

INTERCULTURAL EXPERIENCE-BASED NURSING HOME CARE IN THE CENTRE OF THE HAGUE

The Hague has long been a city with an international flavour. In around 1600, during the second 'Golden Age', many people came to settle here – immigrants, wealthy individuals, skilled craftsmen and artists. They included painters like Jan Steen, Paulus Potter and Jacob Cats, but also the scholars Spinoza, Descartes and Christiaan Huygens. The world-renowned Hague School made its mark here in the third 'Golden Age', from 1850 onwards, and many former Dutch East Indies settlers made The Hague their home. Today, the Peace Palace houses the International Court of Justice, the Dutch parliament has its seat here, and the Queen her residence, while dignitaries from all over the world are frequent visitors, making The Hague a centre for diplomacy. The Schilderswijk neighbourhood, in the centre of The Hague, reflects this rich, multicultural tradition. It is the home of people from more than eighty different nationalities, and a wide range of cultural backgrounds. It is in this neighbourhood, in the Jacob Catsstraat, that we find the Schildershoek nursing home.

In the colourful city centre

Thirteen years ago there was no nursing home care in the city centre. Nursing homes were usually found on the city perimeter, an unfamiliar place to central city residents. This situation came to an end with the merger of three old nursing homes, of differing size, run by the Community Health Service (GDVV). Locating a nursing home in the Schilderswijk was singularly appropriate for a city like The Hague, with its international character. The site had already been found, but who was going to work and live there? Where would they come from? From everywhere, was the answer, bringing with them their own customs, wishes and needs. From its very beginnings, the challenge for the Schildershoek lay in working together to collectively give shape to the care that would be provided.

Experience is the keystone

Because of the wide range of backgrounds of residents and staff, we had to be careful about how we went about our work. At first we approached one another with due circumspection, getting to know each other before we could proceed. This cautious, respectful attitude was essential. We identified the differences and similarities between people, familiarising ourselves with them. Getting to know people from different backgrounds was a stimulating experience for all concerned. Prejudices about the unknown gave way to growing and unconditional acceptance, with respect for each individual and his or her rituals and customs. Over the years this added value, borne of our own experience, has proved to be one of the most valuable and characteristic features of the Schildershoek.

Towards a policy of individual care

In the mid-nineties we became aware, through changes inside and outside the Schildershoek, that it was no longer enough to provide care along traditional medical lines. What was needed was a psychosocial approach, with a clear place for the client. This altered vision of care was also mirrored in government policy: new legislation strengthened the legal position of clients. It became de rigueur to approach things from the client's point of view. The emphasis in care changed from simply treatment alone, to 'accommodating' people. At the Schildershoek, it had long been our experience that the primary point of departure for good care should be the clients

themselves: their stories, their families, their customs and life histories. This meant that their wishes, needs and expectations also had to be the cornerstones of our individual care policy. Clients, care representatives, family and staff – all had a voice. Only then were we in a position to offer the right kind of care. And the key experts here were not the specialists, but the clients themselves.

Clients tell their story

Even before we could formulate an individual care policy and give final shape to the care plan, we needed to sit around the table with the client. Our motto was to listen: the clients and their family were the best people to formulate their own care requirements. We had to let the clients speak; after all, they were the ones who determined the direction we would take. We then made choices, based on the client's frame of reference, experiences, qualities, strengths and weaknesses. The key was to listen to what the client had to say. Our task was to be receptive and responsive to the client's language, both literally and figuratively, to understand their habits and customs. We needed to observe, to show respect, to place ourselves in their shoes, to soak up their words. Each client's story contained not just the question but the answer. We had to get to know each individual person and their history, their cultural history. Open and respectful interaction with our clients created a secure environment in which information could be exchanged in confidence. The information from individual clients, with respect to content, world outlook and personal style, constituted the guidelines for care. Our motto was to proceed from what was possible, rather than what was not.

Finally, we were in a position to formulate our vision of care as follows: 'We seek, in consultation, an appropriate response to the complex care requirements of each client, with autonomy, quality of life, and psychosocial well-being as our central guiding principles'.

The key to intercultural care for our clients

Listening to clients and their family, getting to know the client in every respect, absorbing and using the information the client provides – these have over the years proved to be the secret to our success, the key aspects of intercultural nursing home care.

Client's needs and wishes determined our course

It often emerged that different residents shared the same wishes, giving rise - on a modest scale - to a collective need. We were then able to formulate a collective care objective. Here are some examples. Over the years, we have developed an intercultural menu cycle: we serve dishes from Suriname and, on hot summer days, shaved ice (schijfijis). The different religions determine the celebrations that take place in the Schildershoek: Islamic services are held for both Sunnites and Ahmadiyyah, Hindu services for adherents of both Sanathan Dharm and Arya Samaj, while ecumenical services, prayer meetings, Holy Communion and evangelical services are held for Christians. Imams, pandits, ministers and priests are familiar sights in our corridors. The festivals and anniversaries of the different religious creeds are celebrated and commemorated in style: Divali, which celebrates the victory of good over evil, Holi or phagwa, the New Year celebration which has its origins among Hindustani Surinamers, Ramadan (Ramazan) the Muslim holy month of fasting, which concludes with Idul-Fitr (Seker bayrami), Christmas, celebrating the birth of Christ, with a Christmas tree and Christmas dinner, and the Chinese New Year in January.

We also respond to requests for information so that people can acquaint themselves with specific aspects of another culture. So, for example, we provide information about Winti, and offer a course in Hindustani for beginners. For these activities, which arise out of a specific need, the people who make the request are themselves involved in organising the response. There is no clear, direct targeting of groups at the Schildershoek. Instead, the care is as diverse as the uniqueness of each individual, or small group of individuals.

Developing policy

The number of clients from ethnic minorities in some units approached the 80% mark, with roughly equal numbers of Dutch and minority-group staff. Any decisions we took continued to be based on practical experience. Processes followed their natural course because everyone had a solid grounding in practice. Practice draws attention to useful ideas, but also to pitfalls. This pragmatic view, of information gleaned from practice, has been vital. After all, practice is formed and consolidated over time, thus proving its value. Such developments functioned initially as guidelines, and then as directives. In this way, needs found their way into policy in a bottom-up progression.

Intercultural care: management

In this way we gradually developed specific expertise which met the needs of a multicultural organisation. However, changes did not necessarily happen smoothly, or overnight. It was a constant process of trying out, evaluating, and trying out again, followed by implementation. Had we understood, really understood, the question? Or did we think that we understood, yet our response did not appeal to the client? Doubt and confidence alternated with one another. Fortunately, we were all united and committed to continuing the multicultural discussion.

Giving substance to intercultural management

One thing was clear from the outset, however, and that was that intercultural nursing home care, as we envisaged it, could be carried out only with the support of intercultural management. The diversity within the Schildershoek required a sound basic knowledge among all staff in different fields. We worked hard at this: from interpreter's protocols to courses in elementary Hindi, from elementary Dutch courses to native speakers in each unit. Intercultural personnel policy got off the ground as well. Our culture of working together, which is client-centred and sensitive to other cultures, expanded still further. The multi-level hierarchical organisational structure, for so long a feature of nursing homes, was called into question.

Democratic values

The need for truly democratic care increased. But if you favour a democratic care policy with an emphasis on individuals, you must be prepared to let those same norms and values govern your dealings with colleagues. In effect, these processes reinforce one another. An institution cannot work effectively in a client-centred way if it does not view its own employees as clients and treat them with the same respect. It is vital to have a consistent approach, one that cuts right across the organisation. Managers cannot support democratic values, while ignoring them themselves.

Interplay between the different units and disciplines

Providing democratic care means working hard, together and on an equal footing, to achieve optimum care. It means mobilising forces to cope with shortages and restrictions. That is why we set up a multi-disciplinary care council to discuss and co-ordinate all matters relating to care. As

a result, the various disciplines were able to interact more smoothly and coherently. Barriers were broken down still further, with the various disciplines (social workers, mealtime staff, management, nursing staff, technicians, dieticians, housekeeping staff, doctors etc) having easy access to one another. Clients and members of the Clients Council were involved across the board in care issues and participated in work groups.

Interculturalisation, a process over time

All these developments, over more than ten years, have produced a strong 'us' culture at the Schildershoek. This is due in part to the diverse origins of the staff: Chinese from Hong Kong, the People's Republic and Taiwan, Hindustanis, Berbers, Creoles, people from Iraq, Indonesia, Surinam, the Republic of Cape Verde, Scheveningen, Vietnam, Java, the Schilderswijk, Afghanistan, Ghana, the Antilles, Italy, Portugal, Morocco, the Dominican Republic, India, Tunisia, Iran, Turkey, Germany and elsewhere. It is also due to the cultural characteristics and wisdom that have found their way to the Schildershoek from all corners of the globe. Here they have mingled with the client-centred principles advocated by Carl Rogers. All this has made the Schildershoek the nursing home that it is today, with family talks involving ten people, a daughter who most mornings helps look after her mother, a weekly roster of family members who help Dad with his midday meal, relatives providing volunteer aid in the units, the familiar Surinam bowl which the daughter fills with food, rice with cow-peas and roti, the solemn faces of Turkish villagers, the magic of Winti. This is the daily practice. Over the years the interculturalisation of care has reached maturity.

'Care institutions do not understand ethnic minorities' the Volkskrant newspaper reported last year, following the publication of recommendations from the Public Health Advisory Board. At the Schildershoek it is different: ethnic minorities understand the care we provide very well.

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