played a more central information-provider function for the group during most of the initial meetings. Since other people on the subcommittee weren't as familiar with development of learning goals and its place within the higher education curriculum, it made sense that information-providing behaviors were not as evenly distributed in this case. "In my experience, I have seen…. May I tell you what I found out about…..?"

10. **Compromiser:** The person who, operating within a conflict, offers to give ground, admits his errors, or yields his status in order that action may proceed. If, however, the yielding is due to fear or is an attempt to seek a special favor, it becomes an individualistic and debasing role. Attempts to reach a solution everyone finds acceptable "Nicole, Beth, and Nimat have offered three great solutions. Why don't we integrate them?"

11. **Expediter:** is a task-related role that functions to keep the group on track toward completing its task by managing the agenda and setting and assessing goals in order to monitor the group's progress. An expediter doesn't push group members mindlessly along toward the completion of their task; an expediter must have a good sense of when a topic has been sufficiently discussed or when a group's extended focus on one area has led to diminishing returns. In such cases, the expediter may say, "Now that we've had a thorough discussion of the pros and cons of switching the office from PCs to Macs, which side do you think has more support?" or "We've spent half of this meeting looking for examples of what other libraries have done and haven't found anything useful. Maybe we should switch gears so we can get something concrete done tonight.".
    If you've ever worked in a restaurant, you're probably familiar with an expediter's role in the kitchen. The person working "expo" helps make sure that the timing on all the dishes for a meal works out and that each plate is correct before it goes out to the table. This is by no means an easy job, since some entrées cook quicker than others and not everyone orders their burger the same way. So the expediter helps make order out of chaos by calling the food out to the kitchen in a particular order that logically works so that all the food will come up at the same time. Once the food is up, he or she also checks what's on the plate against what's on the ticket to make sure it matches. Expediting in a restaurant and in a small group is like a dance that requires some flexible and creative thinking and an ability to stick to a time frame and assess progress. To avoid the perception that group members are being rushed, a skilled expediter can demonstrate good active-listening skills by

paraphrasing what has been discussed and summarizing what has been accomplished in such a way that makes it easier for group members to see the need to move on.

12. **Spokesman:** The person who speaks the general opinion of the group in defending it against outside pressures and opponents in promoting its progress.

13. **Recorder:** The recorder takes notes on the discussion and activities that occur during a group meeting. The recorder is the only role that is essentially limited to one person at a time since in most cases it wouldn't be necessary or beneficial to have more than one person recording. At less formal meetings there may be no recorder, while at formal meetings there is almost always a person who records meeting minutes, which are an overview of what occurred at the meeting. Each committee will have different rules or norms regarding the level of detail within and availability of the minutes. While some group's minutes are required by law to be public, others may be strictly confidential. Even though a record of a group meeting may be valuable, the role of recorder is often regarded as a low-status position, since the person in the role may feel or be viewed as subservient to the other members who are able to more actively contribute to the group's functioning. Because of this, it may be desirable to have the role of recorder rotate among members.

14. **Evaluator:** The person who compares or contrasts fact and seeks to determine the progress made in order to reward the group more objectively. He or she sets standards to achieve and seeks out and urges the application of superior methods and procedures. Whenever he makes awards he does so in the name of the group.

15. **Analyzer:** The person who keeps records of the processes going on within the group in order to determine the rate of integration or disintegration.

16. **Status role:** The person whose values, attitudes, abilities or accomplishments are respected both within and without the group and who thus gives status to the group.

BEHAVIORS OF HEALTHY VERSUS SICK GROUPS	
A Group is HEALTHY when….	**A Group is SICK when….**
❖ All members speak up about what they think	❖ A few members to all the talking
❖ Decisions are worked through until a general consensus of agreement is reached	❖ Most members mumble assent
❖ Decisions are worked through until a general consensus of agreement is reached	❖ Competent people sit silently by
❖ Well-informed members contribute ideas	❖ New people with good ideas are not listened to
❖ A member's value is judged by the merit of his ideas	❖ Decision-making is quickly referred to committees
❖ The whole group handles questions that concern the whole group	❖ Minor and simple issues make people seethe and boil
❖ Major issues evoke mature approaches to change and "working through"	❖ Major issues are passed over
❖ Minor issues are settle with the attention they deserve	❖ The same subjects, supposedly settled, keep coming up again
❖ Decisions reached by thorough participation are final and satisfactory	❖ Quick judgments are passed on issues people do not understand
❖ Members really understand one another's ideas, plans and proposals	❖ Members subjectively talk about people in scapegoating
❖ Members objectively center interests on goals and tasks	❖ The group accomplishes little in absence of the chairperson
❖ The group carries forward in the performance of tasks and the achievement of goals	❖ Rewards and criticisms are concentrated on a few
❖ The group sets goals and works toward change	❖ Initiative and responsibility are stifled by dependence
❖ Rewards and criticisms are shared	❖ The group is afraid of change
❖ Initiative and responsibility are encouraged by growth in a sense of personal confidence, competence and worth	❖ No resources outside the group are drawn upon
❖ Search for help from all sources is continuous	❖ Little is told to the group
❖ Information is fed back to the group	❖ The person is squelched in his expression and stunted by growth
❖ The worth of persons is respected.	❖ Action lacks growth and expansion, remaining static
❖ Action is group related	❖ Action is self-centered
❖ Experience is considered the occasion for dynamic growth in responsibility	

and love	

Conditions contributing to the PRODUCTIVITY of the Group

- ✓ It has a clear purpose.
- ✓ Its operations provide freedom for people to contribute their experience and ideas in planning.
- ✓ Members plan clearly defined roles in the group structure.
- ✓ Each member bears responsibility for a clearly defined and worthwhile task to the performance of which he can devote his imagination, skill, initiative and heart.
- ✓ Mutual and constructive criticism makes for progress in the achievement of the group's purpose.
- ✓ Skills for working with and through other people strengthen the feeling of the personal worth of each member.
- ✓ Minds are open to change.
- ✓ A friendly, responsible, relaxed and participative atmosphere exists.
- ✓ Tasks are performed with a confident spirit characterized by wholehearted cooperation, mutual respect and altruistic love.
- ✓ People gain personal satisfaction in worthwhile achievement through their pooled efforts.
- ✓ Reverence for personality is a guiding ethic.
- ✓ The activity is goal-oriented, task-centered, and person-related; a group that gives a satisfying role experience to its members is one that provides growth for people in a goal-oriented and task-centered program productive of change which the members feel to be worthwhile.

Principles that contribute to the establishment of a SATISFYING Group

- ✓ Maintains respect of individual integrity.
- ✓ Emphasizes mutuality of contribution.
- ✓ Avoids making one feel he is "being used" or "taken advantage of".
- ✓ Rotates positions to give all members opportunity to experience different roles and exercise initiative.
- ✓ Builds and keeps open channels of communication between all members and those members momentarily in official roles.
- ✓ Evaluates its purposes regularly.
- ✓ Reviews periodically the role performance of members, their participation and the degree to which the group fulfills member expectations.
- ✓ Has a concern for the total membership cycle by clearly defining what the group stands for and is doing.
- ✓ Inducts, orients, and places new members in satisfying roles for effective participation.
- ✓ Provides opportunities for members to explore new field of interests differing from routine patterns.
- ✓ Offers opportunities for emerging leadership so that members can discover new potentialities within themselves.
- ✓ Encourages the progressive development of skills and knowledge.
- ✓ Recognizes good performance with sincere appreciation.

- ✓ Plans for and facilitates group activities or processes for closure when members conclude their relationship with the group.

TUCKMAN'S FIVE STAGES OF GROUP DEVELOPMENT

STAGE 1: FORMING

FEELINGS

During the Forming stage of team development, team members are usually excited to be part of the team and eager about the work ahead. Members often have high positive expectations for the team experience. At the same time, they may also feel some anxiety, wondering how they will fit in to the team and if their performance will measure up.

BEHAVIORS

Behaviors observed during the Forming stage may include lots of questions from team members, reflecting both their excitement about the new team and the uncertainty or anxiety they might be feeling about their place on the team.

TEAM TASKS

The principal work for the team during the Forming stage is to create a team with clear structure, goals, direction and roles so that members begin to build trust. A good orientation/kick-off process can help to ground the members in terms of the team's mission and goals, and can establish team expectations about both the team's product and, more importantly, the team's process. During the Forming stage, much of the team's energy is focused on defining the team so task accomplishment may be relatively low.

STAGE 2: STORMING

FEELINGS

As the team begins to move towards its goals, members discover that the team can't live up to all of their early excitement and expectations. Their focus may shift from the tasks at hand to feelings of frustration or anger with the team's progress or process. Members may express concerns about being unable to meet the team's goals. During the Storming stage, members are trying to see how the team will respond to differences and how it will handle conflict.

BEHAVIORS

Behaviors during the Storming stage may be less polite than during the Forming stage, with frustration or disagreements about goals, expectations, roles and responsibilities being openly expressed. Members may express frustration about constraints that slow their individual or the team's progress; this frustration might be directed towards other members of the team, the team leadership or the team's sponsor. During the Storming stage, team members may argue or become critical of the team's original mission or goals.

TEAM TASKS

Team Tasks during the Storming stage of development call for the team to refocus on its goals, perhaps breaking larger goals down into smaller, achievable steps. The team may need to develop both task-related skills and group process and conflict management skills. A redefinition of the team's goals, roles and tasks can help team members past the

frustration or confusion they experience during the Storming stage.

STAGE 3: NORMING

FEELINGS

During the Norming stage of team development, team members begin to resolve the discrepancy they felt between their individual expectations and the reality of the team's experience. If the team is successful in setting more flexible and inclusive norms and expectations, members should experience an increased sense of comfort in expressing their "real" ideas and feelings. Team members feel an increasing acceptance of others on the team, recognizing that the variety of opinions and experiences makes the team stronger and its product richer. Constructive criticism is both possible and welcomed. Members start to feel part of a team and can take pleasure from the increased group cohesion.

BEHAVIORS

Behaviors during the Norming stage may include members making a conscious effort to resolve problems and achieve group harmony. There might be more frequent and more meaningful communication among team members, and an increased willingness to share ideas or ask teammates for help. Team members refocus on established team ground rules and practices and return their focus to the team's tasks. Teams may begin to develop their own language (nicknames) or inside jokes.

TEAM TASKS

During the Norming stage, members shift their energy to the team's goals and show an increase in productivity, in both individual and collective work. The team may find that this is an appropriate time for an evaluation of team processes and productivity.

STAGE 4: PERFORMING

FEELINGS

In the Performing stage of team development, members feel satisfaction in the team's progress. They share insights into personal and group process and are aware of their own (and each other's) strengths and weaknesses. Members feel attached to the team as something "greater than the sum of its parts" and feel satisfaction in the team's effectiveness. Members feel confident in their individual abilities and those of their teammates.

BEHAVIORS

Team members are able to prevent or solve problems in the team's process or in the team's progress. A "can do" attitude is visible as are offers to assist one another. Roles on the team may have become more fluid, with members taking on various roles and responsibilities as needed. Differences among members are appreciated and used to enhance the team's performance.

TEAM TASKS

In the Performing stage, the team makes significant progress towards its goals. Commitment to the team's mission is high and the competence of team members is also

high. Team members should continue to deepen their knowledge and skills, including working to continuously improving team development. Accomplishments in team process or progress are measured and celebrated.

IS THE "PERFORMING" STAGE THE END OF THE PROCESS?

While working on a high-performing team may be a truly pleasurable and growthful experience, it is not the end of team development. There is still a need for the team to focus on both process and product, setting new goals as appropriate. Changes, such as members coming or going or large-scale changes in the external environment, can lead a team to cycle back to an earlier stage. If these changes - and their resulting behaviors - are recognized and addressed directly, teams may successfully remain in the Performing stage indefinitely.

STAGE 5: TERMINATION/ENDING/ ADJOURNING

Some teams do come to an end, when their work is completed or when the organization's needs change. While not part of Tuckman's original model, it is important for any team to pay attention to the end or termination process.

FEELINGS

Team members may feel a variety of concerns about the team's impending dissolution. They may be feeling some anxiety because of uncertainty about their individual role or future responsibilities. They may feel sadness or a sense of loss about the changes coming to their team relationships. And at the same time, team members may feel a sense of deep satisfaction at the accomplishments of the team. Individual members might feel all of these things at the same time, or may cycle through feelings of loss followed by feelings of satisfaction. Given these conflicting feelings, individual and team morale may rise or fall throughout the ending stage. It is highly likely that at any given moment individuals on the team will be experiencing different emotions about the team's ending.

BEHAVIORS

During the Ending Stage, some team members may become less focused on the team's tasks and their productivity may drop. Alternatively, some team members may find focusing on the task at hand is an effective response to their sadness or sense of loss. Their task productivity may increase.

TEAM TASKS

The team needs to acknowledge the upcoming transition and the variety of ways that individuals and the team may be feeling about the team's impending dissolution. During this stage, the team should focus on three tasks:

- ✓ Completion of any deliverables and closure on any remaining team work
- ✓ Evaluation of the team's process and product, with a particular focus on identifying "lessons learned" and passing these on to the sponsor for future teams to use
- ✓ Creating a closing celebration that acknowledges the contributions of individuals and the accomplishments of the team and that formally ends this particular team's existence.