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MULTICULTURAL SOCIETY AND AGING - CHALLENGES FOR NURSING IN EUROPE

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MULTICULTURAL SOCIETY AND AGING – CHALLENGES FOR NURSING IN EUROPE

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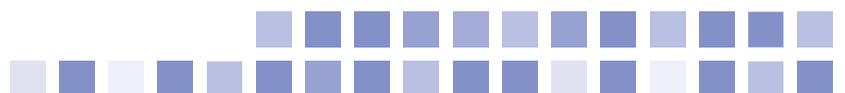
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MULTICULTURAL SOCIETY AND NURSING

Jana Goriup, PhD

INTRODUCTION

Multiculturalism is more than a tradition and an ambition: it is a necessity! No country and no society can allow themselves to fall behind in the rapid development of our increasingly globalised and knowledge-intensive world. Therefore, multicultural approach in nursing is about more than just mobility, it is about participation in our dynamic world. In the rapid development of knowledge, creativity and innovation, it refers to the physical condition of societies, in which the identified differences relate primarily to linguistic, ethnic, health care and religious characteristics.

In the sometime interculturalism refers to a creative process, which requires the acceptance of the other's culture, not in terms of knowledge, but the cultures as such in general, on many and different levels. It includes an interactive dimension and enhances the ability of individuals to create and establish common identities. Both imply interaction, reciprocity and real solidarity.

In this ever more interconnected world, nurses, and their "knowledge" are and will be the major resource for future social, health, cultural and economic development. Therefore, nursing also means sharing, access to new knowledge and innovations in health care, new applications that can benefit for all humankind. Nevertheless, nurses need knowledge, previously regarded as a public good, and then following the logic of capital, turns into services or goods on the market, for which an individual has to compete, in some cases pay. Unfortunately, the positive effects of nurse education and educated nurses to the wider society are often ignored, although society should also be investing in progress through public and accessible education in health system. Therefore, adjustments of the nursing curriculum should be made, in order to include the principles and theories of multicultural nursing.

SOME SOCIOLOGICAL ASPECT OF MIGRATION

A significant outcome of globalization has been a greater movement of peoples - migrations. Consequently, societies around the world are increasingly becoming multicultural. Multiculturalism, therefore, is a major characteristic of modern societies and one, which has significant implications for health care delivery and health care systems. Many of these implications arise from differing health beliefs and values. Different cultural groups will, therefore, have values and attitudes consistent with that culture. Within health care, the norms of the host culture (in immigrant society) tend to dominate resulting in ethnocentrism. This ethnocentric approach to delivery of health care has led to inequities, with immigrant groups reporting dissatisfaction with health care provision.

Migrations and relocations are a complex global phenomenon faced by all countries around the world. The countries are thus the origin of migration, transient destination or place of immigration, usually even all three factors at the same time (IOM, 2005). In each country, the migration policy is intertwined with a range of complex issues. Especially, the issues are those concerning employment and residence of foreigners, their rights and inter-ethnic relations. Often a domestic population has a negative attitude towards the immigration and foreign immigrants, which can be associated with high rates of unemployment and fear that immigrants may become an economic burden or that they will endanger the political and socio-economic stability. The following question raises: are the immigrants able to integrate into society of immigration; and consequently the following issues occur: the issue of civil, social, health, economic, cultural and political rights of immigrants, including measures aimed at their protection.

Consequently, during the course of their studies, students should be properly prepared in order to gain the ability to provide holistic care to people belonging to different cultural groups (Gerogianni & Plexida, 2008).

Proceeding from our own reasons, we have tried to analyse in particular two aspects of multiculturalism in the field of health care and nursing. First, regarding nurses in a multicultural society and second regarding nurses working in multicultural situations and migrant nurses.



In the past, multicultural nursing education was often neglected within nursing curricula and inclusion within curricula. Little is known about nursing students' views on multicultural nursing education. There is a lack of research examining how nurses are prepared in education and practice settings for nursing in a multicultural society.

SLOVENIAN SITUATION

Like many countries, Slovenia recently has seen a substantial increase in its immigrant populations from both within the European Union, but mostly from Non EU countries.

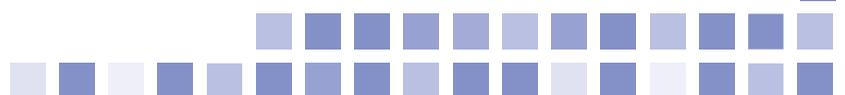
The regulation of entry of immigrants in Slovenia is based on the provisions of the harmonization with European Directives, Aliens and Immigration Law. Large numbers of immigrants in Slovenia are political refugees, asylum seekers, illegal and legal resident immigrants. In recognition of the Ombudsman, there are weaknesses and problems, especially with regard to the establishment of long-term immigration policy. It has also been found that the smooth integration of immigrants in the Slovene society is an essential issue that needs proper handling on behalf of the state and citizens to address the challenges arising from the provision of healthcare services. The health problems that immigrants face, particularly if they are living under difficult conditions and have low wages, are becoming public health problems.

The Slovenian society experienced the aforementioned. Especially because of its geographical position, which is (was) close to the sensitive migration environment of Central Europe, where this social mobility is (was) not unknown. Slovenia has become a host country of immigrants. A major contributing factor to this figure was the expansion of the EU, in May 2004, to include 10 New Member States and the migration waves in the last couples of years, especially in the year 2015 because of the Syrian war. In addition to EU migrants, there has been immigration from a host of other countries, particularly Asia (Syria, Afghanistan, and Pakistan) and Africa. Many are voluntary migrants seeking a better lifestyle, whereas others are involuntary migrants, having to flee their own countries because of war, persecution, political upheaval and natural disasters in their own countries. Clearly, such mass migrations as in 2015 have major implications for the European's health care systems, Slovenian as well. As important as emergency measures are the implications of mass immigration extends to all aspects of health care, with host nations needing to ensure that their health care system is equipped to cater for people from different cultural backgrounds and their different disease profiles, cultural beliefs and health values. Therefore, there is an increasing need for health systems and professionals to become more multi-culturally responsive.

On the other side, currently, in the Slovenian health care there is not a lot of high-quality empirical data relating to the migration of health workers. This made it possible for nurses in some South and Eastern European countries to take up work in the EU bringing immigration to Slovenia to new heights. However, as we know, the majority of employees in nursing are women.

In International Migration Review, Morokvašič assessed already in 1984, the decade of researches in the field of migration of women and she pointed out that when considering the migration of women, the lack of research in this period is not as problematic as the fact that existing studies have had a little impact on policy-making and media, and that the dominant research from a gender perspective is still biased (Morokvašič 2007; Kofman, 2000, p. 269-270). Records of women immigrant show the need for a systematic study of gender and migration and the specificity of the situation of women from the epistemological position, which is still quite inadequate. In the survey, the gender is included quite unsystematic and sporadic as an important category of social stratification. If we take into an account the deficit of current, reliable, quantitative and qualitative statistical data, we can assume that a genuine research of the pursued problem and relevant qualitative research apparatus are needed.

To some extent, the World Health Organisation (WHO), through its International Health Regulations, which promotes multicultural country co-operation in order to prevent, has acknowledged this and respond to acute public health risks, which may cross borders and trigger pandemics.





Theoretical speculations about the causes of migration most commonly arise from the theory of push-pull factors (push-pull theory), although these factors cannot explain why some nurses as individuals move away from a particular environment and others not. Decisions of them to migrate are not (always) a product of the rational thinking. Various subjective factors from rational and emotional, as well as socio-psychological personality of nurses, as individuals are present.

Therefore, the nurse migrations with its various causes and consequences became one of the most pressing challenges of the postmodern world health system, and Slovenian as well. The reasons and motives of nurse's migration we present in three groups, namely:

- Economic and demographic reasons (due to the questions of existence, the improvement of the economic situation, overpopulation, etc.);
- political and military reasons (e.g. forced migration due to the danger, war, discrimination); and
- Personal and family reasons, which are the most diverse (e.g. possibility of obtaining education, employment, marriage etc.).

Komac and Medvešek (2006, p. 233) divided the concept of »migration« on eviction or emigration and immigration; they emphasize that such movements can be internal or international.

In Slovenia internal migration in nursing happened, as nurse migrants came mainly from countries of the former Yugoslavia. However, a review of the more established theories of migration shows that the approaches of classical migration theory largely emphasize the economic aspects of migration, and less emphasis is on citizenship, social inclusion and exclusion, political and everyday strategies of migrants. However, Anthias (2000) pointed out that the push and pull migration model is insufficient. This model stands on neo-liberal economic theory and among the researchers represents a kind of standard classical model, according to which the individuals migrated in particular because of economic reasons. Mostly to ensure themselves and their families a better life, to escape war situation and danger.

Under this economical assumption, the decision to migrate is a rational choice; in the ideal sense, the researchers believed that the behavior of migrants is a rational economic operation where the costs and benefits are weighted and factors of attraction and repulsion are taken into account (Anthias 2000, p. 18). Brettell (2003) estimated that the critics of such "homo economicus" approach have largely been given by social and cultural anthropologists who pointed out that the individual is not only a rational being who migrates only for economic reasons, but the migration processes are created and transformed by the social and cultural contexts.

Castles and Kozack (1973 cited in Kofman, et al. 2000, p. 23) defended one of more established statements. They claimed that job migration is a method through which the poor countries offer development assistance to the rich countries. However, it is unrealistic to assume, that the individuals have the possibility to decide freely about the migration, considering the global inequality in economic and political power and considering the control of dominant countries over the migration, since the dominant countries want to ensure the workforce. Seen recently; did we?

NURSES AND MULTICULTURAL COMPETENCES

Since an increasing number of nurses cross borders every year, searching better working and living conditions, career prospects, or even for personal reasons, they have become important actors in a growing and stark competitive global labour market. The development of the modern field of care requires scientifically based knowledge and responsibility on behalf of nurses in order to be able to respond effectively to existing conditions. Health professionals have a key role in the modern social structure with the overarching goal of optimizing the health status of citizens. Therefore, in determining the shape of society certain factors should be examined. These include cultural, political, economic, environmental, behavioural and psychological. Therefore, promotion of multicultural competence within nursing is a necessity.

Leininger (1978) provided the first formal definitions of multicultural nursing and health-illness practices, beliefs and values. Today one of the



most accepted definitions of multicultural competence is the one developed by Camphinha-Bacote (1999). According to this definition, multicultural competences are demonstrated when practitioners understand and appreciate differences in health beliefs and behaviours, recognise and respect variations that occur within different cultural groups, and are able to adjust their practice to provide effective interventions for people from various cultures. Also Suarez-Balcazar and Rodakowski (2007) believe that for a nurse “becoming multicultural competent is an on-going contextual, developmental and experiential process of personal growth that results in professional understanding and ability to adequately serve individuals who look, think and behave differently from us”.

But it does not follow that being multicultural competent or culturally aware will lead to nurses being also multicultural responsive as it is only by responding to the health care needs of multicultural diverse groups that nursing care will truly meet their needs.

Narayanasamy (2006) refers to multicultural competency as having a number of facets including: cultural awareness, skills of communication, responsiveness and sensitivity, avoidance of stereotypical assumptions about ethnicity, culture and promotion of anti-discriminatory practices. It involves cultural negotiation, compromise, and promotion of cultural safety in practice. It is not necessarily about using cultural and religious fact files in responding to ethnicity and multicultural needs. Fact files knowledge as the cultural competence and such knowledge may be applied indiscriminately based on assumptions about those fitting a cultural fit.

For nurses to achieve competences in multicultural practice is a process, requiring experience and continued interest in learning and in sharpening cultural assessment and communication skills. While nurses may achieve a certain degree of competence in some diverse cultures, they cannot be very competent in all cultures. Yet, nurses are more likely to achieve culturally competent multicultural care when the complex combination of cultural knowledge, awareness, attitudes and skills are used dynamically for cultural assessment of clients' health beliefs and practices, and for negotiating culturally congruent health interventions through skilful multicultural communication.

NURSES AND MULTICULTURAL COMMUNICATION

Nurses shall use multicultural competent verbal and nonverbal communication skills to identify patient's values, beliefs, practices, perceptions, and unique healthcare needs.

Effective multicultural communication demonstrates a wide area of respect, dignity, and the preservation of human rights. Failure in communication can easily be interpreted as bias, stereotyping, or prejudice and subsequently influence the quality of care. Therefore, nurses must strive to comprehend patient's healthcare needs through effective listening, attentive body language, and use of eye contact.

Other cultural nonverbal communication may include perceptions of time and space, values of modesty, touch, silence, dress, provider gender, and other unique cultural patterns and expressions.

In addition, temporality in terms of past, present, and future orientation and the willingness to share thoughts and feelings with family, friends, strangers, and healthcare providers are important.

Familiarity with multicultural context is essential for nurses to provide culturally competent communication. Multicultural and environmental context refers to the totality of an event or experience that gives meaning to patients' expressions, interpretations, and social interaction. If a patient's verbal language is unfamiliar, every attempt should be made to find a qualified interpreter, keeping in mind that cultural values, gender, age, and other diversities, such as socio-economic status between the interpreter and the client should have a strong impact on the interpretation process.

The healthcare system should make every attempt to provide resources for interpretation. Bilingual staff with specific job description to assist





with interpretation is helpful. Interpreters must ensure confidentiality, be knowledgeable about healthcare language, and conduct all sessions in an ethical manner. Family members, especially children, should be used only as a last resort when qualified interpreters are not available because privacy issues and bias in interpretation are potential risks. If time and the patient's condition permits, allow the client and interpreter to have a few minutes together before conducting a thorough assessment. The nurse should be present during the assessment to observe nonverbal communication, advocate for the client, and assist the interpreter as necessary. Clinically important care-specific phrases such as "Are you having pain?" spoken in the patient's mother language shows respect and willingness to value language and diversity.

All print and other media must be selected with respect for the patient's language, cultural values, and age. Before distribution, individuals from the intended should review print material for accuracy, literacy level, and offensive language and pictures.

Some suggestions for implementation of Multicultural Competent Practice for Nurses:

- To establish a trusting relation through open and sensitive communication, active listening and respect of patient's cultural beliefs and practices.
- To obtain focused information about patient's presenting illness and his/her perception of causes of illness and beliefs about cultural treatment modalities.
- To conduct an assessment of patient's physical, psychological and cultural attributes and use assessment data for planning and prioritizing of care.
- To negotiate and implement culturally congruent care and evaluate health outcomes.

Some goals in Nurse's education:

- To provide educational and training workshop to enhance nurses' multicultural knowledge about the ethnically diverse patients who receive health services in the facility.
- To provide educational workshop to enhance nurses' skills in multicultural assessment and communication.
- To develop policies and procedures for ensuring effective multicultural nursing practice.
- To develop assessment strategies to ensure competence of nurses in meeting the health care of patients from various cultures.
- To develop Advanced Practice Nurse (APN) consultants to mentor and facilitate implementation of best evidence based multicultural practice.
- To host clinical and research workshops/conferences to disseminate evidence on effective approaches to culturally congruent nursing practice.

Teacher in Nursing Educational System should use teaching strategies that:

- To increase the understanding of other cultures and peoples.
- To increase the recognition of global socio-political issues that relate to health.
- To increase the commitment to make a difference.
- To provide for experiencing personal and professional growth.
- To contribute to professional development in the host country.
- To make interpersonal and multicultural connections.
- To develop sensitive and effective cultural competence.

What should Nurse dealing in multicultural situation do?

- Use pain scales in the preferred language of the one. Train nurses in interviewing clients from diverse cultures as part of orientation programs.
- Provide resources for translation and interpretation within the organization, when possible.
- Provide accessible references for nurses to learn about specific cultures, ethno histories, and common language terms for groups represented in the clinical setting.



- Provide print and other media in the client's preferred language.
- Encourage nurses to observe for culturally specific paralanguage variations such as voice volume, tone, intonation, reflections, and willingness to share thoughts and feelings.
- Include discussions on culturally specific values, beliefs, and practices in meetings and during in-service and continuing education programs.
- Develop skills in using interpreters.
- Hospitals, clinics, and other healthcare organizations, symbols and pictograms should be used whenever possible.
- Provide patients with educational and discharge materials that are translated into their preferred language.
- Client and faces scales of the ethnicity of the client.
- Continuously collect cultural data on assessments.
- Resist judgmental attitudes such as "different is not as good".
- Recognize that the nurse's beliefs and values may not be the same as the patient's.

Nurses shall have the ability to influence individuals, groups and systems to achieve positive outcomes of multicultural competent care for diverse populations. They should be grounded in an understanding of the social and multicultural determinants of health and the knowledge that human ailments are reflective of longstanding social inequities.

As multicultural competent nursing needs an active leadership, which promotes changes in self, other professionals and organizations to achieve positive health outcomes for individuals, families, communities and populations, nurses should:

- take a leadership role in designing organizational policies and systems of care that strive for equity in access to high quality care and treatment,
- take protection of human rights,
- take advocacy for social justice, and
- take achievement of optimal outcomes of care in diverse populations;
- be actively engaged and facilitate involvement of their organizations in community development and empowerment through local, national and international partnerships.

Inherent in multicultural leadership is the commitment to ongoing self-development in multicultural competence. Multicultural leadership requires self-awareness and self-reflection, sensitivity to cultural differences, and adaptability to various contexts of care. Nurses use leadership skills to implement system-wide programs for staff development in order to promote organizational cultural competence. Nurses need to assume a leadership role in promoting research and integration of best evidence in health promotion and care of culturally diverse patients and communities. Nurses should ensure adherence to national and international standards of health care and evidence-based practice, and model culturally competent adaptation of these standards to different life contexts of individuals, families and communities.

CONCLUSION

What has emerged from the discussions is the need to recognise the role of value systems within nursing and what kind of affects this may have for the patient care. What is required is a mechanism by which nurses will be able to critically examine and reflect on both personally held and professionally embedded values. We are proposing Schon's (1987) model of reflection that can be used as a tool to enhance nurse's multicultural awareness, which can be used in a variety of reflective opportunities that can occur within nurse's work situations.

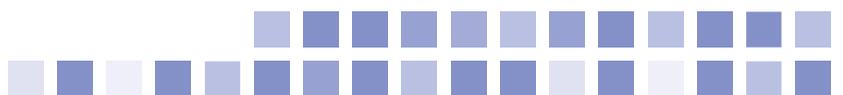


Figure 1: A cultural awareness model of reflection



Reference: Schon (1987 cited in Chambers, D., Thompson, S., Narayanasamy, A. 2013, p.76)

Schon defined reflection in terms of action, both as reflection-in-action and reflection-on-action. Reflection-in-action requires nurse to think what they are doing while doing it. As nurses attempt to interpret and understand the situation they are confronted with, they will ask themselves questions such as:

- *On what basis am I making this judgement?*
- *What factors are influencing my rapport with this patient?*

This includes the feelings that led to the adoption of a particular course of action and the way the problem is initially structured in the mind.

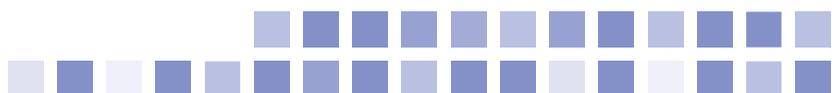


Table 1: Questions aimed at facilitating reflection of multicultural health values

Stage	Purpose of Nursing Actions	Level of Reflection	Questions Aimed at the Reflective Process
Computation Stage	Assessment and Comparison	Reflection Prior-to-Practice	<ul style="list-style-type: none"> *What are my values, assumptions and beliefs about health? (For example, what does health mean to me?) *Where have these beliefs come from? * What social practices are expressed in these ideas of health? * What are my experiences of health, how may they be similar to or different from others? ** What factors constrain my views about health?
Realisation Stage	Promote the implementation of culturally sensitive & responsive care	Reflection-in-Action	<ul style="list-style-type: none"> * What factors may influence the way I provide care to this patient? * How can I elicit my patients' beliefs about health? * Are the needs expressed by my patient reflecting felt needs or normative needs? * Am I coercing the client into working with normative needs? * What are my client's goals with regard to their health? * What factors exist that may serve to impede them achieving their goals? * Does the care I am giving adequately reflect my patient's cultural needs and beliefs? *How am I responding to my patients expressed cultural needs?
Evaluation Stage	Self-appraisal of the Interaction	Reflection-on-Action	<ul style="list-style-type: none"> * On what evidence did I base my actions? * Did my personal values and beliefs influence the interaction? If so, how did they and what can I do to limit this in future. * Did I meet the patient's agenda or my own? * Did I facilitate the interaction or dictate? * What did I do well? * What aspects would I use again and why? * What aspects would I do differently next time?

Reference: Nairn, et al., 2012

All these are brought to the surface where nurses criticise them, restructure and embody them in further action. Taking into account the social multiculturalism, by respecting diversity, peaceful coexistence, social stability and cohesiveness, several EU countries managed the integra-





tion policy whose objectives are based on the fundamental principles and values of equality, freedom and cooperation. Constant and Zimmermann (2006) introduced methodological approach, a so called ethno sizing, which represents the »meter« for strength of ethnic identity of the individual and is formed by monitoring the individual characteristics of immigrants: language, culture, gender, education, religion, social interaction, time of migration and ethnic self-identification. By analyzing these variables, it is possible to determine the degree of integration, assimilation, separation and marginalization. In this multicultural social situation:

Nursing acts as a health care profession that encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.

And therefore:

Culture “refers to integrated patterns of human behaviour that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. The totality of socially-transmitted behaviour patterns, arts, beliefs, values, customs, lifeways, and all other products of human work and thought characteristics of a population of people that guides their worldview and decision making. These patterns may be explicit or implicit, are primarily learned and transmitted within the family, and are shared by the majority of the culture. Cultural patterns can also be transmitted from outside the family by means of pressures exerted by society.

Multiculturalism is any form of activity between members of different cultural groups; or, a comparative perspective on how cultural differences and similarities shape human behaviours and events.

Autonomy for Culturally Congruent Health Care includes the ability of the health care provider to make decisions on the use and quality of healthcare that accommodates personal cultural values, beliefs and behaviours.

Cultural and Linguistic Competence: The way a patient perceives illness, the specific disease and its associated symptoms are tied to the patient’s underlying cultural values and beliefs. A set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in multicultural situations. Multicultural competence implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviours, and needs presented by consumers and their communities. Interpretation involves the verbal explanation of words or concepts from one language to another; whereas, translation refers to the rendering of a written document from one language to another. The capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing. Linguistic competency requires organizational and provider capacity to respond effectively to the health and mental health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity.

Cultural Congruence is the understanding and application of acceptable beliefs, ideas, and practices that result in an interpersonal, social, and intercultural and multicultural understanding and acceptance of differences and similarities of all peoples within a worldview.

Cultural Safety is a nowadays necessity. Health care practices that identify, understand and respect the bio-physical, economic, psychosocial, spiritual and cultural characteristics of the patient, the patient’s family, the environment and the patient’s community. Safety occurs within a process of respectful collaboration to reach agreed-upon health goals, to individualize health education to the individual patient and patient population, and to select and provide health care. Culturally safe practices by the nurse protect patients against devaluation or obliteration of their cultural histories, cultural expressions and cultural experiences

Diverse populations: Individuals, significant others and communities that represent the variety of populations, beliefs, cultures, ethnic groups,



and representational societies from which they emanate.*

Multicultural: A concept or philosophy that recognizes that all cultures have a value of their own and must be equally represented or recognized in the broader society or international context, and encourages enlightenment of others in the worthwhile contributions to society by those of diverse ethnic backgrounds.

Transcultural: A descriptive term implies that concepts transcend cultural boundaries or are universal to all cultures, such as caring, health, and birthing. In contrast cross-cultural refers to a comparative perspective on cultures to generate knowledge of differences and similarities.

Equality is understood as ensuring equal social, economic and civil rights.

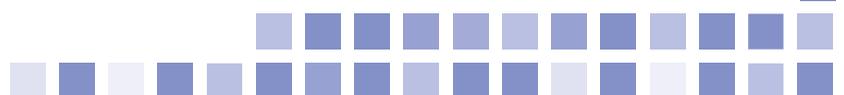
Freedom as an expression of the right to cultural identity, while ensuring respect for the integrity and dignity of each individual and of fostering own culture in accordance with the law and the fundamental values of the Republic of Slovenia.

Mutual cooperation as the right to participation and responsibility of all people who are in a continuous process of creating a common society.

According to mentioned cultural diversity, equity and parity in multicultural nursing are nursing imperatives but should also be moral imperatives. Using “change by drift” strategies to address the lack of multicultural and other diversities in nursing in postmodern society has been ineffective.

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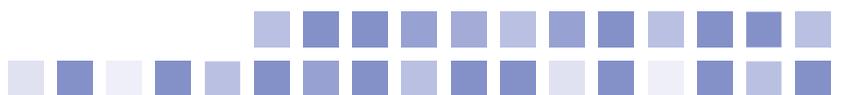
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CULTURAL COMPETENCES OF NURSES

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INTRODUCTION

Cultural competence is a relatively new concept in Slovenian health system, and it represents an entirely new dimension of professional competence. In the area where we live there has always been a diversity of cultures, religions, values, beliefs, attitudes and styles which health professionals were not aware of and which were also not taken into account in their work (Keršič Svetel, et al., 2016).

Culture generally refers to forms of human activities that give such activity significance. Different definitions of culture reflect different theoretical bases for understanding, or different criteria for evaluating human activity. In the broadest sense culture denotes all the products of an individual, a group or a society of intelligent beings. These include technology, art, science, as well as moral systems and typical behaviours and habits of selected intelligent entities. In the narrower sense the term has more specific meanings in various fields of human activity. Different human societies have different cultures (Kultura, 2016).

Until now Slovenia has already been culturally heterogeneous, for we have national minorities of Italians, Hungarians and Romani, ethnic communities of Albanians, Bosnians, Montenegrins, Croats, Macedonians and Serbs, and 48 officially registered churches and religious communities (Urad za verske skupnosti, 2016 - Office for Religious Communities, 2016). We only became more aware of heterogeneity and diversity of cultures during the period of mass global migrations caused by wars, which in 2015 led to the arrival of refugees from Syria, Iraq, Pakistan and Afghanistan, from culturally completely different countries.

The diversity of today's society is reflected in the wide range of different understandings of health, disease, pain and in different perceptions of health care and treatment. All this presents a great challenge for health professionals and health institutions, because in the field of health and health care sensitivity to cultural differences and related appropriate behaviour seem to be necessary (Keršič Svetel, et al., 2016).

Cultural competences are a combination of knowledge and skills in relationships with people that allow individuals to improve their understanding, sensitivity, acceptance, respect and response to cultural differences and relationships arising from them (Glossary of terms, 2016). Cultural competences in health care are based on the recognition of cultural beliefs, habits and values of the patient. They are an inevitable component of quality health services and at the same time a safeguard against unequal treatment of patients (Loredan & Prosen, 2013).

The concept of cultural competence has appeared in English-speaking countries some time ago and means the ability of nurses to use the knowledge about a patient's culture in such a way that the nursing care is adapted to their competences. Respect for others is especially important, since nurses are advocates of patients and as stated by Hvalič Touzery (2015), nurses have the most personal contact with patients and therefore need to be responsive to their culturally conditioned needs that are related to culture, race, ethnicity, gender and sexual orientation.

Nursing care is patient-focused, therefore implementation of culturally competent nursing care is a base for its adequacy and effectiveness (Green-Hernandez, et al., 2004).

With this study we wanted to establish where the cultural competences are on the value list of registered nurses. Furthermore, we analysed the strengths and weaknesses of their knowledge of cultural competences.

Based on the defined research problem we formed the following research questions:

RQ1: What is the level of cultural competence of registered nurses?

RQ2: What value level do the registered nurses attribute to cultural competence as a professional value?

RQ3: How do length of work experience, age and education influence the level of cultural competence of registered nurses?



METHODOLOGY

A non-experimental quantitative study was conducted, with the survey technique.

Description of the instrument

We used the standardized questionnaire the Cultural Competence Self-Assessment Tool (Mason, 1995), developed for health professionals by The Centre for Cross-Cultural Health.

The questionnaire was revised by the authors in January 2010. In the first phase two of the authors of the paper independently translated the questionnaire, compared the translations and harmonized the final version. The questionnaire consists of seven main questions which can be answered with a four-level scale (1-not at all, 2-hardly, 3-quite well, 4-very well; 1-nothing, 2-single copy, 3-some, 4-a lot). To the questionnaire the following demographic data were added: years of work experience in the field of nursing care, type of institution of employment, year of birth, gender and education.

We added a scale to measure the twelve professional values that we identified in the Code of Ethics in Nursing Care of Slovenia (2014). Respondents ranked values, where 1 represented the most important value and 12 the least important value. The questionnaire was designed in the form of an online survey and in paper version.

Description of the sample

All the respondents participated voluntarily in the study, they gave informed consent, they were assured of anonymity, and they were acquainted with the purpose of the study and the application of research results.

We used non-probability, convenience sampling. The study involved 49 registered nurses who attended the regular annual training course for clinical mentors, and 348 registered nurses to whom we sent an online survey. The survey was completed by 102 respondents, who had an average work experience of 21 years, and whose average age was 41, 93 years. 62 respondents had higher education, 11 were university graduates and 19 had post-graduate education (specialization, professional master's degree, Master of Science or doctorate).

Description of conducted research and data processing

Registered nurses filled in the questionnaire on paper on 8th October 2016. The online survey was conducted between 19th October 2016 and 21st October 2016. For data analysis, we used the following statistical methods: analysis of variance (ANOVA) to explain whether the differences between groups were statistically significant (degree of cultural competence according to work experience, age and gender); Spearman's rank correlation coefficient, with which we determined the correlation between the two variables (registered nurses, students) and Fisher's exact test to determine the statistical significance between two categories of variables (degree of cultural competence and education).

RESULTS

Looking for an assessment of cultural competence as a professional value of registered nurses, we first recoded the classification of professional values from each respondent. Thus, each respondent's professional value that was put in the first place received a value of 12, the professional value which was in the second place received the value of 11, and so on until the last professional value, which received a value of 1. In the next step we simply added up the values of all professional values among all respondents. This way, we have compiled Table 1.

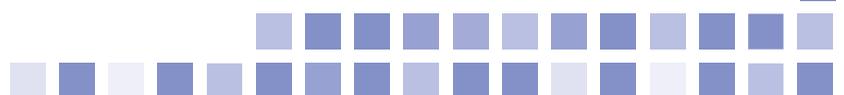


Table 1: Professional values of registered nurses

Rank	Value	Sum of values
1	expertise	923
2	knowledge	867
3	quality	726
4	responsibility	716
5	safety	670
6	benefit of the patient	620
7	teamwork	520
8	professional secrecy	506
9	professional affiliation	332
10	research	313
11	social responsibility	249
12	cultural competence	188

From Table 1, we see that cultural competence is the least important value for registered nurses.

For each question referring to self-assessment of cultural competence of registered nurses, we assigned to the reply not at all a value of 1, to the response hardly a value of 2, to the reply quite well a value of 3, and to the reply very well a value of 4. Depending on the resulting sum of the values of responses we put each statistical unit as directed by the authors of the questionnaire into one of the four groups (table 2). Most registered nurses (60, or 58,82%) are classified in the group that knows diversity well. Follows the group with minimal cultural awareness (22 registered nurses, or 21,57%). In both border groups there were less statistical units.

Table 2: Distribution of registered nurses according to self-assessment of cultural competences

Number of points	Level of cultural competence	Frequency
18 points and less:	cultural unawareness	6
19-36 points:	minimal cultural awareness	22
37-54 points:	good knowledge of diversity	60
55 points and more:	cultural competence	14

Next we were interested in how the questions were answered by the statistical units by the nurses, who were classified as culturally competent. Thus, we first calculated the professional values of registered nurses in this group and they are shown in Table 3.



Table 3: Professional values of culturally competent registered nurses

Rank	Value	Sum of values
1	expertise	102
2	knowledge	91
3	responsibility	83
4	quality	77
5	benefit of the patient	72
6	safety	64
7	teamwork	52
8	professional secrecy	48
9	professional affiliation	32
10	social responsibility	31
11	cultural competence	26
12	research	24

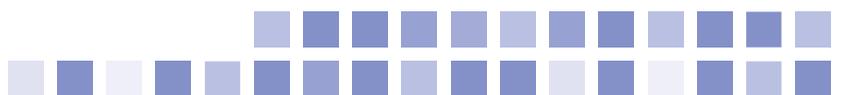
From Table 3, we find that there are no significant differences between the classification of professional values of culturally competent registered nurses and other registered nurses. Culturally competent registered nurses put the value of cultural competence in the penultimate place.

In Table 4, we also examined whether age and work experience affect the cultural competence of registered nurses.

Table 4: Level of cultural competence according to age and work experience

Level of cultural competence	Average age	Average work experience
cultural unawareness	44,00	23,33
minimal cultural awareness	41,90	20,95
good knowledge of diversity	40,19	18,77
cultural competence	41,63	21,38

Significant discrepancies between the groups according to age or gender were not detected. With the ANOVA test, we examined differences between groups according to age and work experience. According to age, groups do not differ in a statistically significant way (p-value = 0,97). Pair-wise comparisons between groups (cultural unawareness and minimal cultural awareness vs. good knowledge of diversity and



cultural competence) show no statistically significant differences. Similarly, we can claim that the differences between the levels of cultural competence according to work experience are statistically insignificant (ANOVA, p-value = 0,66).

To examine whether there is a correlation between education and level of cultural competence, we drafted Table 5.

Table 5: Level of cultural competence according to education

	Education		
Level of cultural competence	1	2	3
cultural unawareness	3	0	0
minimal cultural awareness	12	3	4
good knowledge of diversity	42	5	10
cultural competence	5	3	5

Legend: 1 – higher education, 2 – university graduates, 3 – post-graduate education

62 of the respondents have higher education, 11 are university graduates and 19 have post-graduate education. Because of the low frequencies we combined two levels of cultural competence (cultural unawareness with minimal cultural awareness and a good knowledge of diversity with cultural competence) and education 2 and 3. Then we performed Fisher's exact test, which showed us that there is no correlation between the level of cultural competence and education (p-value = 1). Therefore, statistically we cannot confirm the discrepancies between the combined groups of cultural competence and education.

DISCUSSION

With our research we wanted to establish the level of cultural competence of registered nurses and in which place of the professional system of values they place the value of cultural competence. We were also interested in the influences of the work experience, age and education on the level of cultural competence.

The results of our research have shown, that the surveyed nurses place cultural competence as a value in the last place in the value list of twelve values. Similar findings were made by the authors Razlag Kolar, et. al. (2016) among the surveyed 100 part-time students of nursing care, who had to classify the same values. Therefore we have calculated the Spearman correlation coefficient of the ranks between the professional values of students and the professional values of nurses. It was established, that the two orders correlate strongly. ($\rho=0,98$), which means, that the orders of professional values as placed by the students and by the registered nurses statistically do not differ significantly. From all of the above we can conclude that both of the groups place the professional values in an almost identical order.

When we classified nurses into several groups of cultural competence according to their self-assessment, we have established that almost three quarters of nurses know the diversity of respective ethical groups well, and that they are culturally competent. This was confirmed by Miskin et al. (2015) with the claim, that nurses who treat culturally diverse patients report a considerably higher self-assessment of cultural competence. The opposite was, however, established by Halbwachs and Zurc (2016), who have carried out an empirical qualitative research



among Head Nurses in Slovenia, and established that we cannot talk about cultural competence in nursing care yet, as in this field prevails the absence of the understanding of this term, as well as the absence of appropriate training, education and discussions, that there are present stereotypes and unprofessional reactions towards being different, however, the needs for cultural competence are recognized. Also Babnik and Šavle (2014), who have through summarizing the opinions of two focus groups established that health care workers frequently meet patients from different cultural and linguistic environments, and that there can be present a mutual misunderstanding and the ignorance of the prevailing behavioural patterns, therefore there exists the need for the systemic solutions for a more suitable intercultural and linguistic communication.

The registered nurses who were, according to their self-assessment of cultural competence, classified into a group of the culturally competent, have put the value »cultural competence« at the penultimate place in the value system of selected professional values. The results are in contrast to the research by Caffrey et al., (2005), who have established, that the values and the interpersonal relationship represent the basis for the implementation of competent nursing care. From all of the stated above we can summarize that registered nurses, who place cultural competence in the last place among the selected professional values, do not implement a quality nursing care, adjusted to the needs of the patient.

The development of cultural competences is a process that requires more than merely formal knowledge (Caffrey, et al., (2005), a statement with which agrees also Kokko (2011), who carried out a systematic analysis of literature and emphasizes that also personal growth is important. Also Loredan and Prosen (2013) are of the opinion that the development of cultural competences is not a static achievement, and quote some foreign authors claiming that cultural competence develops through different stages, whereby it is by no means necessary that an individual through development achieves the highest level, which means that he or she develops the appropriate competences.

With our research we have established, that age, gender, work experience and education have no influence on the level of cultural competence of registered nurses. Also Miskin et al. (2015) have found no correlation between the age and gender of the respondents and their self-assessment of the level of cultural competence. However, it has been stated that there exists a correlation between the higher level of achieved competences and the higher level of self-assessment of cultural competences among the nurses. Mareno and Hart (2014) have established an important correlation between the level of education and the level of cultural competence among the nurses, which means that the nurses with higher education levels have higher levels of cultural awareness, knowledge and skills than the ones with lower levels of education.

The results of our research surprised us to a great extent, as they are in contrast to the findings of many authors, who state that the cultural competence is a new term that develops gradually, whereas we have established an already present high level of cultural competence among the registered nurses, who took part in the research. We were as well surprised by the results that the level of cultural competence is not influenced by the level of education, in spite of the fact that certain foreign authors prove the above mentioned correlation, that is, that the nurses with a higher level of education also have a higher level of cultural competence.

The research has a number of limitations, for example the small number of participants in the research as well as geographic limitations, therefore the generalization on the whole population of registered nurses is not possible. Irrespective of this fact, however, the current research highlights the level of cultural competence of registered nurses and represents a foundation for further research in this field.

CONCLUSION

With the global migrational waves, irrespective of the cause, the cultural diversity of the users of health care and with it nursing care is increa-





sing. The treatment by the registered nurse, when different cultures are taken into consideration, has a great influence upon the quality of the nursing care and the achieved results. With the present study we have established that the registered nurses, who participated in the research, have a high level of cultural competence, irrespective of the fact that cultural competence as a value according to their self-assessment does not seem very important to them, as they put it in the penultimate place in the value list.

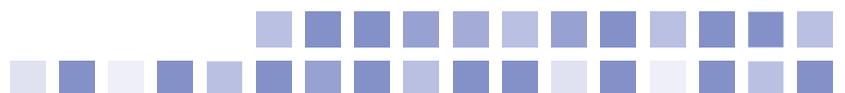
Interesting is also the finding, that the level of cultural competence is not influenced by the level of education. Both findings are in contrast with the findings of foreign authors, and therefore the results were very surprising to us. They, however, represent a good starting point for further research and action in the field of formal as well as continued professional training of registered nurses, with the introduction of relevant contents to achieve cultural competence as well as for the repeated measuring of cultural competence level with a different instrument.

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CULTURAL DIVERSITY IN NURSING CARE AS A CHALLENGE FOR NURSING EDUCATION AND PRACTICE IN POLAND

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INTRODUCTION

The population migration waves observed today result from many factors, primarily from wars and their aftermath, various forms of oppression, poverty, lack of perspectives, violation of human rights, natural disasters and growing inequalities between social groups (Cybulski, 2015; Galen, et al., 2009). The research carried out by the Institute of Public Affairs demonstrates that people who apply for international protection are often regarded as demanding patients (Krajewska-Kułak, et al., 2015). The perception and treatment of foreigners in Poland is a complex and multifaceted issue, as they comprise a quite diversified group in terms of ethnic origin, culture, religion and social rank. Working with them is perceived as particularly difficult due to cultural differences (Krajewska-Kułak, et al., 2015). Men and women in various parts of the world have different social roles and sensitivity due to their education, traditions and religion. Believers, as a result of the principles of their faith, have specific needs both in times of health and disease and during hospital stay (Pruszyński, et al., 2013). Religious practices are one of the major factors with an impact on the mental wellbeing of patients (Lankau, et al., 2015; Luszczynska, et al., 2005). Therefore, medical personnel dealing with people representing different religions should have the essential knowledge to be able to provide the best support and assistance possible. Healthcare professionals should possess basic knowledge on other cultures and religions and strengthen the foundations of respect for other people and their culture (Pruszyński, et al., 2013).

A report of the Central Statistical Office of 2011 mentions the following major cultural and religious groups in the Polish society: Catholics – 33.728 million; Orthodox – 156.6 thousand, Protestants – 122.6 thousand; Jehovah's witnesses – 137.3 thousand; Muslims – 5.1 thousand, Jews – 0.8 thousand, Buddhists – 6.0 thousand, and Indian – 0.9 thousand. (Wyznania religijne w Polsce, 2016; Struktura narodowo-etniczna, językowa i wyznaniowa ludności Polski 2011, 2015). Due to the growing migration movements, the percentages of various denominations can be expected to rise. Therefore, it is important for nurses to prepare for new challenges which may arise from clinical practice. The appropriate preparation of the medical personnel and the continuous development of knowledge is crucial for holistic care for patients, also for those who perceive their life and health through the perspective of their culture, and for avoiding unpleasant situations which may arise, such as offending someone's religious sensibility (Krajewska-Kułak, et al., 2015). Care received by patients should take into account their culture, as they seek understanding on this level just as much as the understanding of their physical or mental state (Szreder & Kurowska, 2011).

The objective of the study is to analyse challenges for education and nursing practice in Poland resulting from an increased diversification of Polish society, based on a interview carried out among the representatives of the Islamic culture.

BACKGROUND

There are many legal and occupational regulations specifying the educational and practice-related requirements for the nursing profession. Ethnic changes in Poland are becoming increasingly more prominent, and the mentioned regulations rarely mention the issue of transculturalism. This study presents an analysis of the mentioned documents in the context of the preparation of nurses for new challenges in their work with patients representing different cultures.

The Constitution (1997) passed on 2 April 1997 is the fundamental legal act in Poland. Chapter 2 of the Constitution discusses the freedoms, rights and obligations of people and citizens towards the State. The chapter emphasises that all persons are equal before the law. It is forbidden to discriminate against anyone (Article 32) and ensures respect for the autonomy of citizens belonging to national minorities (Article 35). The Constitution grants citizens personal freedom (such as freedom of conscience and religion (Article 53) and also political, social and cultural (including a decent standard of living and health protection). The freedom of conscience and religion refers in particular to the freedom to profess or to accept a religion by personal choice as well as to manifest such religion, the freedom to have places of worship, the right of believers, wherever they may be (for instance in hospital) to benefit from religious services and the right of parents to ensure their children an



upbringing and teaching in accordance with their convictions (Article 53).

As far as the right to healthcare services, all citizens are entitled to it, irrespective of their financial situation (Article 68). (The Constitution, 1997). The Constitution is the fundamental law which is directly binding and forms a basis for other legal acts. One of such acts is the Act of 6 November 2008 on patients' rights and the Commissioner for Patients' Rights. The Act contains general and specific patients' rights. The set of patients' rights is extensive and includes the right for healthcare services, the right for information, the right to ask the physician not to provide him/her with specific information identified by the patient, the right to express his/her opinion about the information received, the right for a sufficiently early notice of the physician's intention to withdraw from treatment, the patient's right for the confidentiality of the information referring to him/her, the right to consent to the provision of healthcare services, the right for respect of his/her privacy and dignity, the right to die in peace and dignity, the right to receive services alleviating pain and other suffering in a terminal condition, the right of access to medical documentation, the patient's right to object to the physician's opinion or judgment, the right for respect for his/her private and family life, the right for pastoral care, the right to deposit valuables, and the right to apply to the Commissioner for Patients' Rights (Journal of Laws 2008, No. 52, item 417).

In accordance with the Regulation of the Minister of Health of 20 July 2011 on qualifications required from employees occupying certain types of positions in healthcare establishments that are not entrepreneurs, a nurse is a holder of a Bachelor's or Master's degree in the field of nursing or having secondary education in the profession of nurse (Journal of Laws 2011 No. 151 item 896). In line with the Act of 15 July 2011 on the professions of nurse and midwife, Article 52 (2), currently nursing schools include higher education institutions providing education in the field of nursing within first- and second-cycle programmes. The Act also contains regulations referring to total hours of first-cycle programmes. First-cycle nursing studies in a higher education institution should last at least 3 years and cover at least 4600 hours of occupational training, of which clinical (practical) education should constitute at least half and theoretical classes – at least one third of total hours. Second-cycle nursing studies last at least 4 semesters, and the number of hours of classes and practice cannot exceed 1300 (Journal of Laws 2011, No. 174, item 1039).

All regulations referring to educational standards comply with the Regulation of the Minister of Science and Higher Education of 9 May 2012 on educational standards in the following majors: medicine, medicine and dentistry, pharmacy, nursing and obstetrics. In general educational outcomes, the section referring to the skills of a Bachelor in Nursing states that he/she is able to provide individualised care for disabled and dying patients and to perform his/her profession independently, in line with the general principles of ethics and occupational ethics, and also a holistic approach to the patient, with respect for his/her rights. It can therefore be concluded that individualised care and a holistic approach refers to care adjusted to the needs of patients from different religious and cultural environments. The regulation also contains specific education outcomes with regard to knowledge, skills and attitudes. E.g.: students of nursing have the knowledge enabling them to consider cultural and religious differences and interpret the phenomenon of class, ethnic and sex inequality as well as discrimination. Students also have knowledge on the health insurance system in Poland and the European Union, and are familiar with the Patients' Rights Charter, the Human Rights Charter and the Children's Rights Charter. They are aware of the health-determining factors in an individual and global sense and are able to identify cultural, social and economic factor of public health. As far as skills are concerned, students are able to analyse and critically evaluate the phenomenon of discrimination and racism, and also to help patients in adapting to conditions of a hospital or other healthcare establishments. Students are able to recognise the factors influencing health behaviours of individuals and risk factors of lifestyle diseases and develop and implement individual health promotion programmes for persons and families. As regards attitudes, students of nursing respect the dignity and autonomy of persons under their care and continuously expand their knowledge and skills to achieve professionalism and be able to respond to new trends in patient care. An important aspect in the context of globalisation is also English language teaching, which within Bachelor's studies is provided at the B1 level according to the Common European Framework of Reference for Languages. Theoretical education at the Bachelor's studies level contains a number of elements referring to care for patients from different cultures. However,





practical education components related to this aspect are the ability to perform the nursing profession independently, in line with the general principles of ethics and occupational ethics, and also a holistic approach to the patient, with respect for his/her rights (Journal of Laws 2012, item 631). During second-cycle studies educational outcomes in the area of transcultural care are implemented through the subject called European nursing, where as part of the theoretical module, students become familiar with the nursing care system in the European Union and the rules applicable to nursing around the world, and in the skills module they learn how to analyse the areas of activity nursing in Europe and the rest of the world. Second-cycle studies also provide English language teaching at the B1 level according to the Common European Framework of Reference for Languages and covers language issues used in nursing, with a minimum number of 90 hours. In addition to first- and second-cycle studies, post-graduate studies are being developed on transcultural care. Recently the Medical University of Białystok has launched studies in the field of transculturalism in interdisciplinary medical care (Transkulturowość w interdyscyplinarnej opiece medycznej, 2016) at the Faculty of Health Sciences, with a one-year programme consisting of 110 hours.

Another document of relevance in nursing practice is the Code of Ethics for Nurses and Midwives of the Republic of Poland. The code refers to transcultural care in the oath: »to provide help to everyone regardless of their race, religion, nationality, political views, financial status and other differences«, which also contains a provision about showing patients due respect, not abusing their trust and maintaining professional confidentiality. The main part of the code states that at the request of the patient or his/her family a nurse should arrange contact with a clergyperson, providing appropriate conditions for such contact, and should make all efforts necessary to provide the patient with humane terminal care and conditions for dying in dignity, with respect to values professed by him/her (**The Code of Ethics for Nurses and Midwives of the Republic of Poland, 2003**).

MATERIAL AND METHODS

Aim of the study

The aim of the study is to analyse the challenges for nursing education and practice in terms of care for individuals representing different cultures in Poland on the example of Muslim patients.

Study design

Five interviews were carried out with people representing the Islamic culture, which were recorded and transcribed. The snowball method was used for selecting the representatives of Islam. The method consists of non-random sampling, with the help of other participants. The method is used when reaching the potential respondents is difficult (Explorable, 2016).

Data collection process

The survey was carried out from 20 June to 8 July 2016 at the Islamic Cultural Centre in Lublin. The centre is an open space for dialogue and exchanging views between Lublin residents and Muslims. The activities of the Centre include organising the religious practice of the local Muslim community, education and promoting knowledge of the Islamic culture. The survey covered five individuals, two women and three men, aged from 24 to 69. One of them used specialised medical care in Poland, two of the respondents took advantage of primary healthcare, and the remaining ones did not use healthcare in Poland at all. The interviews took the form of free conversations based on previously prepared subjects referring to the possibility of practising religion while being in hospital, faith-based nutrition, medications, care, communication with medical staff, and problems faced by Muslims in medical care. The survey participants were informed of its objectives and course, of its anonymous nature and data protection, as well as the possibility to withdraw at any stage of the survey. The interviews were recorded with a dictaphone and transcribed.



Data analysis and rigour

A qualitative analysis of the data collected was carried out. A contextual analysis of the research material was performed separately by three people, who identified the main categories appearing in the interviews. After that, on the basis of the identified categories, an independent detailed analysis of the interviews was carried out, with specifying subcategories and assigning quotations from the respondents to each of them on an anonymous basis. After carrying out three independent analyses, the identified subcategories were reconciled and standardised. Quotations were added to each subcategory to enable deeper insight into their content (Hsieh & Shannon, 2005).

Ethical issues

After collecting the data, specifying categories for results and adding quotations to them, the interviewees were asked to accept them. All the respondents approved the quotations and agreed for their publication. In order to ensure anonymity of the participants, they were assigned numbers from n1 to n5 in each of the discussed categories. The numbers of particular persons were identical in each category. n2 and n5 were women's responses, and n1, n3 and n4 belonged to the male participants.

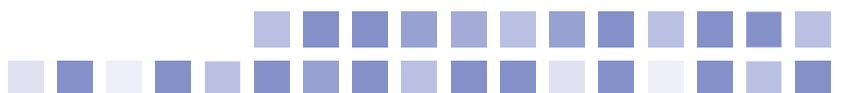
Results

Five categories were identified with subcategories as reported in table 1.

Table 1 Categories and subcategories identified

Categories	Subcategories
I. Prayer in hospital conditions	1. Place for prayer 2. Prayer in difficult conditions
II. Fasting in hospital conditions	1. Fasting during disease 2. Attitude of the medical staff to fasting person
III. Meals in hospitals	1. Nutritional rules of Muslims 2. Nutritional alternatives for Muslims
IV. Care and nursing and the carer's sex	1. The carer's sex
V. Treatment and medications	1. Medications and substances forbidden in one's faith 2. Staff's willingness to cooperate
VI. Challenges in the care for patients representing different cultures	1. Fear of the different person 2. Tolerance for other cultures 3. Knowledge of the medical staff on other cultures 4. Language of communication 5. Cultural sensitivity

The first category is prayer in hospital conditions, with the subcategory *place for prayer*. Currently in Poland only Catholics have hospital chapels, and the interviewed emphasise that patients representing other cultures are entitled to religious practice and therefore a suitable place should be available for them, for instance a room with empty walls, without any religious symbols: [n2] (...) *there are different denominations,*





people of different religions, who should be able to praise God in every situation.« The patient's room is not an appropriate place for Islamic religious practices due to the presence of other patients, the lack of space and contamination, e.g. with blood, etc.: [n4] »it is difficult for us to pray in a hospital room; it must be a clean place". The second subcategory is prayer in difficult conditions. Islam is quite flexible when it comes to disease, and if the conditions do not allow practising prayer in the traditional form, it can be temporarily performed in a different way. [n1] »Islam is flexible enough to take into account the fact that I'm ill and I'm staying in a place with certain conditions (...)."

The second category is fasting in hospital conditions, with the subcategory *fasting during disease*. In the case of a disease, a person's life and health is the most important, so if a physician recommends abandoning fasting, this is the practice among Muslims: [n1] »(...) If a doctor claims that fasting is not allowed, it is a sin to fast in such a situation." Another subcategory is the *attitude of the medical staff to fasting person*, which refers to one of the basic principles of Muslim faith, i.e. fasting during Ramadan. During a disease it is allowed to depart from this principle, but medical staff should explain to the patient the medical aspects of departure from fasting: [n2] »My fasting was not taken into account, I was still ordered to eat! [n5] »I would refuse to eat, but certainly I would hear some critical remarks about it; the nurses here are impolite anyway".

The following category is meals in hospitals, with the subcategory *nutritional rules of Muslims* referring to the prohibition to eat pork. In Polish hospitals means with pork as the main course or containing pork are served frequently: [n4] »I'm not sure whether they wouldn't give me pork in hospital and say that it's beef... (they would lie) to make things easier.« The second subcategory is nutritional alternatives for Muslims. There are situations when the medical staff do not include nutritional preferences resulting from cultural differences and do not offer alternative solutions, due to which the patient's family must provide food for him/her: [n5] »I remember when one nurse told me that it's not a restaurant and that they can give me only what's available«.

The fourth category is care and nursing and the carer's sex, where the subcategory *the carer's sex* was identified. In hospitals Muslims prefer medical carers of the same sex as the patient: [n3] »A woman can only provide care for a woman.« However, when a threat to health is involved and when providing a same-sex carer is impossible, the rule is abandoned, as a person's life and health is of utmost importance: [n5] »if no other person is available, health is the most important, always.«

The next category is treatment and medications, with the subcategory *medications and substances forbidden in one's faith*, where medical staff should suggest replacements for some medication, adjusting them to the patient's religious beliefs, but in the case of their lack, the principle of protecting human life and health as the highest value applies: [n1] »when there is no replacement, it is not a problem, it is treated as a necessity.« Another subcategory is *staff's willingness to cooperate*; care for the life and health is a justification for Muslims in the case of breaching rules referring to consuming prohibited substances contained in medications: [n4] »I would ask for a different medication... But when there isn't any, we are exempt in conscience.« Health is essential, and the hands of a doctor are the hands of Allah.« When replacements of certain medications are available, medical staff members should suggest those to patients of the Islamic culture; yet, the surveyed stated that this is not common practice in hospitals: [n2] »they do not suggest other medications, the rules that apply to us are simply not followed (...).«

The last category is challenges in the care for patients representing different cultures. The first subcategory is *fear of the different person*. According to the interviewees, medical staff and patients react with fear to everything that is unknown and foreign, while anxiety towards different cultures usually results from the lack of knowledge: [n4] »Someone I can see the way people are looking at us when I'm walking with my children and wife, as if they were surprised or something (...)". Fear of the unknown brings out negative emotions in people, which in healthcare often translate into specific behaviour towards the patient. Aggressive behaviour can manifest itself in a verbal or non-verbal way, sometimes even without awareness that another person interprets one's behaviour in such a way: [n1] »There is fear that turns into aggression.« The next subcategory is *tolerance towards other cultures*. The surveyed patients claim that in Polish hospitals there is no respect for views and beliefs that are different than the ones generally accepted in our country: [n2] »this is the lack of tolerance for something that is simply different.« Another subcategory is *knowledge of the medical staff on other cultures*, where, according to the collected data, Polish he-



althcare staff, and also Polish society, lacks knowledge on different culture and traditions and there is little willingness to find out more about these issues, also through asking people representing such culture directly: [n4] »Poles often know too little about us.« Another subcategory is the *language of communication*. In Polish hospitals patients of different cultures often encounter language barriers; few members of the medical staff speak English, and transcultural patients often do not fully understand the Polish language. The surveyed persons understand and feel the need to learn the language of the country that they stay in: [n5] »Language is not such a problem. You know, not everyone of us speaks Polish; we need to learn a lot. But this is our problem.« The last subcategory is cultural sensitivity. The media are one of the most common sources of knowledge about the world, and they usually present a negative image of Islam. Poles do not develop their knowledge by objective information about the sources of prejudices about Islam (Majda & Zalewska - Puchala, 2011): [n7] »Some people are just prejudiced without any specific reason.«

DISCUSSION

The objective of the study was to analyse challenges for education and nursing practice in Poland resulting from an increased diversification of Polish society based on a survey carried out among the representatives of the Islamic culture.

Prayer in hospital conditions. Muslims are obliged to follow five pillars of Islam. One of them is daily prayer, i.e. salat. This is a ritual repeated five times during the day (<http://www.muzulmanie.com> (accessed on: 26. 9. 2016)). Before salat Muslims must be in a state of ritual purity, which is achieved by washing with water or sand. The praying person must place a special rug on the floor (which is not obligatory), turn to Mekka and perform a certain number of bows and gestures and recite specific verses of Koran. Of importance are the Friday prayers are important, practised in a community gathered in mosques, accompanied by sermons (Pruszyński, et al., 2013). Ill people are allowed not to participate in most religious practices (Szreder & Kurowska, 2011). Therefore, it is not surprising that the surveyed, just like Catholics, would like to be able to use a separate place for prayer in a clean environment, in silence and without the piercing looks of other patients. For most of us prayer is a type of intimacy that we seek.

Fasting in hospital conditions. Another important element of Islamic worship is fasting, i.e. Ramadan. It last 30 days from dawn to dusk, always in the ninth month of the lunar year, which falls in varying periods of the solar year. During the fast, Muslims are not allowed to eat and drink, tell lies, smoke tobacco or have sexual intercourses (Guzowski, et al., 2015). The above does not apply to chronically ill people, pregnant and nursing women and travellers. Such people are obliged to fast in another time of the year (Pruszyński, et al., 2013). Following the principles of their faith, during a stay in hospital the surveyed are able to refrain from fasting for the sake of their health. Due to that, the period of treatment is not problematic to them.

Meals in hospitals. However, their nutritional habits and principles are an issue. Muslims are forbidden to eat pork and products containing it, animals killed in an improper way (only ritual slaughter by a Muslim is accepted). It is allowed to eat poultry, beef, the meat of goats, sheep, camels, rabbits, herbivorous fish and herbivorous animals (game). Questionable products include gelatin, enzymes, emulsifiers and other products of animal origin. (Pruszyński, et al., 2013) According to doctors, »Today, when hospitals use the services of external catering companies, it would not be problem to order meals that do not contain pork. However, to make such decisions, one needs non-medical knowledge and the willingness to understand the needs of those who are different. These are of course technical issues related to care for patients from other cultures« (Konopacki & Ryszewska, 2015, p. 320). Muslims have become used to arranging meals for themselves (Konopacki & Ryszewska, 2015). They also lack trust towards Polish medical staff and are of the opinion that they could be deceived as to the contents of their meals.

Care and nursing and the carer's sex. For the followers of Islam the sex of the physician and other members of medical staff is not an issue. They claim that their health is the most important. However, in their countries they follow the rule that medical care should be provided by





medical personnel of the same sex as the patient (Szreder & Kurowska, 2011).

Treatment and medications. Another important aspect in the discussed categories are medications and substances forbidden in one's faith. Forbidden substances have been mentioned above, but in the opinion of the surveyed it is allowed to take medications containing them for the sake of their health. The respondents pointed to the problem encountered in Polish hospitals related to providing no alternatives and the lack of willingness of medical staff to seek replacements (Centrum Kultury Islamu-Katowice, 2016). It should be stated that for Jehovah's witnesses hospitals provide services compliant with the principles of their faith, which is confirmed by the document »Dyspozycje i pełnomocnictwo w sprawie opieki zdrowotnej (Instructions and authorisation in healthcare) (Świadkowie Jehowy w Polsce. Służba Informacji o szpitalach, 2015).

Challenges in the care for patients representing different cultures. Women wearing a *hijab* attract the attention of other people (Konopacki & Ryszewska, 2015). They stand out of the crowd, and they treat the gazes of the passers-by as a lack of tolerance. Apart from physical appearance, factors influencing the perception of people from different culture is hampered intercultural communication. Healthcare staff should provide help in a manner corresponding to the needs and expectations of the patients resulting from their cultural diversity, as everyone is entitled to respect for his/her origin and cultural heritage. It is important for medical staff to have some knowledge on other cultures and religion, which enables culturally sensitive and competent care (Papadopoulos, 2003). Language barriers, such the lack of a basic command of English, is currently a problem. Also perceiving those who are different through the prism of prejudices and stereotypes makes it impossible to perceive them objectively and discourages from communicating with them (Ślifirczyk, 2015). The reservations of the surveyed in this respect are not unfounded. In the 21st century, due to the growing multiculturalism of societies, it is essential to take it into consideration in the healthcare system. It is worth including issues of sensitivity to cultural and religious differences in university course books and programmes for future nurses, midwives, physicians and other professional groups, as they will meet these challenges in their everyday work. It is also crucial to use the skills in practice to abandon cultural stereotypes and reinforce the attitude of trust towards other people, their culture and religion (Van Damme-Ostapowicz, 2015).

Limitations

The statements of the surveyed refer to their experiences related to healthcare in Poland. With time their opinions expressed in answers to the same questions may change due to personal and educational factors as well as further experiences with healthcare in Poland. Therefore, it is difficult to generalise on the results of the survey.

CONCLUSIONS

Multicultural education is based on such elements as: knowledge, which covers command of foreign languages, being familiar with cultures of different countries, concepts of various cultures; skills: communication and conflict management skills, the ability to solve difficult problems; attitudes, i.e. observation, self-reflection, compassion, flexibility, an open attitude and tolerance. The analysis of documents regulating nursing education and profession shows that nurses receive education on transcultural issues but not all elements of multicultural education are included in their educational programmes.

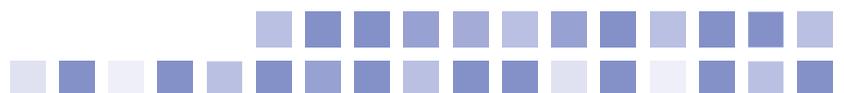
The survey covering people representing the Islamic culture demonstrates that religious practices, cultural differences related to meals, medications, selected medical and care procedures and communication are issues which require greater attention of medical personnel in the process of care for patients representing different cultures – in this case the Islamic culture. Patients from the Islamic culture staying in Polish hospitals are ready to adjust to the healthcare system and to seek alternative procedures enabling them to preserve their cultural identity. Further studies on care and education relating to people from other cultures should be performed to increase the standards of care.



It is also crucial to develop cultural competence in the field of cultural safety and sensitivity among medical staff. The basis for developing the mentioned competence is expanding knowledge on transcultural patients and accepting the diversity of cultures and religions. Developing cultural sensitivity is essential as in order to get to know a different culture one needs to abandon stereotypes and be open to other values. If patients are approached with understanding of their culture by medical personnel, it will be easier for them to function in a new environment and adapt to new situations. Therefore it is important to introduce multicultural education in study programmes and to develop cultural competence.

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ASPECTS OF MULTICULTURAL NURSING PRACTICE IN NURSING RESEARCH. REVIEW OF THE LITERATURE FROM POLAND

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INTRODUCTION

It would be difficult to find a country wholly inhabited by a single nationality. Wars, religious conflict, natural disasters and the increasing globalisation processes have led to the current situation, in which cultural diversity is a rather common phenomenon in the majority of countries in the world. In addition, the development of transport and a progressive improvement in foreign language skills have been extremely conducive to migration (Lesińska, 2014).

First of all, there is a fundamental difficulty in defining what exactly culture, and by extension, cultural diversity, are. There are a number of definitions. According to English anthropologist and ethnologist Edward Tylor, culture or civilisation is “that complex whole which includes knowledge, belief, art, morals, law, and any other capabilities and habits acquired by man as a member of society” (Halicka & Kramkowska, 2010). It can be said that culture is the sum of the principles, rules and methods of human activity, the products of human endeavour and creativity that constitutes the heritage of human societies. As for cultural diversity, it is created by nations, national minorities, ethnic groups and religious organisations.

In Poland historical processes have resulted in a relative cultural uniformity. This is the aftermath of the decisions made by the Big Three during the Yalta Conference in 1945. After Yalta the Polish Republic lost a large part of its population of Ukrainian and Belarusian origin, who mostly belonged to the Orthodox and Greek Catholic churches, to the Soviet Union. In addition, non-Polish nationals were resettled to their mother countries. Furthermore, the Holocaust destroyed the rich Jewish culture – before the War, Poland was home to over 3 million people of Jewish origin (Główny Urząd Statystyczny Rzeczypospolitej Polskiej, 1938). As a result, 97.09% people now identify themselves as Polish nationals and 87% are Roman Catholics (Struktura narodowo-etniczna, językowa i wyznaniowa ludności Polski 2011, 2015).

Examples of cultural diversity can nevertheless be found in many parts of Poland. As mentioned before, the current situation has resulted from centuries-long historical processes. Much of the Podlasie and Suwalszczyzna areas have been inhabited by Tatars for more than 600 years. Overall, there are approximately 2 thousand Muslims of Tatar origin in Poland (Struktura narodowo-etniczna, językowa i wyznaniowa ludności Polski 2011, 2015). This number is increased much by thousands of Muslims staying in Poland in the course of their studies, as well as business, trade or diplomatic activities (Pew Research Center, 2011).

Eastern Poland and the Subcarpathian region are characterised by a relatively strong influence of Orthodox culture. This is a consequence of the multi-faith structure of Poland’s inhabitants from the pre-partition times, when religious freedom was guaranteed to Orthodox people and a remainder of the five pre-War dioceses of the Orthodox Church, which were reorganised due to the loss of Eastern Borderlands (Mironowicz, 2005). Moreover, immigration from Ukraine and Belarus for economic and educational purposes is increasing with every year. In larger cities, in Central Poland and in Łódź there are large populations of Jews with a distinctive culture of their own. This was also shaped by the religious tolerance of Polish rulers from the 15th-18th centuries. In addition to these examples of societies representing diverse cultures living in Poland, there are also people who have immigrated into this country due to political persecution, European integration and the ubiquitous globalisation processes. These include Chechen, Romani, Taiwanese, Saudi, Hindu, Norwegian and Spanish people.

With every year, Poland is becoming a more multicultural, multi-denominational and multinational country. This phenomenon poses new problems and challenges for healthcare professionals and particularly for the nursing staff. This is due to the fact that it is extremely important for the treatment and nursing process of the patient to remain in agreement with his or her religious beliefs (Bielawska, 2014).



MATERIAL AND METHODS

The aim of the study

The objective of this article is to analyse the results of empirical studies available in the Polish academic nursing literature on multiculturalism in nursing practice.

Research problems

1. What issues connected with multicultural nursing care are subjects of scientific research on nurses in Poland?
2. What challenges and problems in multicultural nursing care were identified in studies?
3. Which cultural minorities are the most frequent subject of study in the Polish academic nursing literature?

Method

Manual searching was performed in the databases of the following nursing journals: *Nursing in the 21st Century*, *Nursing Topics*, *Polish Nursing*, *Specialist Nursing*, *Modern Nursing and Health Care*, *Nursing and Public Health*, *Surgical and Vascular Nursing*, *The Journal of Neurological and Neurosurgical Nursing*, *Polish Journal of Public Health* and in such journals as: *Hygeia Public Health*, *General Medicine and Health Sciences*. The following inclusion criteria were adopted: publication language – Polish; article representing original research (qualitative, quantitative and meta-analysis); publication in 2011-2016; the availability of the full text of the article and matching the following keywords: *multiculturalism*, *culturally different patient*, *nursing care*. The exclusion criteria were the following: publication language other than Polish; review article; publication before 2011; full text unavailable; works not matching the listed keywords. 12 articles were eventually selected for the analysis. Taking into account the adopted criteria, a Google Scholar search was also performed using the following keywords: multicultural nursing; multicultural patient; patient from a different culture; cultural sensitivity in medical care. This allowed 6 additional articles to be selected for analysis. A total of 18 works were analysed (Table 1).

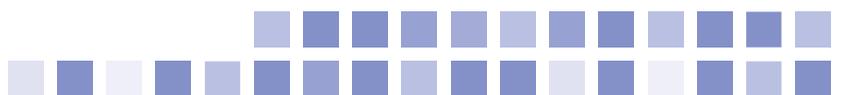


Table 1. Articles accepted to analysis

	Title of the article	Authors	Year of publication	Researched group	Research method and tool
1.	Postawy prozdrowotne studentów wybranych uczelni Polski, Białorusi i Ukrainy dotyczące stomatologicznych badań kontrolnych.	Knaś M., Zalewska A., Kleszczewski T. i wsp.	2015	527 Polish students, 837 Bielarus students, 615 students from Ukraine	Method: survey
2.	Stereotypy i postawy mieszkańców Małopolski wobec przedstawicieli wybranych kultur.	Kamińska A., Majda A., Zalewska-Puchała J., Sajdak I.	2015	120 people living in South Małopolska region	Method: survey Research tool: authors' questionnaire and Bogardus scale
3.	Wybrane elementy stylu życia wyznawców adwentyzmu i katolicyzmu.	Kucharska A., Sińska B., Marszałek K. i wsp.	2015	52 Adventists and 42 members of Catholic Church	Method: survey Research tool: questionnaire
4.	Wpływ przekonań religijnych na ocenę pracy pielęgniarki w percepcji pacjentów	Lankau A., Krajewska-Kułak E., Wrońska I.	2015	150 patients	Method: survey Research tool: questionnaire
5.	Uchodźcy jako przyszli odbiorcy usług medycznych z perspektywy studentów Uniwersytetu Medycznego w Białymstoku.	Laskowski K., Krajewska-Kułak E., Fiłon J.	2015	151 students of the Medical University of Białystok	Method: survey Research tool: Authors' questionnaire
6.	Kompetencje międzykulturowe w pielęgniarstwie.	Zdziebło K., Nowak-Starz G., Makieła E., Stępień R., Wiraszka G.	2014	106 nurses working in different health care institutions	Method: survey Research tool: Authors' questionnaire
7.	Standard edukacji pielęgniarskiej wobec pacjentów z zakresu medycyny podróży	Van Damme-Ostapowicz K., Krajewska-Kułak E.	2013	195 professionally active nurses and nursing students, 40 patients, 2218 analysed patients' records	Method: survey Research tool: Authors' questionnaire
8.	Zachowania zdrowotne studentów pochodzenia wietnamskiego studiujących w Polsce.	Zalewska-Puchała J., Majda A., Antończyk A	2013	30 Students and graduates of Vietnamese origin studying in the universities of Krakow	Method: survey Research tool: Authors' questionnaire regarding health behaviours and the scale of self-efficacy
9.	Stereotypy i uprzedzenia wobec osób odmiennych kulturowo w świadomości studentów pielęgniarstwa	Majda A., Zalewska-Puchała J., Barczyk E.	2013	100 nursing students	Method: survey and method of testing achievements Research tool: Authors' questionnaire and authors' test of knowledge



	Title of the article	Authors	Year of publication	Researched group	Research method and tool
10.	Ocena kompetencji kulturowych wśród pracowników ochrony zdrowia	Szkup-Jabłońska M., Schneider-Matyka D., Kubiak J., Grzywacz A., Jurczak A., Augustyniak A., Grochans E.	2013	200 health care workers	Method: survey Research tool: Cross-Cultural Competence Inventory
11.	Postawy studentów pielęgniarstwa wobec osób odmiennych kulturowo.	Majda A., Zalewska-Puchała J., Barczyk E	2013	100 nursing students	Method: survey Research tool: authors' questionnaire and Bogardus scale
12.	Zachowania zdrowotne studentów pochodzących z Tajwanu studiujących w Polsce.	Zalewska-Puchała J., Majda A., Śmiałek D	2013	60 Students from Taiwan - 40 of them were students of Medical University of Silesia in Katowice, the others studied in their native country	Method: survey Research tool: Authors' questionnaire and the scale of self-efficacy
13.	Pacjenci obcokrajowcy w opiniach polskich lekarzy.	Zgliczyński W., Cianciara D.	2013	141 doctors in training in public health at the School of Public Health Center for Postgraduate Medical Education	Method: survey Research tool: questionnaire
14.	Wpływ poziomu empatii na postrzeganie relacji pielęgniarka-pacjent z innego obszaru kulturowego.	Ogórek-Tęcza B., Kamińska A., Matusiak M., Skupnik R.	2012	167 nurses working in two hospitals in Małopolska region	Method: survey Research tool: Emotional empathy scale of A. Mehrabian and N. Epstein developed by Rembowski
15.	Liczba, charakterystyka i zdrowie imigrantów w Polsce	Cianciara D., Dudzik K., Lewczuk A., Pinkas J.	2012	Emigrants	Analysis of data from the study of international migration and research conducted among migrants
16.	Związek między religią a zdrowiem w badaniach epidemiologicznych.	Zagożdżon Paweł	2012	Different religious groups	Meta-analysis
17.	Zasady pielęgnowania – Muzułmanka w szpitalu	Szreder B., Kurowska K.	2011	Patient	Method: case study, qualitative analysis
18.	Zachowania zdrowotne obcokrajowców studiujących w Krakowie na kierunku lekarskim.	Klimczak K., Majda A.:	2011	111 foreign students of Collegium Medicum Jagiellonian University	Method: survey Research tool: Authors' questionnaire and the scale of self-efficacy, The scale of perceived stress, Fagerström test (FTND)

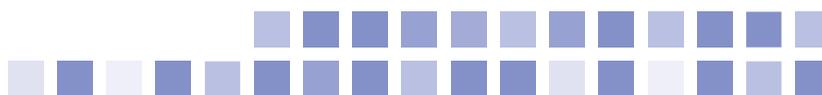
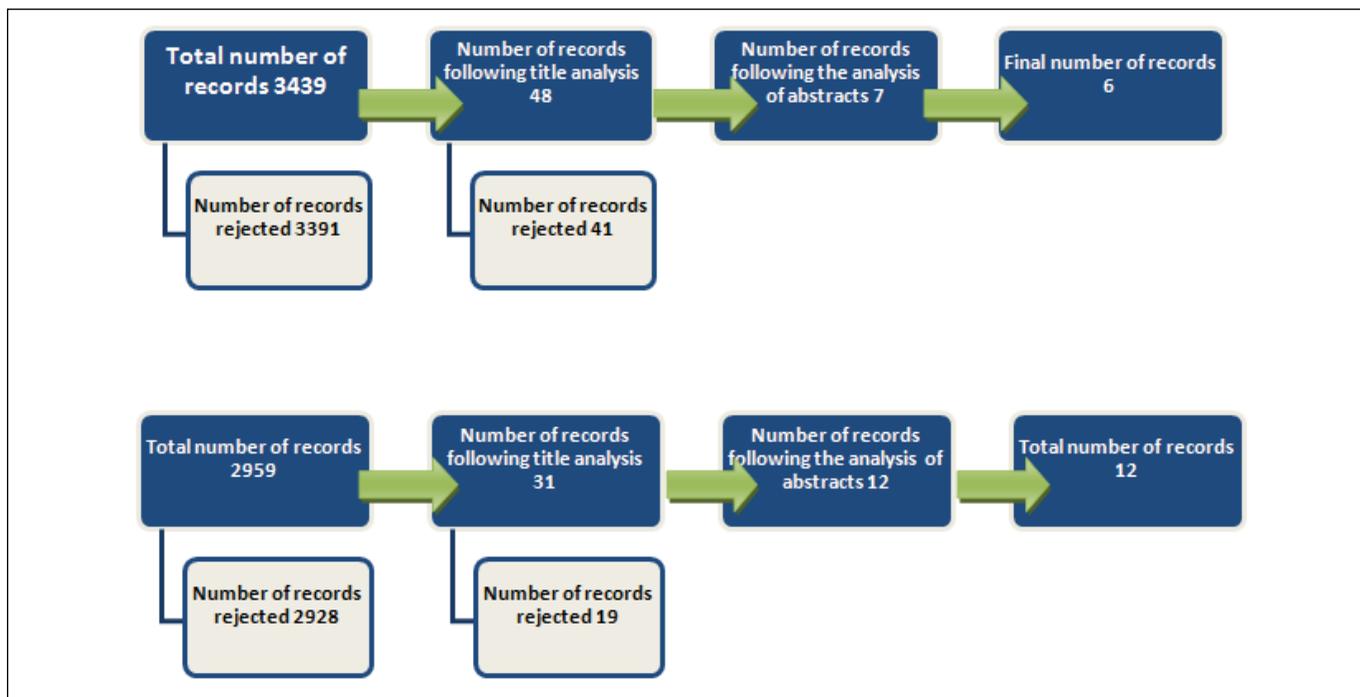


Fig. 1 Stages of the article search process in (1) Google Scholar and (2) in nursing journals



Data analysis

A thematic analysis was performed on the collected material independently by 3 researchers. This was followed by the process of reconciliation and combination of the results. Eventually, the following categories of subjects relating to research in multicultural care in nursing practice were determined:

- I. **Nurses' cultural competence**
- II. **The impact of religious faith on selected aspects of medical care**
- III. **Nursing education and travel medicine**
- IV. **The attitudes of Polish society towards people from different cultures**
- V. **The health-related behaviour of people representing different cultural areas**



RESULTS

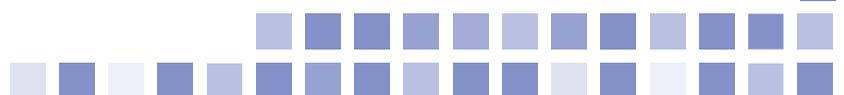
I. NURSES' CULTURAL COMPETENCE

The first aspect that was present in scientific research on nurses relating to multicultural care are nurses' cultural competence. This category is broken down into the following subcategories: *cultural competence areas; the assessment of cultural competence among healthcare professionals; problems connected with multicultural nursing care.*

Research results show that there are three *cultural competence areas* among nurses: knowledge, skills and attitudes. 91,5 % of respondents (N=106) believed that knowledge of other cultures is useful in their work, but as many as 92,5 % did not feel sufficiently prepared to establish appropriate contact with a person representing a different culture. According to the respondents, it would be beneficial to improve their competence with regard to important issues relating to the influence of various cultures on health and diagnosing diseases (57,5 %) and knowledge on cultural diversity (48,1 %). The following skills should also be obtained: identifying problems arising from cultural differences (59,4 %), practising intercultural communication (56,6 %) and overcoming cultural barriers and differences (53,8 %). It was also deemed advisable to work on: an attitude of respect towards oneself and other people (87,7 %), eradicating prejudice and stereotypes (59,4%), sensitivity to and respect for cultural differences (57,5%) (Zdziebło, et al., 2014).

An assessment of cultural competence among healthcare professionals demonstrates that the youngest healthcare professionals have the most developed ability to understand culturally different patients, while the lowest level of empathy is in the 45-60 age group. The youngest respondents were the most open to new experiences and respondents in the 36-45 group were the least open. The data revealed that women have a higher level of ethno cultural empathy. It is also the case with regard to being open to new experiences and displaying cognitive flexibility – women are characterised by a higher level of competence in this field than men. The analysis showed that, depending on the job title, nurses (who represented 58% of all healthcare professionals, n=200 people) were characterised by greater empathy and cognitive flexibility than other groups. This also relates to greater involvement and openness in relations with culturally-different patients represented by nurses than by other respondents (Szkup-Jabłońska, et al., 2013).

The research allowed to identify *problems connected with multicultural nursing care*. As many as 62,3 % of nurses (n=167) indicated difficulties appearing in the course of providing care to patients of different faith. These included: insufficient knowledge about the principles of a given religion; communication problems and the hospital's lack of adjustment to providing care to culturally different patients. According to nurses, action must be taken to facilitate appropriate relations and professional care provided to such patients. This could be achieved by creating standardised rules of conduct for performing all medical procedures (32,3 %) and also expanding knowledge on the principles/customs of a given religion or culture (24,6 %) and adjusting the conditions in wards and in hospitals at large to allow patients to engage in free and appropriate religious practices (8,4 %) Nurses also indicated the need to organise courses and training sessions with regard to providing care to patients coming from other religions/cultures, being able to contact a specialist on other religions and being provided guidelines on how to approach a patient of a different faith (11 %). (Ogórek-Tęcza, et al., 2012)





II. THE IMPACT OF RELIGIOUS FAITH ON SELECTED ASPECTS OF MEDICAL CARE

Another aspect present in scientific research of nurses relating to multicultural care is *the impact of religious creed on the selected aspects of medical care*. The following subcategories were distinguished in this subcategory: *a nurse's religious creed and professional work, nursing care provided to culturally different patients and the relationship between religiousness and health*. Data analysis demonstrated that 45,3 % (n=150) of patients see a nurse's religious creed as not affecting the choice of profession. For two thirds of respondents the religious creed of the nurse providing care to them is of no importance. One in three respondents, however, would prefer the nurse to be of the same faith as the patient. According to patients, a nurse's religious creed affects such medical procedures as blood transfusion, euthanasia and transplantation. If the therapy contradicts the religious beliefs of the patient, the nurse should seek another nurse's opinion according to 42 % of respondents, and if it contradicts the nurse's beliefs, entrust the care of the patient to another person (47,3 %) (Lankau, et al., 2015).

Multiculturalism surveys among Polish nurses demonstrated that they were able to provide appropriate care to a culturally different person when confronted with a Muslim patient. They demonstrated extensive knowledge on the patient's religious creed and the religious principles affecting nursing care and an attitude of openness and respect for difference (Szreder & Kurowska, 2011).

Patients in Poland refer not only to the religious creed of the nurse providing care to them, but also to the creed of other patients and the possibility of engaging in religious practices when in hospital. Being in one room with persons of the same creed is important for 18.7% patients. Most patients (88.7%) declared that a patient should always have the right to engage in religious practices when in hospital. The surveyed patients confirmed that they were provided with pastoral care (Lankau, et al., 2015).

A meta-analysis of scientific research on the correlation between religiousness and health conducted by Zagożdżon (2012) shows that such a correlation indeed exists and is expressed in the fact that participation in religious practices and prayer can result in greater social support and inner peace.

III. NURSING EDUCATION AND TRAVEL MEDICINE

Multicultural care in scientific research on Polish nurses also relates to travel medicine, which is aimed at improving and maintaining an optimum state of health of patients travelling to countries located in different climate zones and with a low standard of living. Nurses and students of nursing are willing to educate their patients and wish to expand their knowledge on travel medicine. Research shows that patients do not have sufficient knowledge about preventive healthcare connected with travelling and that it is also the case for Polish nurses (Van Damme-Ostapowicz & Krajewska-Kułak, 2013).

IV. THE ATTITUDES OF POLISH SOCIETY TOWARDS CULTURALLY DIFFERENT INDIVIDUALS

Another issue appearing in scientific research on nursing relating to multicultural care involves the *attitudes of Polish society towards culturally different individuals*. The following subcategories were distinguished in this subcategory: *stereotypes, prejudice and discrimination against foreigners; problems/difficulties appearing in contacts with foreigners; the opinions of physicians on the positive and negative aspects of treating foreigners; challenges relating to the provision of multicultural care*.

The residents of the Małopolska region surveyed demonstrated various stereotypes about Romani people, Jews and Muslims. The majority of those stereotypes were negative. They also showed signs of discrimination against those foreign groups as demonstrated in their inability to accept them as potential relatives, colleagues, neighbours or citizens of their country. The respondents distanced themselves the most

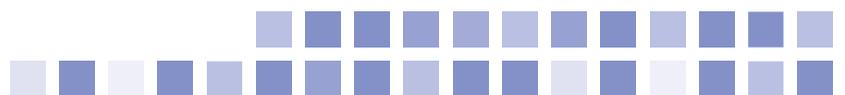


from the Romani community and the least from Muslims (Kamińska, et al., 2015). Similar surveys conducted among nursing students showed that the prejudice was the strongest in response to a situation where a person from a minority group were to become a member of their family (affinity by marriage of someone from their family). In the context of discrimination, as many as 75 % of respondents declared that they had witnessed such acts against culturally different individuals. Only 13% respondents said that they had always tried to help the person discriminated against (Majda, et al., 2013a). As many as 87 % of the surveyed students declared that they had encountered (or still met with) stereotypes. A correlation between the interest of the surveyed students in issues connected with other cultures and their perception of discriminatory behaviour was identified. It demonstrated that students who were interested in issues connected with other cultures noticed discriminatory behaviour much more often, knew what discrimination involved and were able to identify instances of it. Also students who came in contact with culturally different individuals noticed discriminatory behaviour significantly more often (Majda, et al., 2013b). In their attitudes to people of different faith and culture, the majority of nurses declared positive emotions such as curiosity (37,7 %) and friendliness (11,4 %), and also neutral emotions such as indifference (18,6 %) and distance (8,4 %). Contact with a sick person from a different religion or culture for 78,4 % of nurses did not change their feelings about such people, while 13,8 % of nurses saw these changes as positive thanks to the emergence of openness and understanding, friendliness, empathy and reduced anxiety. Although most respondents declared that there was no change in their attitudes towards patients, 57,7 % indicated the negative image of such patients, accompanied by increased anxiety, antipathy, enmity, closeness and even rejection, which probably involves a stereotypical approach. For one third of the respondents, the image of a patient of a different faith/culture was derived from their own experiences. The influence of the media (16,8 %), role models (7,8 %), spiritual leaders (6,0 %) and the Internet (0,6 %) was much less pronounced. (Ogórek-Tęcza, et al., 2012)

According to 52,3 % students surveyed by Laskowski and colleagues (2015), medical personnel experienced problems when meeting refugees. Nearly all respondents stated that the most important problem involved communication difficulties, or the language barrier (94,7 %). In addition to this, other relatively frequent answers were the lack of knowledge and understanding of the principles of a different religion (66,2 %) and a different understanding of the concept of a healthy lifestyle (62,3 %). The respondents noticed not only problems related to care and treatment, but also economic and social problems (Laskowska, et al., 2015). In a different study, physicians identified other problems related to foreign patients. For more than half of them, the problem involved issues connected with health insurance; i.e. they did not know whether the patient was insured and, if so, according to what rules (65,1 %), they had difficulties communicating with the patient due to not knowing the language (60 %), they did not know the rules applied to the insurance of foreign patients in the National Health Fund (54,1 %). Every one in three respondents thought that patients ignored their recommendations. One in four noticed culture-related problems and one in five claimed that patients had different perceptions of the physician's role (Zgliczyński & Cianciara, 2013).

The perceived advantages and disadvantages of treating foreign patients were obtained from an analysis of physician's opinions. More than half of the physicians researched listed the courtesy displayed by foreign patients towards them as an advantage. Other frequent answers involved the respect showed by foreigners (39,7 %), their lack of a demanding attitude (31,2 %) and following recommendations (20,6 %). According to the surveyed physicians, the disadvantages of treating patients from outside Poland included the lack of certainty that the information provided to the patient during the visit has been understood, primarily due to the language barrier (66,7 %). Many patients used their services for the first and only time, becoming "one-time patients" (51,1 %). They often exhibited unusual symptoms, creating both diagnostic and treatment-related problems (34,8 %). Another problem was the need for quick treatment due to a delayed visit and disease progression (24,8 %). Interestingly, research shows that 21,3 % of physicians did not see any positive aspects of treating foreigners. Only 5,7 % did not see any disadvantages of treating foreigners (Zgliczyński & Cianciara, 2013).

The surveyed students claimed that there were a number of challenges in the context of shaping intercultural sensitivity among healthcare professionals. Those that still require considerable work include monitoring the sanitary and epidemiological state of refugee centres (70,2 %) and acquiring professional skills by students (69,5 %) (Laskowska, et al., 2015).





V. THE HEALTH-RELATED BEHAVIOUR OF PEOPLE REPRESENTING DIFFERENT CULTURAL AREAS

The following subcategories were distinguished in this subcategory: *eating habits, preventive behaviour and health-related practices, stress and handling stress, use of healthcare services.*

Patients' diets represent a very important factor in nursing practice. Among the topics raised regarding *eating habits* it was found that religion has a strong influence on the type of diet. For example, as many as 69 % respondents declared following a vegetarian diet in the group of Adventists (Kucharska, et al., 2015). The article by Klimczak & Majda (2011) demonstrated that 40,5 % of foreign students of medicine in Kraków did not eat any pork or ate it on very rare occasions. When asked to identify the most frequently consumed products, students of Vietnamese origin studying in Poland listed rice, poultry, whole grain products, and fruit and vegetables (in order of frequency). The least popular products were dairy products, red meat and sweets (Zalewska-Puchała, et al., 2013a). In another study by Zalewska-Puchała and colleagues (2013b) Taiwanese students studying in Poland were asked to list the most frequently consumed products and the most popular were rice, vegetables, fruit, meat, dairy products, and vegetable fat, while the least popular products included bread goods, both white and brown.

Another listed category involves *preventive behaviour and health-related practices*. The analysed study results showed that students were very physically active, which included doing sports on a daily basis (74,8 %) or 1-2 times a week (43 % men and 22 % women from Vietnam against 52 % men and 47 % women from Taiwan), and going to classes on foot (60 %) (Klimczak & Majda, 2011; Zalewska-Puchała, et al., 2013a; Zalewska-Puchała, et al., 2013b). Students also often slept the optimum number of 8-9 hours per day (57 % men and 53% women) (Zalewska-Puchała, et al., 2013b). An important aspect of preventive healthcare also involves regular dental appointments. For example, in the 2014/2015 academic year both female and male students from Poland and Ukraine visited dentists less often than students of both sexes from Belarus. Belarusian students had more frequent dental check-ups than students from Ukraine (Knaś, et al., 2015). 26 % male and 10 % female Vietnamese students smoked, against 22 % men and 12 % women in the group of Taiwanese students. Over a half of the respondents from Vietnam admitted to engaging in sexual intercourse with casual partners (56% male students and 57% female students), while this percentage was 26 % for Taiwanese respondents. Over a half of the respondents consumed alcohol once a week (53.2%). 55% responded that they had never used any intoxicants (Zalewska-Puchała, et al., 2013a; Zalewska-Puchała, et al., 2013b). However, religion can also influence this aspect of health-related behaviour, as research demonstrated that alcohol consumption was declared by 81 % of Catholics and 6 % of Adventists, and smoking was listed by 33 % of Catholics but no Adventists (Kucharska, et al., 2015).

Another analysed subcategory was *stress and handling stress*. The surveyed students listed different methods of handling stress depending on their gender. Female students declared going out with friends (79 %), sports (43 %) and going on walks (14 %), while 21 % admitted to smoking and 7 % to drinking alcohol. Male students listed exercise (50 %), smoking (38 %), going out with friends (31 %) and alcohol (12 %) (Zalewska-Puchała, et al., 2013 a).

The last subcategory is *the use of medical care*. Migrants often have difficulties accessing medical care and insufficient access to information on the rules of obtaining medical care. They suffer from language and cultural barriers and feel like they are treated less well. Adult patients from different cultures who were provided medical care were usually diagnosed with gastroenterological (18,2 %) and psychiatric/neurological (18,2 %) problems, while children suffered from injuries and orthopaedic problems (30 %) and infections (18,0 %) (Cianciara, et al., 2012).

CONCLUSIONS

Scientific studies by the Polish nursing community in the field of multicultural care are becoming increasingly frequent, although they are still limited to a fairly narrow subject matter. There is a need to introduce multidisciplinary and multi-centre scientific research tackling multicult-



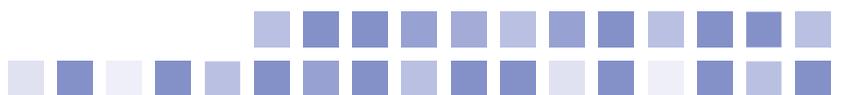
turalism issues in medical care in a broad way. These could then form a basis for improving the standards of education and nursing practice with regard to patients' cultural safety.

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EXAMINING THE LEGAL, PROFESSIONAL AND ETHICAL ISSUES OF GAINING PATIENT CONSENT IN THE UNITED KINGDOM (UK)

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INTRODUCTION

Accountability is defined as “being answerable for one’s decisions or actions” (Royal College of Nursing, 2008, p. 6). Accountability can be viewed as a framework encompassing four pillars; professional, legal, ethical and employment accountability (Caulfield, 2005, p. 3). This notion is important in the nursing profession as it protects the public from potentially harmful acts, regulates nursing behaviours and allows nurses to learn from those who are scrutinised (Griffith & Tegnah, 2010, p. 38). Accountability affects nursing practice in different ways. The potential exists that accountability may lead to defensive nursing practice where practitioners disregard their alternative clinical judgements, instead relying heavily on protocols and procedures (Caulfield, 2005, p. 3). It is thought that nurses feel threatened when their practice is questioned and so seek to avoid this (Burnard & Chapman, 2003, p. 46). For others, accountability provides an “inherent confidence” that allows individuals to be transparent about their nursing practice in a prideful manner (Caulfield, 2005, p. 3).

Nurses are accountable for gaining consent from patients within their care before caring out any nursing activities, treatments, procedures or interventions. Consent may be given verbally (patient directly expresses views), in writing (consent forms) or may be implied (patient offers arm to have blood pressure taken) (Baillie & Black, 2015, p. 33; Teng, 2014, p. 38).

The aim of this article is to examine the legal, professional and ethical issues of gaining consent in nursing practice and the relationship between these three pillars of accountability. Older adults with a formal diagnosis of dementia may find difficulty in communicating their needs and desires to nursing staff or even family and friends, especially as the disease progresses. It is therefore pertinent that there are frameworks in place to protect vulnerable people in society. This objective of this piece is to outline these frameworks and explain their importance in nursing practice.

METHODS

For this discussion piece, a scenario related to consent that is a common occurrence in nursing practice has been proposed. This scenario will be scrutinised to evaluate the legal, professional and ethical issues of gaining consent in nursing practice. Research will be conducted to gather information about each pillar of accountability and how it relates to gaining consent from an individual in practice. The sources used will include acts of parliament, journal articles, books, social policies and professional standards. These considerations will then be linked back to the scenario to display how the pillars of accountability interact in such situations. An example of how consent relates to nursing practice is as follows.

A gentleman admitted to an older adult medical ward has been informed that major surgery is required to sustain his life. During this procedure, the patient would require a blood transfusion. When proposing this procedure to the patient, he declines. It has been established that the patient does not have capacity due to cognitive impairment associated with dementia, and so is unable to understand the nature and implications of the procedure.

RESULTS

Legal accountability:

Nurses are legally accountable for gaining consent from an individual before carrying out any treatments or interventions, a process described as “a defence to a claim of unlawful touching or trespass to the person” (Griffith & Tegnah, 2010, p. 78). If a nurse were to proceed with treatment without the patient’s consent, they would be culpable to a claim of battery, even if no harm is demonstrated (Caulfield, 2005, p. 127; Department of Health, 2009, p. 1). The main precedence for the nurse gaining valid consent is to decide whether an individual has decision



making capacity under the Mental Capacity Act (2005; Department of Health, 2009, p. 9).

Individuals who are presumed to have capacity:

It is to be assumed by healthcare professionals that all individuals in their care have capacity unless proven otherwise (Mental Capacity Act 2005, s.1(2)). This is the assumption that each individual has the ability to understand, retain and use information to formulate a decision and communicate this decision by any means necessary (Mental Capacity Act 2005, s.3(1)). If an individual has capacity and is of “sound mind”, it is deemed they have the ability to make decisions regarding their care and treatment, and are able to decide what is in their own best interests. This right to self-determination should legally be upheld and nurses must support the patient to make decisions during this process. One issue faced by the accountable nurse is when a competent patient declines a recommended treatment, that may be potentially lifesaving, and their reasons for doing so are “bizarre, irrational or non-existent” (Jackson, 2010; Peate, et al., 2014, p. 99). Due to the individual having capacity, this decision should be respected and obeyed “even if on any objective view it is contrary to his best interests” (Airedale NHS Trust v Bland, 1993). Treating an individual who declined treatment against their will would remove their autonomy and bodily integrity (Simpson, 2011, p. 511). Such decisions may lead to unjustified assumptions by the nurse that the patient lacks capacity when this is not the case. The Mental Capacity Act (MCA) (2005, s.1(4)) stresses that, “a person is not to be treated as unable to make a decision merely because he makes an unwise decision”.

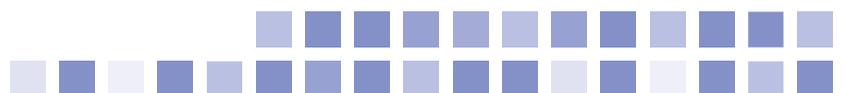
An overview of the Mental Capacity Act (2005): A framework for those who lack capacity.

The Mental Capacity Act (MCA) (2005) provides the legal framework for acting and making decisions on behalf of individuals who have been deemed to lack capacity to make decisions for themselves. The Act incorporates five key principles (Department of Constitutional Affairs, 2007, p. 1, 19; Mental Capacity Act, 2005, s.1):

1. A person must be assumed to have capacity unless it is established he lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practical steps to help him to do so have been taken without success
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done, or decision made, under the Act or on behalf of the person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or decision is made, regard must be had to whether the purpose for which it is needed can be effectively achieved in a way that is least restrictive of the person’s rights and freedom of action.

The two stage test is an assessment used by nursing professionals to determine when an individual lacks capacity and is set out in sections two and three of the MCA (2005, s.2; 2005, s.3; Cox, 2015, p. 315). Stage one determines whether an individual has a disturbance or impairment of the functioning of the mind or brain, such impairments may include, but are not limited to; dementia, significant learning difficulties, and long term brain damage (Mental Capacity Act, 2005, s.2(1-2); Stevens, 2013, p. 36; Department of Constitutional Affairs, 2007, p. 44). Stage two takes into account this impairment, and determines whether it is significant to mean the individual lacks the capacity to make a particular decision (Stevens, 2013, p. 36; Griffith & Tengnah, 2010, p. 90; Mental Capacity Act, 2005, s.3(1)). A person is deemed unable to make a decision for themselves if they are unable to (Mental Capacity Act, 2005, s.3(1)):

- a) Understand the information relevant to the decision
- b) To retain that information
- c) To use or weigh that information as part of the decision making process
- d) To communicate this decision





As mentioned above, if the individual is deemed to lack capacity they are to be treated in their “best interests” a decision making process where the nurse who is accountable determines what treatment would be most beneficial on behalf of the patient (Mental Capacity Act, 2005, s.1(5); Worthington, 2002, p. 379). One factor that should be considered during this process is the patients past and present wishes, feelings, beliefs, and values that would influence their decision if they had capacity (Mental Capacity Act, 2005, s.4(6)). This in most situations can be achieved by consulting the patients relatives, who are the best placed people to inform the nurse of these wishes (Mental Capacity Act, 2005, s.4(8); Cox, 2015, p. 315; British Medical Association, 2015). However, emphasis is placed on the fact that it should remain as a conversation about the patient’s interests rather than what the family would like to happen (Department of Health, 2001, p. 11). The views of anyone named by the person to be consulted on such decisions, anyone engaged in caring for the individual, and anyone that has been granted Lasting Power of Attorney should also be taken into account (Mental Capacity Act, 2005, s.4(7)).

It should also be determined whether the individual has any advanced directives in place. These are advanced refusals made by a competent individual that if a specific treatment is proposed at a time when he lacks capacity to consent, the treatment is not to be carried out or continued (Dimond, 2008, p. 194; Mental Capacity Act, 2005, s.24(1)). The main issue for the nurse is whether the advanced directive is valid and applicable; it should be followed and treatment should be withheld if this is the case (Department of Constitutional Affairs, 2007, p. 173-174). An advanced decision to refuse treatment is only valid if it satisfies the following conditions: the patient made the decision at a time when they had capacity, they specify clearly the treatment they wish to refuse and the circumstances they wish to refuse them, the decision is made without harassment from other parties, and they haven’t said or done anything that contradicts the refusal (National health service, 2014). For the decision to be applicable, the declined treatment to be refused must have come into effect, and the patient must be incapable of making the decision to accept or refuse the treatment themselves (Griffith & Tengnah, 2012, p. 141). A strength of advanced directives are that they allow individuals to exercise their autonomy, even when capacity is lost, providing a framework of care for health professionals guided by the patient’s wishes (British Medical Association, 2004, p. 128; Dempsey, 2014, p. 455). Advanced directives regarding refusals of treatment are legally binding under the MCA (2005, s.24). Directives set out in advance by individuals requesting treatment they would like to receive in particular situations are not legally binding, but should be considered when acting in the best interests of patients (Department of Health, 2001, p. 10).

Professional accountability:

Nurses are professionally accountable to regulatory bodies regarding standards of practice (Royal College of Nursing, 2016). The Code developed by The Nursing and Midwifery Council (NMC) (2015) presents the professional standards of practice and behaviour that nurses and midwives must uphold in order to be registered to practise in the UK. The NMC (2015, p. 6) states that nurses are accountable for gaining properly informed consent before carrying out any therapeutic actions. Informed consent ensures the patient knows exactly what the treatment or intervention entails (Royal College of Nursing, 2015). Nursing professionals should impart knowledge regarding the actions nature, purpose, implications, side effects and any suitable alternatives, before consent is sort (British Medical Association, 2004; Nursing and Midwifery Council, 2004, p. 18). The nurse should then allow the individual time to consider the information and ask any questions, which should be answered honestly and in a sympathetic manner (Dougherty and Lister, 2004, p. 9; Baillie & Black, 2015, p. 34; Care Quality Commission, 2015).

The MCA (2005, s.3(2)) states that a person is not to be regarded as unable to understand information related to a decision merely because the information was given to them in a way that was inappropriate to their circumstances. For the nurse, this is an issue of communication. Nursing professionals will be required to use both verbal and non-verbal techniques of communication depending on the circumstance of the individual, ensuring any communication needs are met (Nursing and Midwifery Council, 2015, p. 7; Dougherty and Lister, 2004, p. 9). Information given should incorporate simplified terms patients and families will easily understand, free from medical jargon (Nursing and Midwifery Council, 2015, p. 7; Megson, 2014, p. 322). The information should be broken down into smaller points if necessary, with the nurse checking



the patients understanding on occasion to minimise any misinterpretations which may invalidate consent (Nursing and Midwifery Council, 2015, p. 8; Department of Constitutional Affairs, 2007, p. 32).

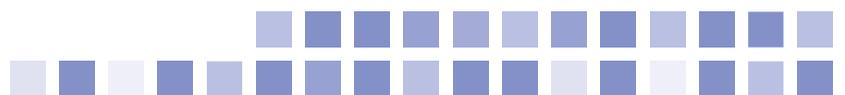
Nurses have a professional duty to allow individuals to exercise their autonomy (Caulfield, 2005, p. 127). An acceptance or refusal of treatment should be respected, supported and documented by the accountable nurse, even if they do not agree that the decision is in the individuals "best interests" (Nursing and Midwifery Council, 2015, p. 5). When faced with the situation where an individual declines nursing care, healthcare professionals have often been found to "go to great lengths to achieve the agreement of the patient" (Aveyard, 2002). However, consent is only valid if it is given freely by the individual without duress or undue influence from other bodies (for example, family members or healthcare professionals) (Caulfield, 2005, p. 132; Department of Health, 2009, p. 9-11). Coercion invalidates consent regardless of good intention; the patient should not feel forced by professionals into making a decision (Cahill, 2004, p. 95; Department of Health, 2001, p. 7). Some argue (Aveyard, 2002) that it is the nurse's professional duty to persuade the patient to accept treatment they consider most appropriate, as they are in a better position to evaluate treatment options than the patient themselves. The Royal College of Nursing (2015) believe a refusal should be taken into account but not forgotten and the nurse should take the opportunity to explore reasons why the patient may have refused the treatment, such as worry or discomfort. Once the problem has been discussed or resolved, the patient may consent to the procedure without any coercion being used, and so is considered a more sensitive approach to managing patient refusals.

The main professional issue for nurses is assessment of capacity and keeping in line with laws and legislation regarding mental capacity (Nursing and Midwifery Council, 2015, p. 6). Griffith and Tengnah (2010, p. 91) proposed four stages of assessment. The "Trigger Phase" is the identification of concerns that an individual may lack decision making capacity, these doubts can occur due to the individual behaviour, circumstance or concerns raised by another person (Community Care, 2008). The nurse should then take all practical steps necessary to help the patient make a decision (practical support phase), involving the impartment of knowledge and use of therapeutic communication, as described above. The remaining two phases complement the requirements for lacking capacity set out in the MCA (2005, s.2, s.3) and involve the identification of an impairment in functioning of mind or brain (diagnostic threshold) and testing how far the impairment affects the individuals decision making capacity (assessment phase). If the individual is deemed to lack capacity, the accountable nurse should abide by their legal and professional obligations.

Ethical accountability:

Ethical accountability is based on the four moral principles; autonomy, beneficence, non-maleficence, and justice (Beauchamp & Childress, 1989, p. 101-249). Autonomy means self-governance or rule and requires respect for choices made by an individual (Beauchamp & Childress, 1989, p. 101; Griffith & Tengnah, 2010, p. 29). Beneficence is the principle of "doing good" and is concerned with the moral obligation to act in a way that benefits others (Peate, et al., 2014, p. 97; Kennedy, 2005, p. 501). Tension arises between the principles of autonomy and beneficence when an individual makes a decision that is difficult to support as it is considered unwise by nursing professionals (Taylor, 2014, p. 36).

Some argue respecting an individual's autonomy should always take precedence over acts of beneficence, as it values a person's right to make choices (Edwards, 1996, p. 98-100; Peate, et al., 2014, p. 97). It is argued that respecting decisions made by an autonomous individual shows appreciation for the individual's right to withhold their own views on what is in their best interests, and their right to accept or decline treatment (Cahill, 200, 102; Griffith & Tengnah, 2010, p. 32). McParland and colleagues (2000, p. 509) argue nurses should not assume that they know what is best for the patient and instead should support the patients right to make autonomous decisions by providing sufficient information and encouragement. In this argument, an individual has the right to refuse treatment regardless of the consequences. A refusal of treatment may be deemed unwise, or inappropriate, if the benefit of the treatment outweighs any potential harm caused if the treatment is not carried out, such as immense pain or even loss of life (Stringer, 2009, p. 33). These "unwise decisions" are heavily contested by the nurse as they go against their moral obligation of beneficence. Beneficence is considered alongside non-maleficence (avoiding harm) with the aim





of producing a benefit that is greater than the infliction of harm on the patient (Gillon, 1994, p. 185; Peate, et al., 2014, p. 97). It is a concept that supports consequentialist theories, which follow the assumption that actions are right or wrong according to their balance of good and bad consequences, hence the balance between beneficence and non-maleficence (Beauchamp & Childress, 2013, p. 354).

The moral obligation of beneficence may be a motivator for nursing professionals to act in a paternalistic manner; acts that are conducted “on the behalf, although not at the behest, of the patient” (Benjamin & Curtis, 1986, p. 53; Edwards, 1996, p. 94). In this situation, the individual’s autonomy is overruled and the nurse acts in a way they believe is for the patients “own good” (Rich & Butts, 2014, p. 113). The nurse considers their perception of what will benefit the patients’ health and welfare a higher priority than respecting the individual’s autonomy and personal choice (Seedhouse, 2009, p. 157). Such acts are considered to be morally wrong as nurses should not impose their own morals, values and beliefs on the patient, even if the consequences of the individual making their own decisions are undesirable. However, paternalism is justified and is considered ethical if an individual lacks capacity, and hence lacks the autonomy to make decisions for themselves (Edwards, 1996, p. 101; Zomorodi & Foley, 2009, p. 1748). Another way in which paternalistic acts are defensible is if the patient is at risk and the act aiming to prevent harm significantly reduces this risk (Beauchamp & Childress, 2013, p. 222). However, such acts are only justified if there are morally no alternatives and the least autonomy restrictive action for the patient is taken (Beauchamp & Childress, 2013, p. 222).

DISCUSSION

Accountability in the context of the example from nursing practice:

In the example from practice, the gentleman displays the right to autonomously make decisions. However, it has already been established that under the MCA (2005), the gentleman lacks capacity due to cognitive impairment associated with dementia which goes against the notion that “decision making capacity is the key to autonomy” (Griffith & Tegnah, 2010, p. 87). The principle of beneficence therefore becomes paramount as the nurse has to act in the best interests of the individual, as required under the MCA (2005, s.1(5); Peate, et al., 2014, p. 97). Beneficent acts made in the best interests of an individual are considered subjective to each nursing professional as they are based on each individual’s own morals and clinical judgement. It is difficult to determine who decides what is of benefit to the patient (Ellis, 2015, p. 59). Although the gentleman lacks capacity to make a decision regarding his surgery, his refusal should still be taken into account when deciding what treatment should be given. This supports the NMC competency of ensuring those who lack capacity, and are being treated in their best interests, remain at the centre of the decision making process (Nursing and Midwifery Council, 2015, p. 6). This standard of care ensures that acts made in the best interests of the individual do not become paternalistic (where the nurse becomes the sole contributor to decisions about the patient). This ensures the principles of beneficence and autonomy are being used in partnership rather than in conflict, guaranteeing “acts of beneficence are those actions which increase the autonomy of the patient” (Kennedy, 2004, p. 505). Beauchamp and Childress (2001, cited in Cahill, 2004, p. 101-103) suggest nursing professionals are obliged to abide by all four ethical principles until a specific situation demands one principle to take precedence over another. In this situation it appears that beneficence would take precedence over the other ethical principles. However, this should not be considered in isolation from the nurses professional and legal obligations.

CONCLUSION

From the discussion above it is clear that the pillars of accountability are not “stand-alone” and each individual situation demands an interplay between all three aspects of the framework. Each pillar has its own importance in nursing practice for different reasons but all move towards the same goal of protecting the rights and recognising the contributions of the individual. The frameworks explained in each section of this discussion piece are there to safeguard and protect the most vulnerable people in society.



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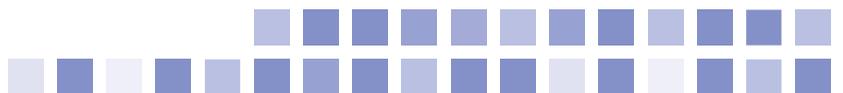
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VIOLENCE IN NURSING CARE. A REVIEW OF CURRENT DEVELOPMENTS IN GERMANY

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INTRODUCTION

In February 2015, German nurse Niels Högel was convicted of having murdered two patients, while working at an intensive care unit in northern Germany. Investigators have since delivered evidence, that he is responsible for the murder of at least 33 patients, a further 200 deaths at his former places of work are still under investigation (Schneider, 2015). This case, at the extreme end of the spectrum of violence, reignited a wider debate about maltreatment of patients in German hospitals (Seidel, 2014). The origins of this discussion can be traced back to the late 1970s, when a similar case happened in Wuppertal in western Germany (Jacobs, 2016). The public debate usually focused on how common violence is in nursing institutions, which factors contribute to the issue and if it can be averted. This article examines, what kind of preventive measures are useful to prevent violence and whether, after nearly 40 years of recurring debates, they have been implemented in German nursing institutions.

METHOD

13 publications, published between 1998 and 2016 by ten different German experts on nursing, discussing the problem of violence in nursing settings, were analyzed for this article. A qualitative approach was chosen to evaluate different perceptions of the issue, the current situation and possible solutions. The authors of the publications included in the research were chosen to reflect a broad range of professions within the nursing community and therefore a cross section of the latter. This includes scientific researchers, nurses, nursing management, owners of nursing institutions as well as journalists working for nursing journals. Publications on the subject by non-nursing professionals were excluded from the research.

RESULTS

Four of the publications analyzed conclude, that violence is no one way street (Kienzle & Paul-Ettliger, 2001; Osterholz, 2011; Seidel, 2014; Schreiner, 2001). A 2009 quantitative study of nurses working in German hospitals found, that 79 % of them had suffered verbal insults at least once within the past 12 month, 56 % were physically assaulted during this period (Berufsgenossenschaft für Gesundheitsdienst und Wohlfahrtspflege, 2011). Aggressive behaviour by patients can cause frustration and anger in nursing staff and some may experience a desire for retaliation, either in a direct or indirect way. This will inevitably start a spiral of violence (Osterholz, 2014; Schreiner, 2001). Therefore acquiring proper techniques to handle one's emotions in this situation and to develop a deescalating approach is indispensable (Meyer, 1998; Seidel, 2014). Furthermore, the professional and emotional support of the whole nursing team is important, to cope with these experiences and prevent escalations (Kienzle & Paul-Ettliger, 2001).

According to the World Health Organization (2011), the risk for a perpetrator to be convicted in Germany is low, because evidence and witness statements are often insufficient or ambiguous. Especially elderly or mentally handicapped patients are rarely taken serious, when complaining about how they were treated (Osterholz, 2014). Learning to respect any patient and their statements equally is therefore essential to change this problematic situation (Meyer, 1998). In addition, most perpetrators avoid violent actions as long as witnesses are present (Schreiner, 2001; Teigeler, 2014). According to Jacobs (2012) and Schneider (2015), there is an established culture of looking away in many nursing institutions, leading to a very high number of unreported cases. Members of staff are used to witnessing a certain level of violence they deem acceptable or don't stand up to perpetrators, in fear of negative consequences for themselves (Teigeler, 2015). This is also a reason, why early warning signs are often overlooked. Early indicators, such as disrespectful language when discussing patients, which can be an expression of dehumanizing patients, are rarely taken seriously enough. Therefore, the mentality of nursing professionals, law enforcement and other professions involved has to change, to prevent violence at an early stage (Beine, 2011; Sowinski, 2005; Teigeler, 2015).



According to Meyer (1998), violence is often not identified as such. Better education on what constitutes violence is necessary to improve prevention. A major issue is, that there is no clear and widely accepted definition of violence within the German nursing community (Jacobs, 2016; Schreiber, 2001). Comprehensive basic and continuous training as well as an increased interest of nurses in current research must be achieved to improve this situation (Deutsche Hochschule der Polizei, 2012; Kienzle & Paul-Ettliger, 2013).

Good communication is the basis for any form of healthy coexistence. Conflicts and escalating violence between patients and nurses can often be avoided by proper communication. Expressing mutual respect is essential for everyone's well-being (Kienzle & Paul-Ettliger, 2013; Sowinski, 2014). Professional communication skills and techniques, such as active listening, are a significant element in this process (Meyer, 1998; Schreiner, 2001). Proper communication, mutual respect and recognition are also important within the nursing team. Combined with clearly structured work organization and thorough planning, they help to create a functioning and safe work environment, in which employees are more satisfied and less prone to aggression and violence (Kienzle & Paul-Ettliger, 2013; Meyer, 1998).

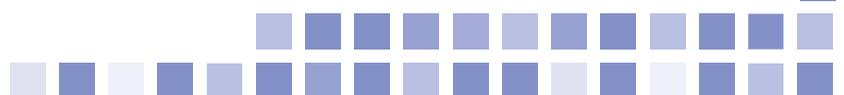
Another important element is the admission, that mistakes can happen to anybody. Dealing with them properly can be a first step towards the prevention of violence. Of the authors studied, only Grond (2007) and Jacobs (2016) put special emphasis on this aspect. Staff have to learn from their own as well as others' mistakes to prevent them from happening again in the future. The sufficient analysis and discussion of errors is therefore essential, but only possible in a good work environment, to improve the quality of work (Jacobs, 2016). It requires a structure, in which mistakes are not primarily seen as a reason for punishment but as an opportunity for learning and improvement (Grond, 2007).

Most authors also agree, that nurses have to sufficiently look after their own needs and have an intact work–life balance, to be able to care for their patients' needs (Meyer, 1998). This includes being aware of ones personal limits and knowing physical as well as psychological warning signs, e.g. symptoms of occupational burnout. Only with sufficient knowledge, nurses can detect issues with colleagues or themselves and react accordingly (Grond, 2007; Kienzle & Paul-Ettliger, 2001; Seidel, 2014).

The question remaining is, whether these aforementioned preventive measures, on which most nursing professionals agree in principle, have been implemented within the German nursing system. There is a broad consensus between all authors included in this study, that the overall situation is still far from satisfying. Most hospitals and nursing homes lack adequate control mechanisms and there are no federal programs or governmental organizations that actively work on establishing them (Jacob, 2016; Schreiner, 2001; Teigeler, 2015). Projects and campaigns to raise awareness are usually short lived (Jacobs, 2016; Sowinski, 2014). Most members of nursing managements perceive violence as a thing only happening in other institutions. They merely begin to act, after there has been a major case of violence within their area of responsibility. But even in these cases, there is rarely any thorough analysis of what influenced these acts of violence, and structural as well as institutional changes are usually half-hearted and short lived (Grond, 2007; Jacobs, 2016; Osterholz, 2014; Schreiner, 2001; Teigler, 2014). The process too often ends with disciplinary action towards the perpetrator and a brief public debate, but without any long-term measure being implemented on higher levels (Teigler, 2015). It can be necessary, to break up and reform long established hierarchies to tackle this problem, but many institutions shy away from taking this step (Teigeler, 2014). Of the authors studied, only Jacobs (2016) and Teigeler (2015) express confidence, that this mentality is slowly beginning to change.

DISCUSSION

The results of the study show, that many necessary changes have not yet been implemented. The main reason seems to be that, as Jacobs (2016) and Teigeler (2014) point out, many institutions as well as politicians and government agencies do not acknowledge the problem at hand. When acts of violence emerge, they are usually classified as tragic but isolated cases, reigniting public debate for a limited amount of time only. Admitting systematic or structural failure could potentially result in an even worse reputation for a hospital or nursing home, there-





fore some managements prefer to depict these cases as an individual's wrongdoing only. Complicating the matter, the number of reported cases represents only a fraction of the actual number of violent acts in nursing institutions, as most of them remain undetected. Therefore, the problem does not seem to be as huge as it really is, making it easier for managements or politicians to stick to the theory of isolated cases.

As patients depend on the nurses caring for them, many are afraid of reporting any wrongdoing or don't expect any positive effects. Many nurses don't report acts of violence, because they either do not recognize them as such or are afraid of facing negative reactions from other staff. This clearly shows that structural changes have to be made, to make sure that complaints are listened to and taken seriously, without the fear of repercussions. Nurses have to be educated about what constitutes acts of violence, especially on the lower end of the spectrum, to notice them and act accordingly. According to Jacobs (2016) assessment, many more cases of violence would surface, if this change were to be implemented. Although this might shed a bad light on some hospitals or the nursing profession as a whole, due to the probably high number of revelations, it would increase the pressure on managements and politicians to finally react properly and open their eyes to the real extent of the problem.

There is a broad consensus between the authors studied, that taking preventive action to reduce violence in nursing institutions is indispensable. Improving communication and mutual respect as well as taking care of each other and creating an open culture of constructive criticism are important steps to prevent aggression and violence within a nursing team. A good work environment is the fundamental basis for delivering a high quality of nursing and care, which should be in everyone's interest. Unfortunately, due to the tenuous financial situation of the German health system and many of its hospitals, economic interests and the rationalizing of work increasingly prevail over the quality of nursing. Understaffed hospital wards have become a severe issue in many hospitals, the individual nurse's workload has multiplied over the past years (Jacobs, 2016). These conditions make it harder to create a good work environment, in which the measures mentioned above could be implemented properly. In addition, they increasingly endanger the nurses' work-life-balance. As Meyer (1998) points out, nurses can only care well for others if they take good care of themselves. Therefore, the economical constrains put on hospitals and staff endanger the implementation of long overdue measures to prevent violence in many ways.

CONCLUSION

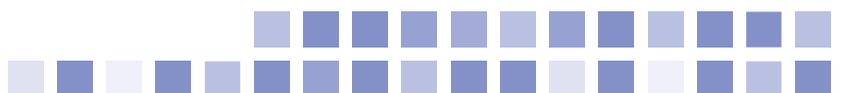
This study concludes that implementing extensive preventive measures to tackle the problem of violence in German nursing settings is indispensable. Despite a decades old debate, nursing institutions, as well as the nursing system as a whole, still shy away from placing more emphasis on the subject and undertaking major structural reforms. This is, at least partially, due to economic constrains and an underestimation of the issue.

This study analyzed a small selection of publications on a qualitative basis, the conclusions drawn only reflect on a portion of Germany's nursing and scientific community and do not claim to be complete or representative. Nevertheless, the overwhelming consensus between the authors studied, regarding the article's central questions, can be seen as an indicator of the general direction, towards which the debate is oriented. Further, more extensive studies, will be necessary for scientific confirmation.



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AGEING – A PROBLEM OR A CHALLENGE FOR MODERN SOCIETY

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INTRODUCTION

In Europe, we are faced with a series of phenomena which require from us new strategies in our care for health and the quality of life of older adults.

According to Eurostat (2013) women and men born in the European Union (EU-27) in 2011 can expect 62 years of healthy life (women 62,2 years and men 61,8 healthy years). At the age of 50, women can expect 17,9 years and men 17,5 healthy years. At the age of 65, which is regarded as the old age limit, women and men can expect extra 8,6 healthy years. Data for the Republic of Slovenia, which is a member of the EU-27, are less favourable. Women born in 2011 can expect 53,8 healthy years and men 54 healthy years. Slovenia is at the very tail of expected healthy years of life in the EU-27, behind it is only Slovakia (women can expect 52,3 years and men 52,1 healthy years if born in 2011). If we look at the data for Croatia, we can see that women born in 2011 can expect 61,7 healthy years and men 59,8 healthy years. The longest years of healthy life can be expected by the residents of Malta (women 70,7 years and men 70,3 healthy years), Sweden (women 70,2 years and men 71,1 healthy years) and Luxembourg (women 67,1 years and men 65,8 healthy years). Žnidaršič (2008) says that a growing share of the elderly population as a consequence affects the growth of demographic dependency rates. The problem raises questions, discussions and studies of trends that have a significant impact and importance for the implementation of the active ageing strategy which will be reflected in the greater inclusion of older people.

Statistical Office Republic of Slovenia (Prebivalstvo Slovenije danes in jutri 2008-2060: projekcije prebivalstva EUROPOP 2008 za Slovenijo, 2009) states that the basic feature of demographic future of European society is ageing. Population of the member states EU-27 is projected to grow significantly older: the median age of the EU-27 population is projected to rise from 40,4 years in 2008 to 47,9 years in 2060. The share of persons aged 65+ in the total population is expected to increase in the EU-27 from 17,1% to 30,0%; the population of such age is expected to increase from 2008 to 2060 from 84,6 million to 151,5 million. In Slovenia according to the medium variant of population projection EUROPOP2008 the share of people aged 65+ in the total population should increase by 16,1% (to 33,4%), the number of inhabitants of such age is expected to increase from 325.300 to 589.900 from 2008 to 2060. Similarly, the number of people aged 80 years or over in the member states of EU-27 is expected to almost triple: from 21,8 million in 2008 to 61,4 million in 2060. In Slovenia according to the medium variant of population projection EUROPOP2008, the share of people aged 80+ in the total population is expected to increase from 3,5% to 14,1%, that is from 71.200 to 249.500 inhabitants.

AGEING AND OLD AGE

Ageing of the population is an important phenomenon in the society, which is to a large extent associated with its medical progress and a better quality of life, which reduce the mortality of individuals and prolong lifetime. We can speak about ageing of population from two aspects. The first refers to the demographic aspect of ageing, and the other to the individual and to the chronological processes of ageing, biological changes and sociopsychological changes of ageing on an individual level (Filipovič Hrast & Hlebec, 2015).

Ageing is a process that takes place throughout life, yet it has the greatest importance in old age. The word 'ageing' is used when talking about what is happening with an individual person no matter how old he is (Ramovš, 2003). Ihan (2012) argues that ageing is a progressive process that changes a healthy, homeostatically adjusted organism into a less healthy, homeostatically fragile organism. The mechanism of ageing is in all species similar (e.g. damage of natural immunity, vascular damage, cancerous diseases, etc.). Jurdana (2011) says that old age has received special attention in modern times, as people more rarely experienced old age in the past. With ageing people lose physical and mental abilities, their social status is lowered, adaptation to new conditions may be stressful, and all of the stated can have a negative impact on self-image. Deterioration of health and loss of physical strength significantly affect the individual's autonomy.



Ageing is a process that depends on many factors, both external and internal, which are intertwined throughout life and have a decisive influence on the course of ageing. Ageing for this reason cannot be avoided, but we can have much influence on old age. Therefore, we have to face ageing and accept it as part of our life path (Renner & Ozimek, 2012).

Ageing is a multifaceted process, and old people are a multifaceted group. Each individual's facing of the old age and adapting to it is very different. Successful ageing is associated with well-being and the ability to adapt to the changes that age brings (Skela Savič, et al., 2010). Ageing is a physiological process, but in no individual this process is only physiological. R. Cijan and V. Cijan (2003) say that together with this process various diseases appear. Consequently, we can talk about physiological, normal, slowed down and accelerated, pathological ageing. Pathological changes are the reason that a person cannot live to his or her potential biological life span. Today, this life span is estimated at 120 years, in reality, the largest proportion of the population in developed countries of the world lives to be between 75 and 85 years old.

Old age or the third age according to geriatric research occurs at 65 years of age (Cijan, R. & Cijan, V., 2003; Brajković, et al., cited in Kadovič & Matijašič Bodalec, 2012; Krajšek, et al., 2012; Lovrić, 2013; Ovsenik, 2012; Ramovš, 2003; Malačič cited in Mlinar & Plesničar, 2012). The maximum life span of man is today estimated to be 116-120 years. Average life expectancy is a variable category, it depends on climate zone, as well as the time period (Cijan R. & Cijan, V., 2003). Krajšek, et al., (2012) believe that the old age starting at 65 years of age is approximate and artificially set. They state that a relatively healthy older person may still have years or decades of very good quality life ahead. Unfortunately, there are many older people to whom this period brings suffering due to disease and social difficulties. Kristančič (2005, p. 54) says that the most recent findings show that the ageing process as a rule starts at 65 to 70 years of age, Jurdana (2011), however, claims that the quality of old age and especially health in old age depend largely on the levers and the earlier developmental stages of life, which can significantly influence the period of ageing.

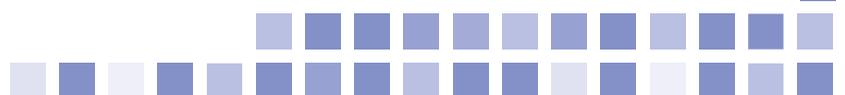
With regard to the fact that we are going to work longer than our predecessors, retire later, and live more years of healthy life in old age, it is necessary to consider a redefinition of the set age limit. Lešnik (2014) notes that people see as "older" people aged 75 years and more.

AGEING AND HEALTH

Ageing and the notion of poorer health that is most often associated with it, can represent a powerful stressor for the elderly. They respond to it in their own ways, however, we can recognize the concept of acceptance in the sense of coming to terms with ageing/poorer health and behavioural adjustment. Old people who participated in the study highlighted the role and importance of accepting ageing and changes in the third age (Domanjko & Pahor, 2011). In the perception of old people health risks prevail. Health problems are one of the most pressing elements that threaten the quality of life of individuals, because in addition to being unpleasant, they make the individual unable to work and thus prevent normal autonomous functioning, which leads the individual to dependency - a fundamental risk of older people (Kavčič, et al., 2012). Modern society is increasingly shifting to the exclusion of older people. Results of the study which was conducted by Hernandez and Gonzales (2008) show that the educational program of intergenerational cooperation had a positive effect on old people, as their well-being improved. In young people who were included in the program, the stereotypical perception of old people decreased.

Ageing is according to Domajnko and Pahor (2009) in an associative relation with health and disease. In their opinion also old age and disease cannot be equated. Disease is present in all ages and modern gerontology has called into question the inevitability of the connection between old age and disease. Ivanuša (2012) believes that care for one's health is life-long.

In old age, attention is paid to the prevention of falls, promotion of physical activity, vaccinations and prevention of infectious diseases in health care institutions. A specific area of work is the fight against the abuse of older people, which is ultimately in close connection with their





health. Between 4% and 6% of elderly people are exposed to neglect, physical, emotional or financial abuse. Šmit and Leskovic (2013) find that the most frequent victims of abuse are old people with dementia and those who are immobile, and the perpetrators in the home are most frequently the roommates and relatives.

Železnik (2014) says that a quality old age depends largely on the habits, acceptance and the lifestyle in the early and active years. General preventive and other measures and endeavours for healthy habits of living and healthy lifestyle from the beginning onwards lead the way to a healthy ageing. It depends on each individual how he will navigate this process, so that in later years he will be able to live high-quality, full and healthy life, which is associated with self-sufficiency.

Good health in old age can be achieved

- by promoting health through all stages of life,
- by creating environments friendly to old age that promote the health of older people and cooperation,
- by providing access to basic primary health care, long-term care and palliative care,
- by recognizing the value of older people and helping them to participate fully in the family and community (World Health Day 2012 – Ageing and Health. “Good Health adds life to years”, 2012).

Cultural capital (institutionalized, objectified and embodied) has a positive effect on health, people with more cultural capital assess their health as better than people with low cultural capital. All forms of cultural capital have a statistically significant positive effect on self-assessment of health in women, whereas in men only the whole cultural capital has a statistically significant effect on the self-assessment of health (Kamin, et al., 2013).

Old people nowadays fall ill and die as a consequence of chronic non-contagious diseases. It has been proven, that the causes for the development of chronic non-contagious diseases that are connected to unsuitable nutrition, physical inactivity and general unhealthy lifestyle can be found in social and economic factors such as the low levels of education, low income and with it worse accessibility to a healthy lifestyle. The inhabitants with higher self-assessed standard, due to many causes (ranging from knowledge to financial standing), do better at following the guidelines for healthy nutrition, are regularly physically active and generally speaking have less risk factors. In this way they care about their health more (Resolucija o nacionalnem programu o prehrani in telesni dejavnosti za zdravje 2015-2025, 2015). The risk factors and the positive pointers of health are the key elements for a healthy, longer and more quality life of an individual (Štemberger Kolnik & Babnik, 2014). The risk factors, however, are according to the opinion of Pandel Mikuš and Poljšak (2011) directly connected with the social, economic and environmental influences on one's health. The greatest influence on the development of chronic diseases have: education, social status, access to healthy nutrition and health care services, and policies and infrastructure that promote a healthy way of nutrition and of life. Hafner (2012) is of the opinion, that the prevalence of chronic non-contagious diseases is going to increase due to population ageing and increased survival rates, which is a consequence of an improved health care and changes in lifestyle as well as the early discovery of chronic non-contagious diseases. We can only hope, however, that the burden of chronic non-contagious diseases is not going to follow that, and that we can see a decrease in the number of severe diseases, as due to the discovery of risk factors, the diseases will be prevented or discovered earlier. Consequently also the treatment of diseases will be more successful, and the quality of life of the elderly will improve. Maučec Zakotnik (2012) claims that chronic non-contagious diseases represent a key burden for the health care system in Slovenia as well as in other developed countries, which weights heavily on the social and economic development of the countries and mostly affects socially deprived groups and increase social inequalities in the society and reduces the quality of people's lives.

Seculi, et al., (2001) established that a chronic disease has an influence upon the self-assessment of one's health, which gets worse with the advanced age. Ule and Kurdija (2013) state, that the data shows a strong correlation between the subjective assessment of one's health, and



the socio-economic position of women. Poor physical and mental health is connected to low income, low levels of education, and lower social classes. Women with higher levels of education, according to Gabrijelčič Blenkuš, et al., (2013), assess most of the pointers connected to health better than women belonging to other education groups. Women, living in urban environment, pay more attention to the care of their health, than women living in the country, or the ones living with a partner. An additional factor for the reduced subjective health in Slovenia is according to the opinion of Malnar and Kurdija (2012) in the low levels of trust in their fellowmen and social institutions, which is the probable cause why the statistically relatively favourable picture of the inequalities does not translate into an equally favourable picture of subjective health.

Perušek, et al., (2013) state, that the old people, who live at home, assessed their own health as satisfactory (42,7 %). One third of old people assess their own health as poor. There exists a statistically important difference between the assessment of the old people's health and their wish to get involved in the decision-making. Davies (2011) claims, that in Great Britain the need of old people for the health care services has been increasing. Due to the increase in life expectancy we can expect that more and more old people will have one or more chronic diseases. Filej, et al., (2015) have established, that with the increase in the number of chronic diseases the quality of life decreases in all of the measured areas of health, that the component »physical health« is assessed lower than the »mental health«, and that it is assessed higher in men.

The health of old people is an important element of the quality of their lives (Lah, et al., 2008; Pahor, et al., 2011). Hlebec, et al., (2010) established, that the perception of more secure, safe, relatively quality future would bring additional positive effects on the quality of life of old people. Old people only very reluctantly think about the future and are at the same time at peace with the present. On one hand that means that the future represents to them a time, which causes them great stress, and on the other hand this is from the point of view of risk-management in the future dysfunctional for them. From the point of view of macro measures it would be necessary to improve the living conditions with the help of various social measures to such an extent that the future would no longer represent such a risky situation, so that we would deliberately and strategically decide on it and pick different measures, with which to improve the quality of life. Such an improvement could bring with it a double effect at the final quality of life.

STRATEGY AND ACTION PLAN FOR HEALTHY AGEING IN EUROPE UNTIL THE YEAR 2020

Active/healthy ageing represents a challenge that we do not pay enough attention to. The World Health Organization (WHO) has prepared a strategy and an action plan for healthy ageing in Europe for the period between the years 2012 and 2020. The vision of this strategy is based on the aging-friendly European region (according to WHO), where ageing is considered an opportunity, and not as a burden for society. The vision is based on the fact that the elderly people should be able to remain healthy, to remain functionally able, and that they feel well, live a decent life, without discrimination and with sufficient financial funds in an environment that supports them, offers them safety, and an active life, social inclusion and access to the suitable high-quality health care and social services. Ageing-friendly European region according to WHO helps the elderly to achieve the old age more healthy so that they can continue to live actively according to their different roles, with an emphasis on employment and voluntary work (Strategy and action plan for healthy ageing in Europe 2012-2020, 2012).

Strategy and action plan for healthy ageing in Europe (2012) specifies the following general goals:

- to enable the elderly a long life in good health, that they stay active as long as possible and that greater inequalities in the old age are prevented;
- to accelerate the access to the quality health in the old age and to the services that offer care and support. The expected years of healthy life should be distributed more fairly within the certain country and among countries,
- to enable the older women and men to stay fully involved in the society , to live a decent and independent life irrespective of their health and their state of dependency
- To increase the awareness and qualifications for preventing discrimination and stereotypes regarding old age.





Strategy for healthy aging defines the following strategy areas (Strategy and action plan for healthy ageing in Europe 2012-2020, 2012):

- Strategy area 1: Healthy ageing through the entire lifespan.
- Strategy area 2: Supportive environment.
- Strategy area 3: People-focused health care system and long-term care, suited to the ageing population.
- Strategy area 4: Strengthening of evidence-based research

Priority measures in frame of the WHO strategy are defined as five measures (Strategy and action plan for healthy ageing in Europe 2012-2020, 2012):

- Priority measure 1: Encouraging physical activity.
- Priority measure 2: Prevention of falls.
- Priority measure 3: Vaccination of the elderly and preventing contagious diseases in health care environment.
- Priority measure 4: Public support of informal care, especially care at home, including self-care.
- Priority measure 5: Building of geriatric and gerontological capacities among the employees in health care and social institutions.

The supportive measures are (Strategy and action plan for healthy ageing in Europe 2012-2020, 2012):

- Supportive measure 1: Prevention of social isolation and social exclusion.
- Supportive measure 2: Prevention of maltreatment of the old people.
- Supportive measure 3: Strategies of quality care for old people, including the care for people with dementia and palliative care for the patients, who need long-time care.

CONCLUSION

There exist only few societies which would not emphasize that the youth is the most fruitful period in one's life, whereas the old age is seen as less pleasant, as the old people are helpless, lonely, ill, frail, a burden to their relatives in case they have them, and also a burden to the employed, as they should show financial solidarity with them. So on one hand the society faces the problems, which accompany the ageing of the population and is too little aware of the fact that the elderly have rich life experience and knowledge, that they are the guardians of the customs, cultures and traditions. Therefore how to find a balance between problems and opportunities and how to use them well, is a challenge for the society today for tomorrow.



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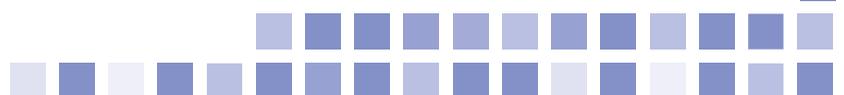
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LEVEL OF HEALTH LITERACY AMONG OLDER ADULTS

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INTRODUCTION

Demographic trends for the members of the European Union show that the European population is intensively ageing, and therefore the proportion of older adults in population is steeply increasing. We are thus transitioning into a long-lived society, which by all means has influence on the whole population and consequences for it (Hlebec, et. al., 2010). By the definition of the World Health Organisation (WHO), an old person is a person after the completed 65th year of age, when biological, psychological and social processes of ageing come to expression (Verbič & Zupančič, 2012).

Ageing is not a disease; it is just one of the stages in the life of a person, with its characteristics and particularities (Ivanuša, 2012). From the point of view of lifelong development, healthy ageing means good functioning of the body and absence of disease, preserving cognitive capabilities and an active life (Špendal, 2015). Health education by all means considerably contributes to quality ageing. A nurse can offer counselling to older adults also about a healthy lifestyle, which comprises physical activity, healthy nutrition and endeavours for absence of smoking and other unhealthy habits. If a disease appears, the nurse teaches the patient how to live with the disease and at the same time preserve a quality life (Verbič & Zupančič, 2012).

The term health literacy, which was first used in the United States of America and Canada, is nowadays used at the international level not only in health care, but also in the framework of public health (Sørensen, et al., 2015). While health literacy now has a wider meaning, which encompasses general understanding of information about health, it has its origin in practical concern about capability of understanding information in printed materials, especially instructions for the use of medication (Hubley, 2013). World Health Organisation describes health literacy as a bundle of cognitive and social skills that influence the motivation and capability of an individual to get access to information, understand and use it in a way that encourage or maintain good health of the individual (Nutbeam, 1998 cited in Jordan, et al., 2010). Sørensen et al. (2012) define health literacy as an individual's knowledge, motivation, and capability to access health information and understand it, capability to estimate and use it, think about it and reach decisions in everyday life, with regard to promotion of health, for maintaining or improving quality of life in all stages of life.

For measuring health literacy a number of instruments have been developed, differing in approach, intention and form, some of them are focused on comprehensive health literacy in population, some serve to establish categories of individuals with low or with high health literacy. European Health Literacy project consortium (HLS-EU consortium) has developed the instrument »European Health literacy survey questionnaire« with the label »HLS-EU-Q« (Sørensen, et al., 2013a) for measuring health literacy on the basis of a systematic review of literature of existing definitions and models of health literacy and a conceptual model of health literacy.

HEALTH LITERACY AND OLDER ADULTS

Older adults are more susceptible to poor health, while the level of health literacy constantly decreases with advanced age. It is probable that the older adults can carry the biggest burden because of inadequate health literacy, which shows as an outcome that is unfavourable to an old person's health (Toçi, et al., 2015). Health literacy of older adults is influenced also by basic socioeconomic factors (Sørensen, 2012). There is also more and more evidence about the relationship between self-perception of health and self-perception of morbidity among the elderly (Toçi, et al., 2015).

Chin et al. (2015) state that health literacy is often defined as capability to find, understand and use the necessary information for health-related decisions, the key challenge for the system of national health care. Liechty (2011) states that health literacy as a concept encompasses skills of general literacy and skills related to health, which demand from an individual to navigate the increasingly complicated system of





health care, and direct the patient into self-care and self-treatment. Parker et al. (2008 cited in Chin, et al., 2015) describe this challenge as a minefield for the aging population, which is beside an inadequate health literacy facing also multimorbidity and an increasingly fragmented and consumerism-oriented health system which hinders the autonomy of the patient. Chin et al. (2015) state that with the advanced age many older adults, who live with chronic illness show a decrease in activities, related to health literacy, like managing medication or understanding complicated information about medical treatment. In the framework of their health care they also do not receive adequate support. Boyle et al. (2013) state that many older adults manage poorly in two special areas of literacy; those are health and financial literacy, which are necessary for many complex and decisive health and financial decisions the elderly face (e.g. planning of retirement, inheritance). A limited level of health literacy among older adults is connected to the increased risk of mortality and disability, higher health expenses and less frequent use of preventive services. A limited level of financial literacy among older adults is also connected to lower savings and investments, smaller funds and complaints about mental health.

Boyle et al. (2013) state that despite an increase of awareness that a limited level of health and financial literacy endangers health, economic security and wellbeing of older adults, up until today there has been relatively little known about the factors that cause the limited level of health literacy in advanced old age. Older adults can have lower health literacy levels because of long-term influences, such as limited education or limited knowledge of expressing themselves. Baker et al. (2008), Bennett et al. (2012) and Wolf et al. (2012 cited in Boyle, et al., 2013), state that ageing is accompanied by cognitive decline, and a number of studies show that a decline in cognitive functions is connected to health literacy in old age, whereby a limitation of most studies is that they did not include people with dementia. Baker (2006), Baker et al. (2008) and Dewalt et al. (2004) state that besides that, several other resources (e.g. education, word knowledge, decision-making manner) contribute to health literacy and relate to recollection or memory function, however research did not attempt to explain the effects of health literacy on the memory function in the old age. Boyle et al. (2013) describe that the understanding of the complicated interrelation between aging, recollection or memory function, and connected resources that contribute to health literacy is essential for developing targeted interventions for improvement of health literacy and thus consequently for better health and financial outcomes among the already large and fast-growing population of older adults.

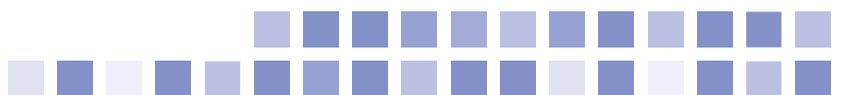
Considering the increase in chronic non-contagious diseases in the world today and thereby the presence of multimorbidity of older adults, it is worth to call attention to the importance of health literacy for individual groups of patients with chronic illnesses (Štemberegr Kolnik & Babnik, 2012). To control chronic non-contagious diseases it makes sense to intensively include the patient into medical treatment or management of his illness for which the patient needs functional health literacy, which demands him to understand instructions, use calculations, distinguish which information is relevant or not, and of course transfer this information into everyday life (Jeppesen, et al., 2009; Cavanaugh, et al., 2011; Xu, et al., 2014).

Health literacy influences health behaviour and the use of health services, which consequently influences health outcomes and costs of health care in the society (Sørensen, et al., 2012). Health literacy is connected to health outcomes most likely because it influences the understanding of information needed for self help (Chin, et al., 2015).

The intention of this paper is to present the level of health literacy among older adults.

We have formed a research aim: to determine the level of health literacy among older adults.

On the basis of the defined research problem we have formed the next research question: What is the level of health literacy among older adults?





METHODS

For the study we used a quantitative research approach, the descriptive method was used. Data were collected with the interviewing technique.

Description of the instrument

The research was conducted by using a structured instrument in the form of an anonymous written questionnaire, which was developed on the basis of a review of domestic and foreign professional and scientific literature (Sørensen, et al., 2013; Zavod Viva, 2013; Hozjan, et al., 2014a; Hozjan, et al., 2014b) and divided into three sections. In the first, we used an instrument authored by Zavod Viva – Institute Viva (2013), which the authors developed after the model of »European Health Literacy Survey Questionnaire - HLS-EU-Q47« (Sørensen, et al., 2013) and partially modified it with regard to the specifics of the Slovene space, for which written consent was obtained. We adapted the measuring instrument (Zavod Viva, 2013) to the older adult so that the questions that were not directly connected to the study (the explanation of technical terms) were left out, and 4 questions were added. Questions 5, 8, 13 are original, question 19, which relates to work environment, did not seem relevant to the older adult and was left out, whereas question 22 was taken from HLS-EU-Q47 (Sørensen, et al., 2013). Respondents were asked to circle the number in front of the statement or answer that was applicable to them. Before carrying out the research, we tested comprehensibility of the measuring instrument. In the pilot study, 10 older adults participated. Because no deviations in understanding the measuring instrument were found, further changes were not necessary. All 28 questions of the first section of the questionnaire are posed as direct questions, where a 4-level scale was used to assess viewpoints, where 1 means - very easy, 2-easy, 3-difficult, 4-very difficult. Demographic questions with the following independent variables were: gender, year of birth, education, amount of monthly income, type of residence. The survey questionnaire did not include any personal data that could reveal the identity of an individual.

Sample

We used a non-random, purposive sample with an age restriction of respondents aged 65 years and more. The study included older adults who live in urban and rural areas of the Savinjska region, and older adults who live in three nursing homes in the wider Savinjska region. The sample included randomly selected older adults who met the pre-specified criterion of age and were not diagnosed with dementia. A total of 148 questionnaires were distributed. In the nursing homes, 48 questionnaires were distributed, 50 questionnaires in rural areas, and 50 in urban areas.

Out of the total of 148 distributed questionnaires, all 148 were returned; thereof 8 were invalid, which means that 140 were valid. The realization of the sample was 94%.

Description of data collection and analysis

Before carrying out the research we obtained written consent in all three homes where we conducted the survey. Research in the three nursing homes took place from the 26th of November to the 2nd of December 2015. Respondents were addressed with a short introductory address at the beginning of the questionnaire. The survey was conducted with the help of an interviewer. Anonymity was ensured in the following way: after the completion of the survey, respondents put questionnaires in envelopes and put them in a closed box, which was in the multipurpose room where we conducted the survey. To complete the questionnaire, respondents needed 30 minutes. In a domestic environment, we conducted a survey from the 1st of November 2015 to the 10th of January 2016, first in rural areas, and then in the urban environment. At the beginning of the questionnaire, the respondents were addressed with a short introductory address. Anonymity was ensured in the following way: after completion of the survey, respondents put questionnaires in envelopes and then put them in the interviewer's sealed box. To complete the questionnaire, respondents needed on average 30 minutes. In carrying out the research all ethical aspects of



the research were ensured: the principle of usefulness, harmlessness, confidentiality, fairness, truthfulness and the principle of security. To all respondents the right to a full clarification and the right to privacy, anonymity and confidentiality were ensured. The principles of the Code of Ethics in Nursing Care Slovenia (2014) and the principles of the Oviedo Convention were considered. All participants gave informed consent, and were informed that they may at any time withdraw from the research.

The data obtained were statistically analysed with the program MS Excel 2010 and SPSS 22.0.

RESULTS

The analysis of the results showed that 25,7% of respondents very easily and 56,4% easily understood instructions of their physician or pharmacist regarding taking prescribed medication or following appropriate therapy. 25% of respondents very easily, and 47,9% easily found information on how to deal with unhealthy habits such as smoking, lack of physical activity and excessive alcohol consumption. Understanding why they need vaccination, for example against flu, seemed very easy to 23,6% of the respondents, to 48,6%, this seemed easy. 15,7% of respondents believed that it was very difficult, and 60,0% that it was difficult to assess whether the information about a disease which they received in the media was reliable. 9,3% of the respondents replied that it was very difficult to assess the advantages and disadvantages of various health options, whereas 62,9% of them responded that this was difficult. 17,9% of respondents answered that it was very difficult to judge when they needed a second opinion from another doctor, whereas 53,6% of them responded that this was difficult. To understand the information on declarations of food products seemed very difficult to 15,7% of the respondents, for 49,3%, this was difficult.

For easier analysis of each of the concepts of health literacy, we calculated the corresponding indexes. To calculate the average values we used a 4-point Likert scale pattern, with 1- very easy, 2 - easy, 3 – difficult, 4 - very difficult. For each individual, who within the dimension answered the minimum number of questions required to calculate the index, the average score of all the elements within the dimension has been calculated. For ease of calculation and simplified comparisons we used the following formula to convert all average values into indexes, which are standardized on a scale between 0 and 50:

$$\text{Index} = (\mu - 1) * (50/3),$$

where:

Index: is the specific index being calculated

μ : is the arithmetic mean of all included claims of all participating (qualified) respondents

1: is the minimum value of the arithmetic mean

3: is the range of the arithmetic mean

50: is the selected maximum of the new measure

Health literacy indexes were calculated according to the model of calculating the index of health literacy which was used in its research by Zavod Viva - Institute Viva (2013). Reliability of indexes of health literacy was assessed by Cronbach alpha coefficient, which is a measure for the calculation of internal consistency. The results are shown in table 1.

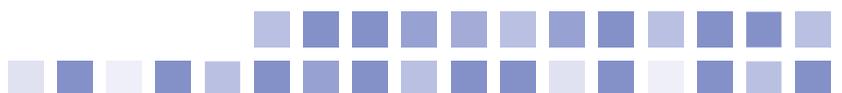




Table 1: Reliability of indexes

ACRONYM	RELIABILITY OF INDEX	CRONBACH ALFA
GEN-HL	General health literacy	0,926
HC-HL	HL in the field of health care	0,859
DP-HL	HL in the field of disease prevention	0,799
HP-HL	HL in the field of health promotion	0,774
RN-HL	Registered nurse counselling	0,707

Table 1 shows the reliability of indexes. Coefficients for all indexes are relatively high, the highest is for General health literacy, the lowest is 0,707 for the index for Registered nurse counselling. In addition to Cronbach alpha coefficients, also all elements with an index correlate with more than 0,3, which indicates that all the elements are good enough to make up the indexes.

Indexes of health literacy were divided into 4 groups: (1) insufficient health literacy, (2) problematic health literacy, (3) sufficient health literacy and (4) excellent health literacy.

The boundaries between the classes were taken from the boundaries in the European Health Literacy Study, which enabled a comparison with the indexes measured in this study. The boundaries between the classes have been set according to the following criteria and are shown in Table 2:

Table 2: Boundaries of the classes of health literacy

Level of health literacy	Level of health literacy	Index value
Limited health literacy	Insufficient	0–25
	Problematic	26–29
	Sufficient	30–36
	Excellent	37–50

Source: Zavod Viva - Institute Viva, 2013

When interpreting the results we use the term limited health literacy, this term is used for insufficient and problematic health literacy combined into one class; in the interpretation of the results we therefore talk about limited, sufficient and excellent health literacy.



Table 3: General health literacy among older adults

Type of health literacy	Index value		AV	SD
	min	maks		
General health literacy	8,7	48,0	27,0	7,8
Health literacy in the field of health care	8,3	48,6	26,2	7,9
Health literacy in the field of disease prevention	0,0	50,0	28,8	9,0
Health literacy in the field of health promotion	5,6	50,0	26,6	8,7
Registered nurse; Counselling	11,1	50,0	34,6	8,5

AV: average value, SD: standard deviation

Table 3 shows general health literacy among older adults, from which it is evident that among the respondents the lowest achieved value in the field of health literacy is in the field of health care (AV=26,2), whereas the highest achieved value is in the field of counselling by a registered nurse. (AV=34,6). The highest variability of the achieved results in the field of health literacy is present in the field of the disease prevention (SD=9), whereas the lowest variability is present in the field of general health literacy (SD=7,8).

DISCUSSION

The level of health literacy tells us, how an individual understands the instructions that he or she receives within the health care system, how he or she functions within the health care system, and with its help we can as well predict, how healthy an individual is going to be in future. (Sørensen, et al., 2015). That is extremely important when taking into consideration more vulnerable population groups, such as older adults, the group which can nowadays be linked to multimorbidity, loneliness and related medical social problems. In frame of our research we have in the first place tried to establish the level of health literacy in older adults, included in the sample. We have established that the general health literacy in older adults, who have participated in our research, is limited. Limited is as well health literacy in the fields of health care, disease prevention and health promotion. Zavod Viva (Institute Viva) has in the year 2013 conducted a research in the field of health literacy of the general Slovene population. The research has shown that in the field of general health literacy three quarters of Slovene population have limited health literacy, whereas in the field of the knowledge of the Slovenian health care system two thirds have limited health literacy, that in the field of disease prevention more than a half of the general population have limited health literacy, whereas in the field of health promotion almost three quarters of the population have limited health literacy. Limited health literacy is present in almost three quarters of the respondents above the age of 50, and the level of limited health literacy increases with age. We have established, that the situation is not optimistic, the results were, however, expected, as the limited level of health literacy is more frequently present in more vulnerable population groups, for instance in older adults, people with lower levels of education, individuals belonging to ethnic minorities and others, as established by Van Servellen (2009). Also Toçi et al. (2015) state that the level of health literacy progressively decreases with the increasing age, whereby the





elderly adults carry the heaviest burden due to limited health literacy, which shows as harmful to their health.

The findings of the research that we have conducted, are comparable to the preliminary findings of the European research Healthy Lifestyle for Ageing Well (The College of Nursing in Celje, 2016), and show that the majority of older adults in Slovenia, in Poland, as well as in Portugal, have a limited health literacy in the fields of health care, disease prevention and health promotion.

The results also show that the majority of older adults, included in the research, experience no difficulties understanding their physician's or pharmacist's instructions, in regard to taking the prescribed medication or concerning appropriate therapies. Older adults, included in the research, have no trouble finding data on how to get rid of unhealthy habits like smoking, insufficient physical activity or excessive alcohol consumption. They also understand why they need to get vaccinated, for example against the influenza. Older adults experience, however, more difficulties judging the information on diseases, which they hear or read in the media, as they are not certain about the reliability and credibility of such information. The older adults, who participated in our research, have emphasized that they have great difficulties judging the advantages and disadvantages of different treatment methods, and understanding information on food products declarations.

Also included in our research was the so called concept of the registered nurse in connection with the health literacy of older adults. From our research it can be concluded, that the nurse has a good starting point for health-educational work with an older adult person. The contribution of a nurse to an increase in the level of health literacy in a patient can be, irrespective of the patient's medical condition, substantial, as through every interaction with a patient the relationship works in a health-educational manner and educates the patient, whereas in the planned or not planned manner. (Štemberger Kolnik, 2011; Babnik, et al., 2013; Hozjan, et al., 2014a). For patients with a low or limited level of health literacy, the health-educational work is of extreme importance, and it is even more efficient, when conducted individually. (Rothman, et al., 2004)

We are of the opinion that the role of the nurse in health promotion should be strengthened and become more prominent. Perhaps it would be meaningful to think about new forms of work in the field of health promotion in older adults. In addition to the reference clinics and reference centres for health promotion we would in the local communities establish counselling centres for elderly adults, where we would offer additional health literacy training, promote a healthy lifestyle in old age (healthy nutrition and physical activity), promote their autonomy and independence, and promote their safety and prevention against non-contagious chronic diseases. With the synergy of knowledge and experience in form of interprofessional cooperation of various experts – physicians, physiotherapists, work therapists and social gerontologists – we would offer older adults a holistic treatment, which would contribute to a healthy, active and quality ageing. Such a form of counselling centres should also be available to all the older adults, living in nursing homes, as they are deprived of the treatment by the reference nurse. According to the findings of our survey, the older adults, who live in nursing homes and are functionally able, would certainly need health-educational treatment, which would help them change the unhealthy lifestyle habits and postpone or slow down the occurrence of non-contagious chronic diseases. It is of utmost importance, that nursing students achieve skills in the field of therapeutic communication already during their studies, and master the understanding of the holistic approach towards an older adult.

CONCLUSION

Health literacy is one of the factors, which significantly affect the life quality of the elderly. The results of our research show that older adults, who took place in our research, have limited health literacy. Therefore there exists a danger, that an insufficient health literacy in this already vulnerable and deprived population group, will show itself in the form of the incorrect use of medication, the incorrect use or non-use of health services, in poor management of chronic diseases, and in an unsuitable response to the emergency situations, in poorer health condition of older adults, in the lack of self-efficacy and confidence, and as a financial burden for the individual as well as for the society, which consequently leads to an even bigger social inequality. We are of the opinion, that the present situation is certainly a sign, which shows that



older adults need health-educational treatment and health promotion, with which we are going to raise the level of health literacy among them, and by all means it would be necessary to develop the norms for health literacy for general Slovene population.

Registered nurses are the ones, who can contribute to an increase in health literacy in all areas of their operation. Because in the process of treating diseases and in the process of disease prevention nurses are the ones who spend the most time with an older person, they can do a lot of good in the field of health promotion and inspire an older adult to change their behavioral habits and unhealthy lifestyle. A nurse will, with the choice of suitable medical education techniques, educate and empower an older person, so that he or she can recognize how his lifestyle influences their health and what risk factors he or she may face. An older adult, who will be educated and empowered, will know how to keep, strengthen and achieve their health, and in the case of an illness he or she will know how to effectively navigate the health system – such an older adult is health literate.

The contribution of a nurse towards the increase in health literacy of a patient can be, irrespective of the patient's health condition or age, substantial, as the nurse through every interaction with the patient works health-educational, whether planned or unplanned. The success of a nurse's work does not depend merely on their knowledge and the achieved education, but on their social and cultural capital.

It is necessary to develop certain programs for health education and health promotion for older adults, as well as the programs to increase health literacy, whereby it is necessary to take into consideration, that older adults possess already formed standpoints and values, and that their ability of learning new skills and taking in health-educational recommendations is highly influenced by the possible (bad) experience from their schooldays.

The increase in the number of older adults represents a challenge that we must face, discuss, and solve it with the help of an intergenerational dialogue.

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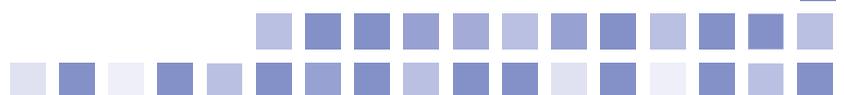


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ALCOHOL DEPENDENCY AMONG ELDERLY PEOPLE IN GERMANY - AN UNDERESTIMATED PROBLEM?

Nele Neveling, Tina Munkelt, Beata Boronczyk, MSc

INTRODUCTION

During the work as a nurse one comes along a wide range of possible working places. One possible working place is the psychiatry, where many different psychiatric disorders are treated. Alcohol addiction is one of such psychiatric disorders but is often not seen as a disease itself, although alcohol addiction is the commonest psychiatric disorder of men in the western industrial countries.

According to a survey 1.77 millions of people in Germany are addicted to alcohol; the drinking patterns of another 1.61 million people are classified as alcohol abuse. Nearly 74.000 people die per year due to the risky consume of alcohol (Anon., 2014). But the published data mostly treats people between 18 and 64-years. There is no actual or accurate data about the spread of alcohol abuse or addiction when it comes to old people. Only 12.8 percent of the people between 60 and 64 years do have a problematic alcohol consume, whereas 40 percent of the people between 18 and 24 years abuse alcohol regularly (Deutsche Hauptstelle für Suchtfragen (DHS) e.V., 2011).

People are guessing that 3 % of the men and 1 % of the women in an age over 65 years do live with an alcohol dependency. However about 28 % of the men and 18 % of the women in an age of 65 years or older are drinking more than 24 grams or 12 grams of alcohol daily, overriding the limit of a low-risk consume. Risky consumption patterns are more likely to be maintained than a low-risk consumes (Deutsche Hauptstelle für Suchtfragen (DHS) e.V., 2008).

Having these information and numbers we will now take a deeper look concerning the guiding question: „Alcohol dependency among elderly people in Germany - an underestimated problem?“, considering all important sub-themes which will help coming to a conclusion.

DEMOGRAPHIC CHANGE IN GERMANY

To emphasize the effect of alcohol abuse of elderly people in Germany, it is important to have a look at the demographic change in Germany, because Germany is one of the countries which will suffer from a shrinking birthrate and a generation which is characterized by many old people.

To find reasons for this dramatic change we have to go back in time:

In 1871 a german woman gave birth to approximately five kids. Many people earned their money through farming or by working as craftsmen, which weren't profitable jobs to have so they had to face with poverty most of the time. Having a lot of kids helped those families because the children were cheap workers and guaranteed their care in an old age. Within the process of the industrialization, urbanization and introduction of retirement plans the „economic use“ of having many children diminished: In 1935 a German woman only gave birth to approximately two kids. This phase was followed by a so-called „baby-boom“ until the end of the 1960s „with peak levels of more than 2.5 children per woman“ (German Agency for Civic Education, 2013).

However the „baby-boom“ wasn't for so long, even if the economic situation of Germany increased. Especially the change in society was a reason for the ongoing shrinking birthrates: The role of women in the society began to change with the effect that females were able to finish school and even entered universities, their lives were no longer bound to the kitchen. In 1961 the introduction of birth control pills took place which emphasized the new responsibility of women concerning their plans of family building, with the consequence that leading a childless life got accepted in the German society.

Nevertheless not only shrinking birthrates are a reason for the demographic change in Germany but also the improved medical supply, the nutrition-conscious lifestyle and the better working conditions in Germany which lead to a continuing aging process. The life expectancy nowadays for men is 78 years and for women 83 years, whereas in 1900 only five percent of the population of Germany reached an age over 65 years (German Agency for Civic Education, 2013).



Regarding the developments of the structure of the population in Germany, the country has to face a society which is characterized by many old people. Taking a look at the graphic below - showing the contribution of the respective age classes in the total population - one can see that in 1950 the graphic was shaped like a „pyramid“, whereas the graphic of the prognosticated population in 2050 looks more like a „mushroom“, meaning that the overall population in Germany is getting older and especially less, followed by a low birthrate. Those developments also mean that Germany has to face the problems which are accompanied when it comes to such a demographic change. Not only the retirement plans become an important issue in the following years but also the increasing need of care for old people and their physical and psychological changes (treating topics like aggression and alcohol abuse), which need to be handled (Süttlerin, 2008).

PHYSIOLOGY OF AGING

After having summarized the effects of demographic change with the conclusion that Germany's population is constantly getting older, one has to face the physiology of aging because aging is often connected with many changes.

In the process of getting old the people become pensioners, they overtake new roles in their families - getting „grandfather“ and „grandmother“ - and they have to accept that friends and partners - who followed them through most of the times - die. However those are not the only changes which take place, the elderly people also often have to suffer from cognitive changes: The short-term memory eases off, the learning process succeeds more slowly and the adaption to something new represents itself as a difficult situation. This part of cognition is referred to the so-called „fluid capability“. The „fluid capability« decreases in the process of getting old whereas the „crystalline capability“ increases. The „crystalline capability“ describes the amount of experiences and the strategies to deal with different life situations. For example the vocabulary of an old person is much bigger and the capability to understand some words in comparison to a young person (Oelke, 2012).

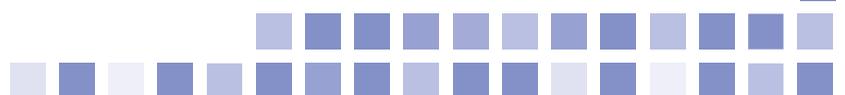
But not only cognitive changes take place, old people also experience psychological changes. The old generation often makes the impression as if they are more balanced and calm. They radiate a strong stability of satisfaction and intelligence and seem to have a solidified self-esteem. On the other side they tend to passivity if they are not able to handle situations by themselves. Resignation is an often seen phenomenon.

Not to forget are the social changes which come along the process of aging. The social contacts do often experience a decrease, because many friendships are ending through death and due to restricted mobility old people are often dependent on local proximity. Nevertheless not the quantity of the meetings is decisive but the quality.

Physical changes are the most visible changes: the hair slowly gets grey, wrinkles develop and the pigmentation of the skin changes. But for old organisms it's a lot more difficult to handle diseases, because:

- they are not compensated that good enough anymore
- they have another course compared to young people (e.g. infectious diseases)
- they are often chronic
- they come along with other diseases (multi-morbidity) (Oelke, 2012, pp. 94-104).

The most occurring diseases which come along in the process of aging are often part of cardiovascular diseases, metabolism supplements, muscle and skeleton disorders and malignant tumors. (Oelke, 2012, p. 103).





ALCOHOLISM

Keywords:

First of all one has to differentiate the terms abuse and dependence:

Abuse

– *to use something for the wrong purpose in a way that is harmful or morally wrong* (Cambridge University Press, 2016a).

Dependence

– *the situation in which you need something or someone all the time, especially in order to continue existing or operating* (Cambridge University Press, 2016b).

In this paper one wants to concentrate on the term of dependency.

The ICD-10 diagnostic criteria for alcohol dependence determine that the diagnosis of alcoholism applies when at least three of the following criteria could have been diagnosed during the last 12 months:

1. “ A craving or feeling of compulsion to use the alcohol
2. Evident impairment of the ability to control use of alcohol. This can be related to difficulties in avoiding initial use, difficulties in discontinuing use, difficulties in controlling the level of use
3. Withdrawal state, or use of the substance to mitigate or avoid withdrawal symptoms, and subjective awareness of the efficacy of this behavior
4. Presence of tolerance to the alcohol's effects
5. Progressive neglect of pleasures, behaviors or interests in favor of using alcohol
6. Persistent use of alcohol despite evident presence of harmful consequences“(Deutsche Hauptstelle für Suchtfragen (DHS) e.V., 2011).

ALCOHOL DEPENDENCY AMONG ELDERLY PEOPLE – CONSEQUENCES

Everyone knows about the long-term consequences of an excessive consumption of alcohol - the risks of coming down with liver cirrhosis, pancreatitis or gastritis are pretty high. But when it comes to a specific age the alcohol tolerance decreases due to shrinking water content in the blood vessels of the body. That's why older people have a higher alcohol level than others even when they drank the same amount of alcoholic drinks. The second consequence of aging is that the liver needs much more time to break down the drunken alcohol. Even the nerves react more sensitive towards alcohol, so than an abuse or addiction of the drug can lead to a damage of the central nervous system.

The biggest but not sufficient enough investigated problem is the possible interaction of prescribed medication and alcohol. Especially dangerous is the combination of psychotropic drugs (e.g antidepressants) with alcohol, that's why the physicians have to be informed even about occasional alcohol consumption. Alcohol consumption does also affect the organism in general referring to their mental and physical performance because the cells need approximately 80 % of the available oxygen to break down the alcohol. This process is even more severe knowing that the absorption capability of oxygen decreases while aging (Deutsche Hauptstellen für Suchtfragen (DHS) e.V., 2008).



ALCOHOL DEPENDENCY AMONG ELDERLY PEOPLE - SYMPTOMS AND POSSIBLE CAUSES

Symptoms

Recognizing an alcohol dependency among elderly people can be made difficult because sometimes the difference between age-related changes and alcohol related damages isn't that clear.

Possible symptoms are:

- Falls, especially repeated falls
- Cognitive deficits such as:
 - Lack of concentration
 - Decreased mental performance
 - Lack of attentiveness
 - Disinterestedness
 - Self-neglect
- Diarrhea
- Flushing
- Dizziness
- Tremor
- Loss of appetite
- Mood fluctuations“ (Deutsche Hauptstellen für Suchtfragen (DHS) e. V., 2008).

Possible causes

When it comes to alcohol dependency among elderly people one differentiates between the so-called „early onset“ and „late onset“. The term „early onset“ describes that an alcohol dependency already exists since the early or middle adulthood. Reasons for the „early onset“ are in general multifactorial conditioned - biological factors (genetics, physical conditions), psychological factors (personality, positive and negative experiences) and social factors (current life situation , reactions of the environment/family) play an individual role. „Late onset“ in comparison is used for people who developed a dependency in a higher age. Reasons for „late onset“ are to find in critical life events which come along with the process of aging, such as the loss of the life partner or the retirement. The retirement can encourage problems like social isolation or financial problems (Deutsche Hauptstellen für Suchtfragen (DHS) e. V., 2008).

SUMMARY OF THE PERFORMED PROJECT „INTERREG PROJECT ADDICTION AND ELDERLY“

Like already mentioned in the introduction of this paper there are only a few studies or surveys about the occurrence of alcohol dependency among elderly people. Most of the found data treats the alcohol dependency of people between 18 and 60 years and those studies about the older generation aren't longer current. That's why we would like to present the performed project „INTERREG Project Addiction and Elderly“, which was funded by the EU and aimed to assess the alcohol consumption (and also the use of benzodiazepine) „in different settings using self reports and questionnaires, third party reports and biomarkers“ (Kunz, et al., 2014, p. 45).





Therefore they asked 131 general practitioners, 455 elderly in 33 different retirement homes and 123 inpatients of four different hospitals. Furthermore they gained third party reports from for example nurses or ward physicians and investigated approximately 304 urine samples and 334 hair samples for ethyl glucuronide. The most relevant result from the investigation of the hair samples is, that about 10 % of the elderly in retirement homes and 30 % of the inpatients in hospitals more alcohol than the recommended 10 grams per day. The general practitioners state that one in ten of the examined elderly people has an addiction problem and 77 % see a need for action. As a conclusion for their project they indicated that the awareness must be increased among elderly but also among relatives and physicians. Highlighting that the offering of a treatment could be helpful. (Kunz, et al., 2014, pp. 105-112).

THErapy AND TREATMENT METHODS

In general the offers of the addiction care and the old people's welfare should cover the possible therapies for elderly. However the Deaconry (2008) found out that the addiction care isn't able to access old people whereas the old people's welfare has too less knowledge about addiction problems and isn't qualified enough to conquer those. An intern investigation of the Deaconry's report from 2008 confirms both establishments see alcohol dependency as a risky problem but they do not offer targeted programs. A second problem which also has to be mentioned is that addictive disorders fall in another category of benefit legislation: In the background of the addiction treatment are four different law books - SGB V (health insurance), SGB VI (pension insurance), SGB XI (rehabilitation and participation of disabled people) and SGB XII (integration aid). Having those four law books, it isn't always quite clear who covers the responsibility of the financing; consequently there is a lot of bureaucracy. Referring to the used source, it's important that there are awareness campaigns in e.g. retirement homes or other establishments of the old people's welfare to inform not just the elderly but also relatives and reference persons about possible treatments. The main task of the old people's welfare and the addiction care is the performance of training courses for all employees with regard to the specific risks and possibilities for prevention and therapy of elderly with addiction problems (Zeman, 2009). In the following there will be some examples for possible therapies in general:

- *Substance abuse therapy*
If an alcohol dependency could have been diagnosed a stationary substance abuse therapy is indicated. During this therapy the patient has to abandon alcohol entirely and gets medication to alleviate possible withdrawal symptoms. Within the scope of this therapy the affected persons try to understand the background of their dependency and to develop new behavior patterns through individual and group interviews. Old people often need more time and intensive care to reach a persistent success.
- *Psychotherapy*
During a psychotherapy with elderly it's important that the therapist doesn't use a confronting but a more cautious and accepting style. The therapist should appreciate the people's life experiences and achievements because those could work as important resources treating the alcohol dependency (Deutsche Hauptstelle für Suchtfragen (DHS) e.V., 2011, pp. 21-33).
- *Self-help groups*
- *Cognitive behavioral therapy*
- *Psychoanalytical or depth psychology oriented Psychotherapy*

CONCLUSION

Germany is one of the countries which have to face demographic change in an extent like no other country in the world, including a birthrate which isn't increasing anymore and a society which is marked by many old people having a life expectancy between 78 and 83 years. Probably the prognosis will be modified due to the current rising immigration rate in Germany. However the amount of elderly people in Germany will stay the same and increase not least because of the modernization of medicine. Having investigated the physiology of aging it became



clear that the old people have to face new problems while entering the retirement age. Social Isolation, the loss of life partners or reduced financial means are common consequences. Those consequences often indicate a cause for the „late onset“ alcoholic dependency as mentioned above. However getting old doesn't immediately mean that people are more endangered to get addiction problems - quite the contrary. Most of the old people enjoy their lives in retirement, finally having enough time to spend with their life partners, families and friends.

Like portrayed in the introduction only 12,8 % of people between 60 and 65 years and 3 % of people over 65 years do have a problem with alcohol dependency, however 28 % of the men and 18% percent of the women in this age consume alcohol while overriding the limit of low-risk consume. The consequences of drinking in an higher age are also more dangerous affecting the organism in different ways and increasing the chances to get secondary complications through alcoholism.

Having summarized the performed project „INTERREG Project Addiction and Elderly“ helped getting a small insight in the current situation of alcohol dependency because of a lack of recent studies. Even if this study isn't a significant study for whole Germany because there were too less participants and investigated locations, it gave a overview for a small part of Germany - highlighting that this survey also confirmed a consume of elderly which overrides the recommended amount of 10 grams per day.

At last this work investigated the possibilities of therapies that elderly people can have access to when the got diagnosed a alcohol dependency. Both establishments - old people's welfare and the addiction care - do not offer specific targeted programs for elderly addicted people, which means that those establishments have to develop new ways to address old people.

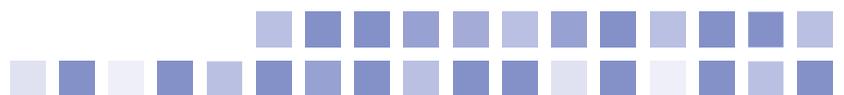
After having analyzed all of the sub themes, we need to focus to the key question: „Alcohol dependency among elderly people in Germany - an underestimated problem?“ again.

Alcohol dependency among elderly people isn't an underestimated problem in Germany right now, the current figures of old people with a alcohol dependency are low and the society is aware of the fact that some things have to be changed like the focus on therapies for elderly or at least the sensitization for addiction among those and their relatives (Zeman, 2009), caregivers and physicians, that's what the INTERREG project also found out during the study. There have to be more studies like this, because there is a need of a follow up of current data.

However the society has also to take into account that the demographic change may change the amount of diagnosed alcoholism among elderly. The birthrate is shrinking leading to a generation in which many people stay childless. This childlessness can lead to a reinforced feeling of social isolation and lead to a vicious circle of dependency. As long as the society is conscious about those possible problems the alcohol dependency among elderly people in Germany may become a problem but not underestimated.

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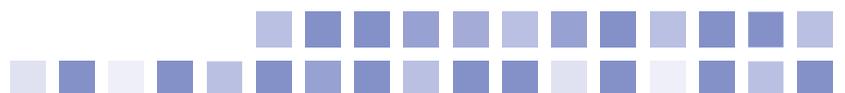
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