Reflections on partnership and co-creation in an EU project: GNurseSIM Intercultural Simulation for Caring for Elderly Patients.

Sheila Cunningham, Pam Hodge and Nora Cooper (Middlesex University)

Introduction

Reflection within practice-based professions such as nursing allows for personal introspection and critical analysis of situations in order to make sense of practice and ultimately to improve it. It is a core tenet of nurse education to enable sensemaking of actions, emotions, consequences and ultimately, learning. Practice healthcare environments, patients (elderly or otherwise) and staff co-exist in an extremely broad and complex way. Navigating and developing these environments involves reciprocal relationships between professionals, people using services, and communities to enhance care. The term 'knowledge mobilisation' is used in the healthcare literature to describe the active, iterative and collaborative process of creating, sharing and using research evidence (Melville-Richards et al 2019). This involves a range of 'co'-approaches which are used interchangeably within literature i.e. co-production, co-creation and co-design. In this case-based study, a key influence was 'co-creation', where students are considered as equal partners rather than consumers of education and where teachers and learners challenge their assumptions as well as perceptions of their respective roles in education. A successful learner-teacher partnership is defined as 'a collaborative, reciprocal process through which all participants have the opportunity to contribute equally, although not necessarily in the same way, to curricular or pedagogical conceptualization, decision-making, implementation, investigation, or analysis' (Cook-Sather et al, 2014, pp 6–7). This EU funded project (GNurseSim Intercultural Simulation for Caring for Elderly Patients) provided a practical opportunity to work in partnership with students and shape their own, peers' and teachers' learning and clinical practice perspectives.

What?

The core purpose was to develop resources for nursing (and healthcare) students on Intercultural Simulation for Caring for Elderly Patients. The global need drives this since the number of people over the age of 75 is expected to more than double by 2050, with the number of persons aged 80 years or older expected to triple by 2050 to around 426 million (WHO, 2022). Furthermore, globalization and population mobility mean it is likely that the elderly patients will be cared for by professionals with as diverse values, traditions and cultural background as their patients or people they are caring for. Like many high-income countries, the United Kingdom (UK) has one of the most culturally and linguistically diverse (CALD) populations. Challenges with language or culture may present a threat to patients' safety in hospitals and care environments. It is further recognised that diversity is wider than culture, embracing community, customs, practices, identity, sense of belonging, sexuality and beliefs. All influence how health or ill-health may be approached, experienced and encountered by students and healthcare professionals. Further challenges were identified: terminology varied across countries and evoked among the project team (and students) the issues of 'labelling' ('older', 'elderly' or 'geriatric'), discriminatory attitudes and unconscious bias (WHO, 2016). This may complicate care further if older people feel a burden or perceive their lives to be less valuable, risking depression and social isolation (RSPH, 2018).

Health and social care settings offer the best learning experiences for students, however older people may be in many different settings and students may not see all in practice or have equitable practice learning opportunities. Simulation as a solution can support wider learning experiences to develop skills for complex and cultural needs either instead of, or prior, to real-life clinical experiences. This EU funded project, GNurseSIM, offered an opportunity to contribute to this simulation experience. The project consortium comprised seven partners across five countries (UK, Poland, Malta, Finland, Spain). The project itself had a variety of outputs which included scoping the literature, scoping benchmark professional competencies for intercultural care of elderly people (Tohmola et al, 2022), devising a 'course', and making resources. The resources were thirty video scenarios in all partner languages. As the UK partner we produced five video simulations scenarios (https://gnursesim.eu/). Whilst this project was led and managed overall by academic staff

at the various European partner institutions, a core tenet was engaging and involving nursing students and clinicians. Student participation was planned from the outset. Open invitations were sent at different stages of the project to support the outputs: scoping, reviewing the scenarios, making the video simulations, reviewing the 'course' with other students, and dissemination with clinical partners. The project team's philosophy was equality, respect and support. Students were voluntary partners in this project for as much or as little as they were, or felt, able. Their practice experience, and opinions and guidance on making simulation outputs were valued and welcomed. This is not unique within this faculty and reflects nursing professional values which are core to all programmes. The UK university chose to draw on challenging situations which may be encountered within a clinical practice situation and which reflected intercultural issues.

A key consideration and point of complexity for students and colleagues was the nursing context. This project did involve a number of EU partners and thus the context of nursing and practice was different and yet shared similar features. Unlike Europe, in the UK nursing is diversified into 'fields': either adult care, child and young person's nursing, mental health nursing or learning disabilities nursing. Situations where students encounter older people in the UK could be within mental health locations (for example people with dementia), adult or elderly wards or community care centres (learning disabilities) yet not all these areas exist in the same form across Europe. This was key in preparing and clarifying any simulation, given that the context, practitioner or experiences of patients may be vastly different, yet needed to resonate with all EU partner countries' contexts. The learning resources were simulation videos located within a clinical simulation laboratory. Nursing students were invited to participate voluntarily. Our nursing students are familiar with participating and co-creating outputs (eg. STEP project, Morley et al, 2017) and so encounter these opportunities regularly. It is also beneficial that students see academic staff in a variety of environments adopting differing roles and contributions, e.g. clinical or community practice areas, skills laboratories, classrooms, events. Five nursing students volunteered balancing this between full timetables and placement responsibilities, offering their valuable time. Those who came forward were briefed to take the scenario outlines and to make these as authentic as possible as if encountering the situations in clinical practice. It was important to establish a shared understanding of partnership and each person's role, open constructive

communication and value each other's contributions. Technical elements (filming) were undertaken by the university media team. This process offered learning opportunities for both staff and students such as repeats of scenarios, challenging the meaning within scenarios, and revisions and clarifications, especially of intended learnings from the scenario. Students' views and expression of key cultural and diverse topics was essential and the range was broad including sexuality, loneliness, culture, food, power relationships, family dynamic, socio-financial concerns.

So what?

Debriefing and group reflection were considered important not just for evaluation, but also for exploring each other's feelings, learning, insights and impact on self, both personally and professionally. The discussions and reflections were not a formal evaluation requiring ethical approval. Students and staff each offered their own written and verbal feedback which the five students and three academic staff jointly collated. A narrative synthesis reveals a variety of not only the drivers amongst students to participate, but also of the perceptions of the making, viewing and suggesting changes to the scenarios and also of the impacts on themselves as people and professionals. The staff did try to make this an equal partnership and the extent to which students felt it was equal was not clear. When staff joined in the video simulations or wore the uniform 'scrubs', students admitted seeing staff in a new light, as practitioners and professionals.

Four themes emerged from the reflections and debriefing:

- Motivations and feelings about being involved
- 'Acting' and simulating practice
- Seeing oneself and gaining insight
- Impact on practice and skills

Motivations and feelings about being involved

Motivations varied from learning and extending oneself to just 'joining in'. Emotions ran high at times with relationships evolving and the sharing of practice and individual skills and

experiences. Reports of going 'beyond my comfort zone', 'building my confidence' (student A) and extending clinical experiences and skills, to joining in everything 'just because' and to almost add a list or collectable menu of extracurricular activities for some unknown future purpose. These were mostly second year students and they had some clinical experiences to build upon. They knew some of the academic staff and skills laboratories well. It does not appear to be curiosity of the environment or staff but rather the content and skill development which drove them. Interestingly comments such as 'pushing myself' show a level of personal knowledge, insight and reflection and a determination to not just know, but also develop. Deficiencies in practice situations and workplace constraints led one student to comment on an opportunity to participate to remedy this:

> '*And it doesn't play a big role in [practice] finding out more about your patient's backgrounds. You are co-ordinating other things, but then forget about the fact that the person that you are taking care of has got a background, has got a history, and so it's equally important to know.'* (Student B)

One student (student D) was a first year student whose curiosity was piqued and, in an attempt to meet a wider group of people, volunteered. Student D identified a deeply held belief and sense of their own culture and a need to analyse this, dispel stigma and misunderstanding around challenging issues such as mental health and chronic conditions:

> *'I saw a general e-mail for everybody who was interested. So I read it, I was interested. I haven't done any acting or anything like ever before. But then I knew was for educational purposes and then I felt like I could learn something from it.. it was cause of from my culture. I'm from West Africa. Precisely, Ghana. And with our culture there are a lot of stigma and then misunderstanding …. to mental health. Physical issues like diabetes and the food we eat especially with the rise of diabetes, you realize most of its it's culturally centred, especially when you go to the Caribbean's and African's homes*' (Student D)

‘Acting’ and simulating practice

The role and position of the students within the production of the video took some time to establish. The partnership approach meant students could guide, act, revise and be equals in the video production. However, there were challenges: the location offered restrictions due to availability of the clinical simulation room and the media technicians. The initial set-up added to the complexity and was a potential barrier to authentic ‘being’ in the scenario. Furthermore, the students did not all know each other and initial ‘breaking the ice’ was required which added to stress and uncertainty:

> *‘First day – I asked myself - did I really do the right thing here because I didn't really know anybody … then you have people who make you feel welcome and then like we… So we all got interacting. So it was a bit easier*.’ (Student D).

The patient was a mannequin which, whilst familiar in skills simulation sessions, did prove a challenge with the types of scenarios. The sense of wanting it to be realistic was a strong theme and there was some inevitable disappointment:

> *‘get a real person instead of the mannequin, which would have been much more realistic’* (Student B).

> *‘So it could be if we were doing it again, we would be a bit more creative. But you're right, because it was a little bit difficult pretending that the mannequin was real. [It] took me a bit to get into the zone because I felt a bit silly talking to, well, talking to the mannequin when someone behind was talking’* (Academic A)

The issue of being an ‘actor’ or using a script’ caused some anxiety, however, reflecting on this, it emerged that this was similar to any simulation activity. Also, since the ‘script’ was loose, it offered a means to be reactive as if in clinical practice, adding to the realism of the situation by going into ‘nurse mode’:

> *‘in real situations, I mean you wouldn't have a script or anything to go by. You would have to do what is right at the moment. So I mean the situation was actually, you know, conducive for what it was…. think on your feet basically and act right’* (Student B)

> *'in real scenarios when you're working in the world or community, wherever are working, it's unpredictabl*e' (Student D)

It was obvious students rationalised this in a variety of ways, such as this being a learning situation:

> *'nobody's going to give you a script to read …. I was kind of pep talking to myself like, OK, I mean try and do this for a good cause. It's not like I just acting somewhere, you know, and then you are also learning'*. (Student B)

In the practice, or 'dry' runs, students explored with the academic lecturers ways they would manage the situation in reality and improve the authenticity, including verbal and non-verbal communications. Through this, reciprocal learning appeared to emerge. For example, the lecturer roleplayed the nurse in conversation with an aggrieved friend after observing the students and vice versa.

Seeing oneself and gaining insight

Students reported a number of insights from seeing themselves enacting or engaging with skills, such as communication or even how they responded in situations. Observing themselves made them question their professional practice and own skillset as the difference between their perceived (or theoretical) way of doing something and seeing themselves do it was a revelation.

> '*seeing yourself…your standing position, you interacting with a person you're gesturing. Is it intimidating? Reading about communication, you know, sitting down, facing the person and all that. I might have read about it, but it in acting it I see it differently'.* (Student B)

> *'That was saying at the beginning and it definitely put me out of my comfort zone because for me, it was part of being unique. For me personally, I'm working my confidence, public speaking and it's something that I'm open about. I've struggled with this and so I mean that put me out of my comfort zone, which was good'*. (Student A).

These were challenging scenarios and students reported a growing humility for culture, norms and making assumptions. They challenged how a person may appear and make judgments and be misperceived even with good intentions.

> *'one thing that sticks in my mind is actually a very good thing because it just goes to show you how people can get heated up when you could be discriminating against them without even knowing… It was an eye opener. So we're going into the profession to be careful of certain things and being aware, be culturally sensitive and aware of other people's requirements'* (Student A).

> *'Don't assume, assumption is so bad if you see two elderly women there together. You think? Oh is that the sister or a friend? Don't assume because I think in the scenario it was the wife. The nurse assumed it was a friend. If you're not sure, you could ask...because you know when… you assume wrongly in any situation it changes that dynamics of the whole thing'.* (Student D)

This was a challenge for one student who could not empathise or identify, which in itself was an insight, but also pointed to the professional collegiality of the students when support was offered by a peer:

> *'I just can't get into the emotion of it. And I think someone had to jump in and take over because I was doing a terrible job'*. *(*Student C).

There were clear connections with the students' professional programme, values and boundaries. This emerged across all the students and took a variety of forms, from skills and qualities to challenging practice:

> *'I think it is a very, very good thing that we do this. Not only for people watching, but even for people who participate as well. Because I learned a lot from it as well, you know, learnt a lot from meeting others as well. You always have to empathize people. You need to put yourself in their shoes'* (Student D).

> *'After we made these I looked at others [videos]… from Malta. I think where they needed an interpreter for an elderly man, the nurses were on their iPhone, like, demanding if there's a family member out there to interpret. What about confidentiality?'* (Student B)

Interestingly, for the academic lecturers, this also evoked a nostalgic sense of practice and 'being' a nurse:

> '*I really quite liked putting the scrubs on because I felt like I was going back in practice … once I got into it, I really did enjoy it and I really enjoyed [being] back to what I always did, and would still enjoy if I was to go back'*. (Academic A)

Impact on own practice and skills

After the experience of making the video simulations, students reported unexpected impacts on their own skills and attitudes in practice. This enduring, powerful effect enabled students to draw on their insights, awareness, and support development of their own strategies to 'perform' in practice. The level of empathy and connection with their chosen profession emerges very clearly, including the need to see learning as ongoing after their course finishes.

> '*It taught me how to sort of like deal with my nerves, like for example, this morning I was doing patient handover… but I'm starting to learn that, you know pretend no one is watching'* (Student A).

> *'I took some of whatever I learned to placement as well, especially maintaining the professional boundaries. You know you have to show your compassion and everything, but then you need to know where you draw the line and then also establishing a therapeutic or rapport with your service users [patients] is very important'*. (Student D).

Cultural awareness also grew even within academic staff. Cultural frames expand as we encounter them and can only add value to teaching and learning within clinical practice. Sharing such insights with students emphasises the life-long learning for practice.

> *'So many medications have got eggs and pork in them, and… trying to work out, you know, where that sits with the person for cultural reasons and also for allergies.* (Academic B).

To improve patients' health outcomes within a cultural context, nurses and health professionals need knowledge of, skills in, and attitudes towards transcultural or cross-cultural issues. The outputs from this EU project intend to enrich this diversity and cultural exposure within the context of elderly care, but it was the partnership which deepened learning. The challenge is to do this in a lesson using the scenario artefacts.

Now What?

Patient simulation is often used to teach physical or biomedical aspects of care with less focus on the psychological, cultural, and environmental context. However, these can integrate in a variety of ways. Nursing education continues to move from traditional pedagogies to constructivist approaches which rely on educators being partners in the learning process. Research shows that nursing students who engage in active learning exhibit higher order thinking skills and are better able to construct new meaning out of what is taught (Pivac et al, 2021). As mentioned by one student, reflecting on this experience and working alongside nurse academics gave her the opportunity to 'walk in another's shoes' (Student D). Co-creation and partnership work enable exploration of concepts related to cultural awareness, inclusivity, and other topics that are difficult for nurse educators to address in traditional learning environments.

Following on from this project, more work in the department is occurring producing co-created artefacts to support practice learning, for example, preparation for practice videos. Several of the students who were involved have also volunteered to be part of other resource development projects and continue to want to 'be part of it'. Having been part of this project has also positively influenced one of the lecturer's approach to co-creation in her PhD project.

In summary, the opportunity to create, debate and modify the scenarios in partnership with students produced a very powerful reciprocal learning experience, connecting with the profession programmes and practice.

Acknowledgement

Support for this research was provided by the GNurseSIM – Improving Geriatric Patient Satisfaction: Development of a High-Fidelity E-learning Simulation Course to Develop Intercultural Skills in Geriatric Patient Care project (Project 2020-1-PL01-KA226-HE-096353). This project has been funded with support from the European Commission. The outputs are freely available on the project website https://gnursesim.eu/. Any opinions, findings, and conclusions or recommendations expressed in this material are those of the author(s) and do not necessarily reflect the views of the European Commission. We are indebted to our faculty, technicians and collaborators on this project. This project could not have been completed without them.

References

Cook-Sather, A., Bovill, C., and Felten, P. (2014). *Engaging students as partners in learning and teaching: a guide for faculty*. San Francisco: John Wiley & Sons. ISBN: 9781118434581

Driscoll, J. (ed.) (2006) *Practicing Clinical Supervision: A Reflective Approach for Healthcare Professionals*. Edinburgh: Bailliere Tindall. ISBN: 0702027790.

Melville-Richards, L., Rycroft-Malone, J., Burton, C. and Wilkinson, J. (2019) 'Making authentic: exploring boundary objects and bricolage in knowledge mobilisation through National Health Service-university partnerships'. *Evidence and Policy*, 2, 1–23. doi.org/10.1332/174426419X15623134271106

Morley, D., Wilson, K. and McDermott, J. (2017) 'Changing the practice learning landscape'. *Nurse Education in Practice*, 27, 169-171. doi: 10.1016/j.nepr.2017.03.010.

Pivac, S., Skela-Savic, B., Jovic, D. Avdic, M. and Kalender-Smajlovic, S. (2021) 'Implementation of active learning methods by nurse educators in undergraduate nursing students' programs – a group interview'. *Biomed Central Nursing* 20 (173) Available at: https://doi.org/10.1186/s12912-021-00688-y (Accessed 02 January 2023)

Royal Society for Public Health (2018) *That age old question: how attitudes to ageing affect our health and wellbeing*. Available at: https://www.rsph.org.uk/static/uploaded/a01e3aa7-9356-40bc-99c81b14dd904a41.pdf (Accessed 02 January 2023)

Tohmola, A., Saarnio, R., Mikkonen, K., Kyngäs, H., and Elo, S. (2022) 'Competencies relevant for gerontological nursing: Focus-group interviews with professionals in the nursing of older people'. *Nordic Journal of Nursing Research* 42(3), 123-132. https://doi:10.1177/20571585211030421

World Health Organisation (2016) *Discrimination and negative attitudes about ageing are bad for your health*. Available at: https://www.who.int/news/item/29-09-2016-discrimination-and-negative-attitudes-about-ageing-are-bad-for-your-health (Accessed: 20 December 2022)

World Health Organisation (2022) *Ageing and Health*. Available at: https://www.who.int/news-room/fact-sheets/detail/ageing-and-health (Accessed: 17 December 2022)