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Understanding Cultural Competence from the Perspective of Registered Nurses Working in Community Health Care Settings

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Understanding Cultural Competence from the Perspective of Registered Nurses Working in Community Health Care Settings

by

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ABSTRACT

Canada's immigrant population has been growing steadily for decades, and, as a result, the health care system is attending to increasing numbers of patients from ethnically diverse backgrounds. With increased migration, culturally competent care from nurses has become an expectation to prevent cultural impositions and to foster respect for national diversity when providing effective patient care. Using descriptive phenomenology methodology, the purpose of this research is to describe the essence of cultural competence by exploring the strengths, challenges, and barriers that public health nurses face in community healthcare settings. The primary research question is: What are the lived experiences of nurses with respect to cultural competence? Individual in-depth interviews were conducted with seven nurses who work in community health clinics. This study suggests that there are inherent challenges to working with culturally and ethnically diverse populations. These include language barriers, limited cultural knowledge, and lack of organizational support which hinders the nurse-patient relationship. Cultural competence education for nurses working with ethnically diverse patient populations is neither mandatory nor readily available; as a result, nurses working in cross-cultural settings often have insufficient cultural knowledge and lack the cultural skills required to work cross-cultural situations. Professional development in the form of workshops and seminars is required on an on-going basis for nurses to develop their cultural awareness and skills. Cultural competence education should be a required aspect of the undergraduate nursing curriculum, as well as the in the workplace.

keywords: cultural competence, cultural competence education, nursing education, cultural awareness, cultural skill

Preface

This thesis is original, unpublished, independent work by E. Anokye-Owusu. The Ethics Certificate number REB15-1910, was issued by the University of Calgary Conjoint Health Research Ethics Board and operational approval by Alberta Health Services Managers for the project Understanding Cultural Competence from the Perspective of Registered Nurses Working in Community Health Care Settings on February 18, 2016. Necessary amendment to the ethics approval were obtained on July 31, 2019. This thesis was professionally copy-edited with approval from the Faculty of Nursing.

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Dedication

This thesis is dedicated to,

My son, Duke, my unborn child, and my Grandmother, Adwoa Theresa Serwaah alias *Mama,* who is watching over me and smiling down. You are my inspiration Mama, may your soul rest in perfect peace.

"Be strong and courageous, do not be afraid or tremble at them, for the LORD your God is the one who goes with you. He will not fail you or forsake you."

- Deuteronomy 31:6

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CHAPTER ONE: Introduction

1.1 Personal Narrative

My name is Evelyn and I am a Registered Nurse. However, my occupation is only a part of who I am as a person. I would like to share with you some of my personal experiences, for you to understand the inspiration of this thesis.

I am a first-generation Canadian, of parents who immigrated to Canada over 30 years ago. My parents had a dream of a better life for themselves and their children. In the eyes of my parents, migration from Ghana (West Africa) was necessary to provide better opportunities of education and employment. My parents only left their native country in the physical sense, they have always been Ghanaians living in Canada. I, and my siblings, were raised to know our heritage, traditions, culture, and language. We grew up eating predominantly Ghanaian cuisine and we wore the fabrics of our ancestors with pride. Although growing up knowing I was Canadian by birth, I always felt very connected to my parent's native country. Having been taught about Ghana's rich history and culture, I feel that I had the right to call it my own.

Growing up I had watched my parents struggle with the challenges of being immigrants in Canada. They had to encounter blatant racism and intolerance from other ethnicities, and had difficulty navigating the social and healthcare system due to their lack of understanding of Canadian norms and policies. I always knew that they had to struggle to succeed and adjust here in Canada. However, it was not until the unfortunate passing of my Grandmother, that I truly understood the extent to which they had to adjust.

A few years ago, I returned to Ghana for the customary funeral of my Grandmother, and though I had been exposed to Ghanaian culture my entire life, I was in a state of culture shock. I witnessed firsthand the customs and traditions that go along with customary funeral rites. I, as a Canadian, had to adjust to the norms of my parents' culture, and felt moments of confusion,

frustration, but also moments of curiosity as to why practices were being done a certain way. Despite the confusion, there was something beautiful about seeing my mother be a part of a community that could anticipate her needs during this difficult time. Community members greeted each other with customary sayings in the native language to encourage each other. Food and drinks were brought to the family house on a regular basis. Everyone took the time to care for each other in a genuine fashion which was the norm. Everyone understood each other, and what needed to be done. The community came together and functioned as a singular unit, and as expected the customary funeral took place without any issues.

As a nurse, I reflected on my experience of feeling culture-shocked in what I understood was my own culture, and began to ponder on how others coming to Canada must feel when their sense of community and familiarity is not present in their new environment. Moreover, I asked myself "do other nurses ever have the same thoughts that I am having? How can culture shock affect a person and their health?" With these thoughts, I embarked on a journey to better understand the nurses' preceptive of the role and impact of culture on health, culminating in the written work you are about to read.

1.2 Background

Cultural competence encompasses the awareness, skill, and knowledge of diverse cultures to best work within cultural context of patients and families (Campinha-Bacote, 2002). In healthcare, these concepts date back to the seminal works of Dr. Madeline Leininger's Culture Care Theory (1978). This was the first theory of its kind to focus on the impacts of culture on nursing care. Forty years later, the daily experiences and encounters of nurses who work with ethnically diverse patient populations still have not been examined in great detail (Cioffi, 2005). With the growing immigrant population, patients coming into contact with the healthcare system

bring with them their own views of health and illness (Salman, McCabe, Easter, Callahan, Goldstein, Smith, White & Fitzpatrick, 2007). Cultural competence education is now recognized as an important tool for preparing nurses-in-training and certified nurses for future interactions with increasingly ethnically, linguistically, and culturally diverse populations. Cultural competence education has been shown to increase cultural awareness and to decrease ethnocentrism and bias in healthcare (Brusin, 2012; Delgado, Ness, Ferguson, Engstrom, Gannon, & Gillett, 2013; Majumdar, Browne, Roberts & Carpio, 2004). The implementation of cultural competence in health care settings has also been shown to improve patient satisfaction through better communication (Weech-Maladonado, Elliot, Pradhan, Schiller, Hall & Hays, 2012). Improved communication and understanding have the potential to decrease the likelihood of misdiagnosis and mistreatment, and to increase the likelihood of patients adhering to treatment plans (Williams, 2007).

Cultural competence education has been recognized as a method for fostering understanding among healthcare providers so that they are able to provide cultural congruent and holistic care effectively for Canada's growing diverse population (Callister, 2005; Gallagher & Polanin, 2015; Leininger, 1995). Recognition of changing population demographics propelled the Canadian Nurses' Association to develop a position statement identifying that cultural competence is an entry-level to practice competency for Registered Nurses (CNA, 2010).

Despite this recognition, cultural competence education in nursing schools has not been taught consistently; further, in nursing practice, cultural competence is emphasized as an important component of care, but cultural competence education is not consistently provided, nor is it mandatory. Educational institutions are responsible for the incorporation of culturally competent education into their nursing curriculums. However, it is difficult to accurately assess

the extent to which this has been done, as each school has the liberty to provide education in different forms (Canadian Association of Nursing Schools, 2014). In Calgary, Mount Royal University offers an optional course titled *Diversity in Health.* The university's website states the course goals as "examining the underpinnings of diversity, inclusiveness and cultural attunement" (Mount Royal University, 2015). Even though this course is available to nursing students, it is not a Bachelor of Nursing required course for graduation. Other institutions may incorporate concepts of cultural competence education in various courses throughout the curriculum, making it difficult to compare the extent of cultural competence education in their curricula (Diaz, Clarke & Gatua, 2015). For instance, the University of Calgary undergraduate nursing program outlines Term 7 to be a leadership term, where students build "competence and confidence in clinical decision-making" (University of Calgary, 2019), yet course descriptions are not clearly linked to cultural competency concepts. To the best of my knowledge, once nurses are in the workforce, there is no standardized cultural competence continuing education for nurses to develop further their cultural competence care skills while working with ethnically diverse communities.

1.3 Problem Statement

Nurses are the frontline workers who have the closest encounters with patients and families. The relevance of nursing to cultural competence lies in the fact that we deliver care that affects personal health decisions. Evidence also suggests uneasiness and discomfort discussing cross-cultural situations; however, resolutions for this matter are also limited in scope. There is a lack of Canadian resources and courses on cultural competence education despite legislation such as the multiculturalism policy of 1971 and the Canadian Charter of Rights and Freedoms 1982, which mandated the implementation of policies and practices that address the needs of

Canada's diverse population (Majumdar et. al, 2004). Moreover, the format through which education should be delivered is vague in the literature, and content-specific guidelines are unclear and, at times, unmentioned, leaving the question of what format of cultural competence education is most beneficial for nurses to receive.

According to the 2016 Canadian Census, 21.9% of the population were foreign born immigrants (Statistics Canada, 2017). Immigration increases ethnic diversity. It is projected that by 2030 net immigration may be the main source of Canada's population growth (Statistics Canada, 2007a). Canada's diverse ethnic population is growing steadily. In 2016, 22.3% of Canadians identified themselves as ethnic minorities, an increase from 19.1% in 2011 and 16.2% in 2006. (Statistics Canada, 2013, Statistics Canada, 2017). Of the ethnic minority population of 2011, 65.1% were born outside of Canada and have come to Canada to live as immigrants (Statistics Canada, 2013). Alberta is one of four provinces with the largest number of foreign-born Canadians, 23.5% of its population are visible minorities an increase from 18.4% in 2011 (Statistics Canada, 2013; Statistics Canada, 2017). Alberta has seen a large increase in the number of new immigrants with an increased from 6.1% in 2001 to 17.1% in 2016, which was the highest increase of immigration in Western Canada (Statistics Canada, 2017).

With Canada continuously growing in diversity, it is imperative that nurses know how to work effectively in cross-cultural situations. Excellent patient care is the goal of nursing, and providing holistic care requires nurses to understand patients' individual perspectives. Cultural competence has the potential to build foundational knowledge to improve professional practice that impacts our patient care (Delgado et. al, 2013). Providing continuing education to nurses solidifies the experiential knowledge of nurses who have travelled and experienced other cultures and ethnicities, while also providing an opportunity for all nurses, especially those whom have

not had the opportunity to travel and experience other cultures personally, to learn strategies for working effectively and respectfully with diverse populations.

1.3.1 Statement of purpose. Studies focusing on nurses' experiences of working with diverse populations are also limited in number; this suggests that further investigation is necessary to understand nursing perspectives of cultural encounters for the development of targeted educational resources. The research in this study explored how cultural competence is understood through the lived experiences of nurses currently in practice. The focus was on public health nurses working in heavily diverse communities; however, the findings may be transferable to nurses working in other settings with high ethnically diverse patient populations.

1.4 Researcher Assumptions

While working on this study, is was important for me to be clear about my own assumptions to denote any bias I may have. I am a first-generation Canadian who has seen firsthand the struggle immigrants face with the Canadian healthcare system. I am also a Registered Nurse who has had the pleasure of working with individuals and families who do not speak much English, but who must navigate the healthcare system. Seeing the perspectives of families dealing with the healthcare system and as a healthcare provider trying to provide care to such families, I recognize there is at times a lack of easily understood resources for families, and lack of resources for nurses who are caring for families. My assumptions are that cultural competence education is not at the forefront of nursing in undergraduate education or in the workforce, and that this has negatively impacted nurses' ability to address cross-cultural issues that arise in the healthcare setting.

1.5 Overview of Methodology

This study was conducted using descriptive phenomenology, which is a methodology used to describe the lived experiences of persons or groups. This methodology is best suited for my study as the goal of the study is to describe and analyze how cultural competence is understood by registered nurses, and also how cultural competence is viewed in practice.

This thesis will be organized in five chapters: introduction, review of literature, methodology, results, and, lastly, discussion and recommendations.

CHAPTER TWO: Review of Literature

The literature was searched using the databases of CINHAL and the Nurse Reference Library. Search terms included culture, cultural competence, nurse, practicing nurse, continuing education, workshops, diversity, nurse experience, and health disparities. Peer-reviewed articles published between 2003-2015 were selected. The initial search of cultural competence yielded 10,200 for CINHAL, and 429 for Nurse Reference Library. The addition of the search terms above with inclusion criteria of peer-reviewed, full-text articles published between 2003-2015 yielded 65 articles, all in CINHAL. Articles were then manually selected to eliminate those that did not relate to the research question of nurses' experiences. Exclusion criteria included articles that did not pertain to nursing, those published before 2003, those which focused on measuring and validating cultural competence tools, and those which did not research the impacts or delivery of cultural competence education. The total number of articles after the above-listed exclusions yielded 32 articles. Seminal works of Dr. Madeline Leininger (1978, 1995) and guiding frameworks on culture and cultural competence were included to provide context. The literature search flowchart is included in Appendix A.

In the main findings of the review of literature, culture represents the values and beliefs of an individual or group that influence how they understand and make sense of the world. The history of understanding culture has influenced nursing theories including the Culture Care Theory, which is the seminal work by Dr. Madeleine Leininger, on which the principles of cultural competence in nursing care is based. The review was analyzed and will be presented in the following themes: culture and history; cultural competence; cultural competence education; health disparities and inequities; education and policies; and, lastly, deficiencies in the literature.

2.1 Culture and History

Culture is defined as a set of values, beliefs, and ideals to which a group or person may adhere (Groves, 2010; Markus and Kitayama, 1991). According to the World Health Organization (WHO, 2015), culture is recognized as a social determinant of health, acknowledging the fact that an individual's circumstances and beliefs impact their health and health behaviours. Factors such as marginalization, stigmatization, and access to culturally sensitive healthcare services for diverse individuals are affected by socio-economic factors that are determined by cultural values (Public Health Agency of Canada, 2014). The significance of culture is rooted in its ability to help people define themselves and to influence daily decisions for survival in specific environments (Wilson, 2012). Kleinman's Model of Explanatory Health and Illness (1978) assumes the position that patients understand their illness through cultural context. Societal and cultural factors influence how illness is viewed, and, thus, how it is treated. Through exploration of the patient's view on illness, it becomes clear that culturally informed or ethnic specific beliefs often do not align with the traditional biomedical model (Nunnelee & Spaner, 2000). Fostering dialogue and building rapport through communication can further bring understanding of a patient's explanatory model that is layered with influences from family, friends, culture, and healthcare providers (Mahoney & Engebretson, 2000). Through careful understanding of the patient's explanatory model, healthcare providers can analyze and restructure explanatory models to provide "feedback to influence health seeking behaviors on the part of the patient as well as enhancing the provision of culturally sensitive treatment on the part of the clinician" (Mahoney & Engebretson, 2000, p. 185).

Leininger's Culture Care Theory (1978) focuses on the manner by which culture affects health. According to Leininger, the need for nurses to understand and care for patients

holistically requires they be cognizant of the cultural beliefs and values that patients may have. Leininger's attention to the importance of understanding cultures outside of one's own influenced the discipline known as Transcultural Nursing. The fusion of nursing and culture would make "professional nursing knowledge and practices culturally based, culturally conceptualized, culturally planned, and culturally operationalized" (p. 12), in order to best care for diverse individuals and families. In 1995, Leininger coined the term *culturally congruent* to refer to situations where decisions and healthcare practices were appropriate and respectful of the patient's cultural beliefs, ensuring safety and preservation of culture while also creating rapport and trust in the nurse-patient relationship (Leininger, 1995).

The philosophical assumptions of the Culture Care Theory were that there are universalities (commonalities) and diversities (differences) that are present among cultures. These differences and similarities needed to be explored and analyzed to create a foundational body of cultural knowledge for nurses (Leininger, 1997). Through the exploration of culture in practice, understanding can develop, and nurses can both adequately provide care according to cultural needs, and also foster a safe environment for patients to express their cultural needs and expectations. This would be accomplished by understanding individual worldviews which are influenced by technology, religion, philosophy, kinship, cultural values, politics, economics, and education. This is illustrated in Leininger's Sunrise Model. The model provides different influential factors that affect the care and wellbeing of patients. The contributions of Leininger's theory to the discipline of nursing and formation of transcultural nursing set the stage for other nursing theorists to explore the constructs of culture and how they manifest in healthcare. The focus on how healthcare providers can become more culturally aware to provide adequate care for diverse populations increased with the creation of frameworks focusing on cultural

competence in healthcare, including that of Campinha-Bacote's (2002) *Process of Cultural Competence in Delivery of Healthcare Services Model*. The concepts of this model include cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural desire, which will described in greater detail in the following section, are exhibited in studies such as Delgado et al. (2013) who, through cultural competence training, improved cultural knowledge and awareness for nurses working at a medical centre. Majumdar et al.'s (2004) study similarly shows the impact of cultural sensitivity training for nurses in improving health outcomes for patients without increasing health expenditures. Patients' increase in trust and rapport with their healthcare providers as a result of increased cultural competence and sensitivity attest to the importance of cultural competence education in nursing (Callister, 2005; Wilson, 2012).

2.2 Cultural Competence

While there is increasing acknowledgement of the importance of cultural competence education in nursing, there is still a lack of consensus around one definition across healthcare disciplines (Engebretson, Mahoney & Carlson, 2008; Suh, 2004). Cross, Bazron, Dennis, and Isaacs (1989) defined cultural competence in the healthcare system as "a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enables that system agency, or those professionals to work effectively in cross-cultural situations" (p. 28). This definition coincides with Leininger's notion that maintaining cultural congruency is necessary to ensure safe preservation of cultural values and effective healthcare.

Campinha-Bacote's (2002) *Process of Cultural Competence in Delivery of Healthcare Model* (PCCDHM) identifies five attributes of cultural competence: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. Cultural awareness requires

that healthcare providers understand themselves through critical reflection. Through this understanding, biases towards and assumptions about other cultures can be identified prior to potential conflicts. Cultural knowledge consists of healthcare providers obtaining credible knowledge of cultures other than their own through accessing resources. Gaining knowledge, through experiences and resources, about cultural practices can decrease misinterpretations and stereotyping (Fox, 2005). Cultural skill requires a healthcare provider to have the ability to accurately perform a cultural assessment (Leininger, 1978). Skills such as communication are imperative to ensure that experiences are defined in the patient's view (Wilson, 2012). Cultural encounters are meaningful engagements with patients of different ethnic backgrounds. Through these encounters, healthcare providers can broaden their horizons and build understanding of cultural values according to their patients. Lastly, cultural desire is a yearning, zeal, or passion to know more about other cultures. Desire is the catalyst that ignites the process of cultural competence for healthcare providers (Campinha-Bacote, 2011). The relevance of having these constructs in nursing practice is that they help nurses relate to their patients, increase their understanding of patients' situation and perspective, and, thus, improve the quality of nursing care. Cioffi (2005) found that nurses working on medical inpatient units found that lack of cultural knowledge hindered the nurse-patient relationship. The necessity of nurses to understand their patient population is key, as this understanding can greatly impact the care they provide and result in better patient outcomes (Gallager & Polanin, 2015). Cultural influences guiding behaviours and health practices should be better understood by healthcare providers in order to best facilitate appropriate treatments. For example, cultural influence might advise the use of hot-and-cold therapy for the treatment of illnesses in individuals from Asia, as such a practice

relates to Asian/Oriental approaches to health and healing (Tseng & Streltzer, 2008; Williams, 2007).

In the discipline of social work, the process of becoming culturally competent on an individual level is similar in nature to Campinha-Bacote's theory (Horevitz, Lawson & Chow, 2013). Cultural competence in social work is broken into three categories, which include: *ability*, which allows for resolution of cultural differences; *openness*, which is the respect of different cultural groups; and lastly *flexibility*, which requires the adaptability to cultural situations (Suh, 2004). While cultural competence may take on different definitions, the objective of having a cohesive relationship between patient and nurse or healthcare provider is foundational in order to ensure holistic and culturally safe care is being provided.

2.3 Health Disparities and Inequities

Health disparities are the differences in health status among different groups as the result of systematic imbalances or institutionalized racism that negatively impacts disadvantaged groups, causing for poorer health statuses and unequal access to care. (Dehlendorf, Bryant, Huddleston, Jacoby, & Fujimoto, 2010). The burden of decreased health outcomes for patients of diverse backgrounds is heavily stated in the literature (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003; Gallagher & Polanin, 2014; Muslino, Burkhalter, Crookston, Ward, Harris, Chase-Cantarini & Babitz, 2010). Lack of cultural competence has been noted as a plausible cause for some of these disparities through miscommunication leading to misdiagnosis, differences in referral, and prescription patterns according to ethnicity and prejudice (Anderson et. al., 2003). Williams (2007) states that barriers such as lack of trust, inadequate communication, and marginalization of diverse groups affects quality of care. Historical events such as the Tuskegee Syphilis Experiment in the United States of America exemplify how

mistrust can be created between healthcare providers and patients. This experiment, now infamous for its unethical abuse of power, saw researchers and healthcare providers misleading African American men into believing they were being treated for their condition, while in actuality, the men were subjects for the observation of untreated syphilis (Cobb, 1973). The lasting effects of this and other similar situations has resulted in skepticism and mistrust amongst African Americans toward the healthcare system and healthcare providers. Additionally, research has shown that the marginalization and stigmatization that Aboriginal/Indigenous people experience by healthcare providers and within the healthcare system tends to further ostracize them from healthcare, causing such challenges as an increase in non-compliance in healthcare and poorer health outcomes (Siaw Teng, Phyllis, Pyett, Furler, Burchill, Rowley & Kelaher 2011). Indigenous cultures can be classified as collectivist cultures which will be explained in the following section.

Harding (2013) categorizes cultures into two groups, collectivist or individualistic. Collectivist cultures are those where "loyalty to a group may outweigh individual rights" (p. 6). The majority of the world's cultures (African, Asian, Middle Eastern, etc.) are collectivist cultures, while the remaining English-speaking western societies (North American, Australian, and European) fall into the individualistic culture category, where the rights of the individual are considered to outweigh the collective rights of the group. Historical events such as colonization have saw the subordination of the cultural values of collectivist cultures by more individualistic cultures, and this has resulted in social injustices and inequities. The hierarchy and ethnocentrism of colonization was studied among Aboriginal groups in New Zealand. The Maori people, who are collectivist in nature and value kinship ties, had their beliefs and kinship structure threatened by dominating cultures (Almutairi & Rondney, 2013). The domination of one culture over

another threatens identities and individuals' views on health, and may result in a power struggle which puts cultures values, customs, and traditions at risk. Wenchi et al.'s (2008) examination of Chinese cultural beliefs on health highlighted cultural practices such as modesty and self-care as negatively influencing the likelihood of women to seek treatment or preventive measures, such as breast cancer screening. The study suggested that Chinese women seldom discuss issues such as cervical cancer and PAP testing. Aside from modesty and self-care, traditional remedies such as hot-and-cold therapy or the use of herbs to rid the body illness are strong forms of health beliefs in African, Native American, and Asian cultures, alike (Williams, 2007). The expectation that western medicine will always be the main form of treatment is unrealistic. It threatens cultural beliefs and strains patient and healthcare provider interactions, hampering trust and honesty as patients may not feel inclined to discuss traditional methods with healthcare providers.

In New Zealand, the Cultural Safety model of practice is defined by the Nursing Council of New Zealand (2011) as:

> the experience of the recipient of nursing service and extends beyond cultural awareness and cultural sensitivity. It provides consumers of nursing services with the power to comment on practices and contribute to the achievement of positive health outcomes and experiences. (p.7)

Cultural safety began with the drastic health disparities seen between Indigenous (Maori) and non-Indigenous colonizers (Pakhea) (Richardson & Carryer, 2005). Cormack, Purdie, and Robson (2007) found that Maori people were only 9% more likely to develop cancer than Pakhea, yet they were 77% more likely to die from cancer than non-Maoris. The post-colonization Treaty of Waitangi (1840) was developed as a foundational agreement to change

statistics such as these, and to give the Maori a voice; in doing so, this treaty created a shift from a mono-cultural (western) worldview to a bi-cultural worldview recognizing the culture and health practices of the Maori people (Woods, 2010). The effects of this treaty formed the development of Cultural Safety Education for nursing students by the New Zealand Nursing Association to help nurses grow a sense of cultural awareness, whereby nurses would learn to practice free of ethnocentrism in order to prevent cultural impositions. Organizations that value the importance of a workplace free of ethnocentrism create a culturally safe space for diverse cultures. Minority patient populations have increased barriers to accessing health resources, and these barriers have a negative impact on health outcomes (Almutairi and Rondney, 2013; Williams, 2007). Creating a society and healthcare system in which individuals with differing cultural backgrounds are understanding of one another's values, beliefs, and healthcare practices is imperative to ensuring accessible healthcare for all.

In order to decrease health disparities among ethnically diverse populations, it is important to conceptualize that culture is a determinant of health (Kongnetiman & Eskow, 2005). Through recognition of common cultural beliefs, values, and behaviours, effective health and healthcare programs and care within healthcare systems can be implemented and specifically tailored to the population. Wilson (2012) found that lack of cultural competence among midwives resulted in the assumption that Somali living in Norway would want natural childbirth. Not providing all the options available subjected these Somali women to unnecessary pain and increased complications. As one of the mechanisms to address these growing health disparities, cultural competence education has been implemented in various countries to improve minority access to healthcare and to increase health outcomes through focused programs that address specific health

prevalence among ethnic groups (i.e. diabetes, heart disease, obesity etc.) (Callister, 2005; Cioffi, 2005; Horevitz, Lawson & Chow, 2013; Siaw Teng et al. 2011).

2.4 Existing Cultural Competence Education

Cultural competence has been largely recognized since the 1980s. Efforts have been made to implement core concepts of cultural competence into undergraduate nursing education. At the University of Pennsylvania, educators have implemented a Blueprint for Integration of Cultural Competence in the Curriculum (BICCC). The blueprint was aimed to serve as a foundational tool to train nursing students as culturally competent advanced-beginner clinicians in healthcare practice (Cuellar, Brennan, Vito, & De Leon Siantz 2008). The components of this blueprint were included as objectives in each of the four years of the nursing program. The components include cultural knowledge, skill, and awareness, with each area having curricular key objectives. The core concepts include defining diversity, the analysis of social constructs, and clinical decision-making, as well as issues in health disparities. In the area of skill development, concepts include self-assessments of stereotypes and biases of other cultures. Finally, in the attitude/awareness area, students should form self-awareness to recognize strategies that can reduce stereotyping and increase comfort in cross-cultural situations (Cuellar, Brennan, Vito, & De Leon Siantz 2008). The BICCC model is comprehensive, with clear objectives for each year of the undergraduate nursing program, and can be used as blueprint for other nursing schools.

In the first year of nursing school, students are expected to take liberal arts courses in the humanities and sciences that contribute to a well-rounded student, such as human psychology and sociology; this requirement is similar to of the University of Calgary nursing program. However, at the University of Pennsylvania Bachelor of Nursing, program which currently implements the BICC model, alongside the elective course are nursing courses that are heavily

focused on foundational concepts of culture, such as ethnicity and the importance of diversity in practice. Students are also paired with alumni nurses for real-world experience of cultural competence in practice (Cuellar et. al, 2008). The second year builds upon the foundational knowledge of the first, and ties in the application of health disparities. Students should be able to describe health disparities by race, ethnicity, or gender by the end of the second year, and they should understand concepts about the allocation of resources using cultural frameworks. The students begin to develop clinical skills in the second year, and they are immersed into the concepts of diversity in relation to the nursing process. In the third year, nursing curriculum focuses on analysis and implications of health and wellness/illness on specific cultural groups. Students are to understand the differences and to have appropriate approaches to caring for patients with culturally specific healthcare needs; the authors state examples such as cultural rituals during pregnancy or gender issues (Cuellar et al., 2008). Finally, the fourth year of nursing school focuses on the synthesis of the core concepts and the ability to exhibit practicing in a culturally competent manner in a specific area of practice, whether it be psychiatric nursing, general medicine, or in the community. Students are expected to be able to recognize and analyze issues related to diversity in the workplace, gender issues, cultural conflicts between staff, and nurse-patient relationships. Application and synthesis of nursing theory alongside clinical practice are meant to be applied in the final year to exhibit the understanding of culture in care in a practical way.

The BICCC model does not only refer to students, but it also lays out methods educators can use to engage students. Within the four-year curriculum, the use of guest speakers from various cultural backgrounds, role-playing different cultural and social issues, and examining case studies of cultural conflicts with the healthcare system are all included in the teaching

strategies. The goal of the BICCC model is to incorporate the concepts of cultural competence throughout the curriculum in an integrated fashion that students apply in all clinical situations (Cuellar et al, 2008). The blueprint presented by Cuellar et al. (2008) is the model used at the University of Pennsylvania Faculty of Nursing. This blueprint does not evaluate the outcomes of the nurses when they graduate, but instead is meant to be an example for other nursing schools to use as reference.

In foreign countries, cultural competence education is also being taught. Lin, Chang, Wang, and Huang (2015) evaluated the longitudinal effects of a cultural competence course on students enrolled in a two-year BSN program in a major urban city in Taiwan. The cultural competence course was a two-hour course delivered weekly over an 18-week period to an experimental group which was to be compared with a control group of students. The course consisted of 26 hours of lecturing:

> The first domain (five classes) provided a basic introduction to the concepts and framework of cultural competence, clarified related definitions, and identified current personal beliefs, values, and experiences. The second domain (four classes) focused on the importance of cultural background. The third domain (one class) focused on decision-making and cultural issues. The last domain (three classes) developed clinical practice skills related to assessing and communicating on cultural competence health assessment which included cultural competence training for biological variation among the dominant ethnicities in Taiwan such as Vietnamese, Indigenous Taiwanese, and Indonesians. (p. 1270)

The course incorporated methods that included question and answer, student group presentations, videos for stimulating discussions about stereotypes and prejudice, and a reflective writing

exercise about the student's personal background to recognize biases. Students were then evaluated using the Cultural Competence Assessment Instrument-Chinese Version. Pre-test scores were not significantly different between control and experimental group; however, post-test results reveal that the cultural competence of students in the experimental group was significantly higher following the 18-week course. At the six-month follow up, both groups' test scores had decreased significantly. This study brings to light the issue that while cultural competence education does increase cultural competence outcomes, without continuing education cultural competence in nursing students decline.

2.5 Education and Policies

Across Canada, much work has been done to bring forth cultural awareness; this work including that by the Aboriginal Nurses Association of Canada for the creation of Cultural Competence and Cultural Safety in Nursing Education (2009), and the Canadian Nurses Association (2010) Cultural Competence Position Statement. The Canadian Multiculturalism Policy of 1971, sworn in by then Prime Minister Pierre Trudeau, aimed to showcase the importance of diversity in Canada as well as the need for the respect and inclusion of various cultures. Cultural competence education is recognized as a fundamental requirement to build competency for nurses (CNA, 2010). Despite this recognition, there is no consensus on how culturally competent education should be delivered (Rowan, Rukholm, Bourque-Bearskin, Baker, Voyageur & Robitaille, 2013). Great gains have been made in the province of Ontario where the nursing licensing body, the Registered Nurse Association of Ontario, has developed a document titled, *Embracing Cultural Diversity in Health Care: Developing Cultural Competence Guideline (2007)*. This document provides nurses with not only best practice guidelines for patients, but also guidelines for healthy diverse work environments. This

document has three recommendations for individuals: self-awareness, communication, and new learning. On an organizational level, recommendations for continuing education in concepts of cultural competence are emphasized. Not only is continuing cultural competence education supported, but the teaching of cultural competence is recommended in undergraduate nursing education. Although this document remains a good resource for planning towards cultural competence, it is not a legal mandate. As a result, the uptake of recommendations depends on the organizations that may or may not choose to implement it.

At the Hospital for Sick Children in Toronto (n,d) , online cultural competence training modules for healthcare providers who are interested in receiving professional development at a personal or organizational level have been developed and made free and available (The Hospital for Sick Children Toronto n,d). The focus of health equity is emphasized (World Health Organization, 2015), reminding healthcare providers that ignoring specific cultural difference is not beneficial to meeting the needs of specific health populations. In-depth sessions on cultural competence, cross-cultural communication with practical application, complementary medicine, and grief practical application are also available. Workshops are tailored to participants with both clinician and non-clinician roles. Since these workshops have been provided, over 2000 staff members have been trained, with 73% of staff attending the workshops committing to changing their practice to improve cultural assessments and communication through use of interpretive services (The Hospital for Sick Children Toronto n,d).

Nova Scotia's Department of Health published a document titled, *A Cultural Competence Guide for Primary Health Care Professionals in Nova Scotia (2005)*. This guide provides in-depth definitions of cultural concepts, tools, and resources for both healthcare providers and mangers working at all levels of healthcare. This is a comprehensive guide that contains self-

assessment tools as well as organizational assessment tools to ensure the concepts are able to be evaluated at all levels of the system, including community resources.

Here in Alberta, the College and Association of Registered Nurses of Alberta (CARNA) recognizes the need for cultural safety in entry to practice competencies (CARNA, 2013). Kongnetiman and Eskow (2005) in partnership with Alberta Health Services has published a document titled, *Enhancing Cultural Competency- A Resource Kit for Health Care Professionals.* This document provides cultural profiles for various cultural groups, representative of the ethnically diverse population in the Calgary, Alberta. This tool is to be used as a clinical guide for all healthcare professionals, and is not meant to stereotype certain ethnic groups.

All of the resources mentioned above go into detail regarding the various definitions of culture, and how culture pertains to identity. Both the Enhancing Cultural Competence Resource Kit from Alberta and the Cultural Competency Guideline for Primary Care Health Professionals in Nova Scotia provide sample cultural assessments for healthcare providers. The cultural assessments allow for healthcare providers to look at how they interact with individuals and families of diverse cultures. The Enhancing Cultural Competence Resource Kit self-assessment is comprised of three sections: physical environment and material resources; communication styles; and, lastly, value and attitudes. Physical environment focuses on the representation of diverse cultures in the material resources healthcare providers use and showcase in their work area. Recommended communication styles encourage the healthcare provider to assess the use of language in encounters with diverse populations. The value and attitude portion of the assessment focuses on the how the healthcare provider recognizes the values and attitudes of their own culture, as well as those of the culture with which they are working.

The Nova Scotia Guideline is structured in sections addressing various levels of administration and how that affects cultural competence in healthcare. The guides are population-focused according to location, and are inclusive of Indigenous and other ethnic groups in respective provinces. The foundational work of the resource kit and guidelines are generic and are meant to be inclusive; however, the use of the framework and guiding theory are not explicitly stated. The use of the tools is meant to have healthcare providers be more cognizant of culture in practice, and, thus, form their methods of practice with knowledge of cultural sensitivity.

Mareno & Hart (2014) assessed the amount of continuing cultural competence education received by undergraduate degree nurses and graduate degree nurses in the workforce. While both groups of nurses reported low levels of continuing education, graduate degree nurses reported slightly higher levels of cultural awareness. Results of this study suggest the implementation of cultural education at both baccalaureate and graduate degree level is necessary.

Nurses working with diverse populations face varying degrees of challenges, from the lack of cultural knowledge to language barriers. Cioffi (2005) studied nurses' experiences and found that nurses believed that cultural education was inadequate. Nurses felt the need to know more about culture; however, not all received or knew how to obtain adequate education. This deficiency may lead to nurses relying on stereotypes to make assumptions about patients and their families, and to nurses turning to informal modes of education such as internet searches.

2.6 Deficiencies in Literature

The concept of cultural competence education in nursing is not a new idea, but the adoption of cultural competence education into nursing curricula did not take place in the United

States until the 1980s (Gallagher & Polarin, 2015). In the United States, the Culturally and Linguistic Appropriate Services (CLAS) Standards (U.S. Department of Health & Human Services, n.d.) were developed to " Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs" (p. 1). This national standard has been set as a framework for organizations to follow, with 14 standards in three categorical themes: cultural competence, language access services, and organizational supports for cultural competence (Weech-Maldonado et. al, 2012). According to Mareno and Hart (2014), cultural competence education for nurses is said to be a core curriculum standard. This would enable practicing nurses to have some foundational cultural knowledge; however, in an earlier study, Cioffi (2005) found that practicing nurses feel they lack cultural knowledge and require further education. In British Columbia, Canada, Almutairi, Adlan, and Nasim (2017) found that nurses' age and country of birth played a significant role in their perception of cultural competence, with younger nurses and those born in Canada having a higher perception of cultural competence. The study also concluded that there was a need for ongoing cultural competence education for nurses in the workforce to address differences in culture between nurse and patient. The recognition of the need for cultural competency education is clear; however, follow up on the impact of cultural competency education on healthcare providers and their patients needs to be studied in greater detail.

2.7 Research Question and Research Goals

The goal of this descriptive phenomenological study is to describe the essence of cultural competence, exploring the strengths, challenges, and barriers that nurses face in community healthcare settings. My intended research question is: What are the lived experiences of nurses

with respect to cultural competence? The secondary questions would include: What are the challenges and barriers that nurses experience while working within culturally diverse care settings? Do nurses feel adequately trained to care for culturally diverse patients? Are there educational resources that nurses feel are necessary to help them best serve ethnically diverse populations? These questions are intended to provide a rich description of the essence of cultural competence among nurses in community care settings, as well as the daily challenges nurses face when working with ethnically diverse populations that could be addressed by educational resources.

CHAPTER THREE: Methodology

3.1 Introduction

The purpose of this study is to answer the question: What are the lived experiences of nurses with respect to cultural competence? In order to accomplish understanding of the lived experiences, the philosophical methodology of Edmond Husserl known as descriptive phenomenology and the theoretical nursing model entitled the *Process of Cultural Competence in the Delivery of Healthcare Model* (2002) of Dr. Campinha-Bacote were employed. Husserl's descriptive phenomenology is a methodology that aims to uncover the essence of a phenomenon through detailed description by the individuals experiencing the phenomenon in question. In this study, the phenomenon of cultural competence is aimed to be understood through the eyes of registered nurses working with ethnically diverse patient populations. The theoretical perspective of Campinha-Bacote (2002) was used to guide my research design, and to answer the research questions in a fashion that can be related to healthcare professionals in practice. Both the philosophical framework and theoretical perspective in relation to my study will be described in more detail.

3.2 Theoretical Perspectives

Dr. Josepha Campinha-Bacote created the *Process of Cultural Competence in the Delivery of Healthcare Model* (2002). Her model defines cultural competence as a process in which nurses and other healthcare professionals propose to be able to provide care within the cultural context of an individual or family (Campinha-Bacote, 2005). According to Campinha-Bacote, cultural competence is not a destination but a journey, and one is never fully competent, but rather embarks on a journey that increases one's competence with each cultural encounter. The constructs that make up the model include cultural knowledge, cultural awareness, cultural skill,

cultural encounters, and cultural desire. Each construct works in conjunction to provide culturally competent care. In this study, the constructs within this model were used in the formulation of the interview questions and to analyze the data. The constructs, as well as how they were used to guide my research process, will be described in more detail.

Campinha-Bacote (2002) defines the constructs as follows: Cultural awareness is the ability to recognize self-biases that a practitioner may have of other cultures; these biases are not always known and, therefore, the healthcare practitioner is required to critically reflect on those biases. With the identification of biases, practitioners will be able to appreciate cultural difference and diminish cultural impositions, whereby an individual may view their cultural beliefs as superior and impose their cultural beliefs on others. Cultural knowledge is the seeking of education around health-related issues, beliefs, values, and cultural practices, as well as disease incidence and prevalence in a culture. The knowledge a practitioner gains helps them understand their patient's worldview and how they perceive and understand their own health, fostering a greater understanding between the practitioner and the patient (Campinha-Bacote, 2002). The attainment of cultural knowledge increases the health practitioner's ability to understand issues facing a particular cultural population. With increased knowledge, practitioners are better equipped to address cultural issues. Cultural skill requires practitioners to be able to conduct a cultural assessment that shows understanding of relevant issues for the patient. Skills include effective communication, whereby practitioners use resources around them, such as interpreters or visual aids, to communicate effectively. The skill of the practitioner consists of being knowledgeable of cultural variations, such as race and prevalence of illness of disease within a cultural group, in the assessment. Cultural encounters refer to the number of engagements a practitioner has with patients or families of diverse cultures. Every encounter is a

cultural encounter that has potential for cultural enrichment (Wilson, 2012). Encounters make up experiences that nurses have with their patients. Lastly, the construct of cultural desire, which is the catalyst of cultural competence as it requires practitioners to have a genuine willingness to learn and to be exposed to cultures other than their own. Through the construct of desire, practitioners take an active role in sustaining the process of cultural competence.

The research process began with the selection of the topic of cultural competence. When exploring cultural competence in the workplace, it was important to have a guiding theory that exemplifies how cultural competence should look in the workplace. The decision to use Campinha-Bacote's (2002) Process of Cultural Competence in the Delivery of Healthcare Model (PCCDHM) was based on its relevance and practical application for how nurses would demonstrate cultural competence in the workplace. Also, and importantly, the model's simple-to-understand constructs help nurses understand the method of self-development in the area of cultural competence. Through the formulation of the research questions, it was important to uncover the essence of how nurses understand cultural competence. In order to achieve an understanding of the primary research question, it was important in the formulation of the interview questions to include questions that spoke to the cultural awareness of the participants. Questions such as, "Can you tell me how the culture of your patient affects the care you provide?" were formulated to get a sense of the participants' awareness of their patients' culture. Questions pertaining to skills and attitudes were also asked to gain insight into skills and beliefs currently used in practice. Throughout the interview, asking participants to share what they felt was necessary to better the area of cultural competence in their workplace showcased the desire for improvement in the area.

While selecting the methodology of this study, it was important to select a method that would capture the essence of the lived experience in order to best represent the feelings of the participants. The theoretical perspective helped to keep the feelings and findings of this study focused to those of cultural competence in the delivery of healthcare. Throughout data collection, the five constructs were intertwined through the interview guide. Through analysis, the creation of units to represent the essence of the nurses' lived experience incorporated the constructs of desire and cultural awareness, and brought forth the recognition of where the constructs were lacking. For example, the constructs were lacking in the area cultural knowledge, which will be made more apparent in the results section. Drawing final conclusions of the study brought light to the constructs of this model as through the description of the lived experience with respect to cultural competence, it can be seen that cultural desire is evident with the participants, and, further, that the areas in need of improvement through education are cultural knowledge and cultural skill. The practicality of the model helps conceptualize the experience of cultural competence for the participants. Practically capturing the process of cultural competence was one aspect of the method. The PCCDHM guided my research in seeing how nurses viewed cultural competence through their thoughts, feelings, and actions in practice, while Husserl's descriptive phenomenology was used to describe the phenomenon of cultural competence itself through scientific reasoning.

3.3 Descriptive Phenomenology

Descriptive phenomenology is a philosophy and methodology that describes a phenomenon and aims to describe "what is" in conscious thought. The essence of phenomenology is to evoke or understand meaning through lived experiences. To better understand the meaning and goals of descriptive phenomenology, a brief understanding of the

founding father, Edmond Husserl, and his philosophical underpinnings of essences and consciousness relevant to this study will be described.

Edmond Husserl (1857-1938) was an Austrian born philosopher who believed that philosophy should be considered a rigorous science with merit (Husserl, 1973; Streubert & Carpenter, 2011). Husserl's work on phenomenology emphasized the consciousness in the world, and how consciousness contributes to knowledge (Husserl, 1973; Rodgers, 2005). Consciousness can be described, as Husserl's work was predominantly epistemological, meaning his focus was on knowledge and justified beliefs (Holub, 1995). In order to assure that phenomenology was viewed as a rigorous and respected school of thought, Husserl opposed two dominant schools of thought, which were naturalism and psychologism (Holub, 1995). Naturalism was refuted by Husserl as a school of thought based on the argument that things in the natural world cannot be reduced to the level of an object, and this distorts the phenomena being studied (Giorgi, 2009). Husserl believed naturalism had no way of explaining worldviews, and, thus, discredited the notion. The idea of psychologism, which Merriam Webster's (n.d.) defines as "a theory that applies psychological conceptions to the interpretation of historical events or logical thought," is relative to either a species or to the human mind. Making truth only relative to those by whom it is interpreted, Husserl's notion of phenomenology constituted that knowledge is not singular, in opposition to that which psychologism suggested. Absolute truth meant that truth was eternal, regardless of context. Husserl's goal was to have a clear, untainted understanding of a phenomena in relation to consciousness, and in order to do this, his methodology employed the use of bracketing to find the true essence of a phenomenon. My study employed the areas of consciousness and essences to obtain the lived experience of nurses

in relation to cultural competence in the workplace, and, therefore, the two facets will be explained in relation to my study.

3.3.1 Consciousness. Phenomenological philosophy focuses on the conscious experience, or "humans as embodied beings, meaning they experience life through their physical bodies" (Connelly, 2010, p. 127). In my study, the nurses' experiences within their work environments are examples of how physical bodies are a mode through which experiences are experienced. Physically, the nurses are in the world, coming into contact with other people, and having encounters that are conscious to them. In other words, the events happening to the nurses are shaping their experiences, which is the focus of Husserl's work to understand anything that can be experienced through the consciousness of a person or object (Giorgi, 2009). The word "phenomenology" comes from Greek word "phaino," which means, "to bring light to or appear" (Holub, 1995, p. 289). The relationship between objects and perception are reciprocally affected by one another, and, thus, shape how each is perceived (Rogers, 2005). Phenomenology centres around the term *lived experience*, which is defined as "Personal knowledge about the world gained through direct, first-hand involvement in everyday events rather than through representations constructed by other people" (Chandler and Munday, 2011 para 1). Lived experience delves into what it feels like to be within a situation, and not simply the reaction to the experience (Connelly, 2010). This is the essence of being within an experience. In phenomenology, the essence of being in the experience is the actuality of the experience in conscious thought. For this study, the nurses' personal experiences with their ethnically diverse patients are reflected upon in conscious thought through dialogue during the interview process. To understand the nurses' lived experience, thoughts and feelings about their previous encounters were explored with questions that prompted them to share details of past experiences.

The knowledge they had or have gained through the experiences was also discussed and brought to light through the nurses' personal reflection on past encounters. From the philosophy of "conscious being" to the method of "actively being" within a conscious experience, phenomenology has evolved to encompass the experiences of individuals and their surroundings (Rodgers, 2005). For the purpose of understanding nurses' lived experience while working with ethnically diverse cultures, the descriptive phenomenological philosophy was employed to describe the relationship of the nurses' conscious experiences to that of their patients within the healthcare context, which would be considered their surroundings.

From conceptualizing the research question, "what is the lived experience of nurses in relation to cultural competence," it was important to formulate a description that was from the nurses' perspective, and not that of the researchers. Descriptive phenomenology was used because it is a methodology that stands to bring clarity to an issue or area that is not greatly understood (Matua & Van Der Wal, 2015). Understanding the nurses' perspectives on cultural competence in practice is not heavily prevalent in literature; therefore, forming a clear, non-biased understanding of current feelings and experience of nurses working with culturally diverse patients needs an untainted, unaltered description to help voice and validate the concerns of nurses living this experience. During the interview process, nurses explained how they felt their knowledge of culture and cultural skills affected their practice. Furthermore, nurses expressed how their surroundings (their ethnically diverse patient population) affected their thought processes or nursing care. The nurses' awareness of difference or similarity in culture was presented in the conscious, meaning it was viewed in relation to them.

The interview questions were structured in a fashion that would allow the nurses to express how they consciously viewed their experiences; the use of open-end questions allowed for the

nurses to explore their thoughts and feelings in their experiences, and to share them in a manner that was authentic to them. The open-ended questions also allowed for the nurses to add more rich description to their experiences that may have not been directly asked by the researcher. All of the experiences were then analyzed, ensuring that there was bracketing by the researcher. Bracketing, according to Husserl, is the removal of a priori knowledge, or previous knowledge, of the investigator that can influence interpretation of the finding (Giorgi, 2009; Husserl, 1973). This step is very important as assumptions and prior knowledge incorporated with findings do not create a true essence of a phenomenon or descriptive phenomenology, but rather present a form of interpretive hermeneutic phenomenology.

Hermeneutic phenomenology, also known as interpretive phenomenology, was made known by Martin Heidegger, a German philosopher, who focused on finding the deeper meaning and meaning of text in understanding an experience (Matua & Van Der Wal, 2015). Heidegger was not interested in bracketing the researcher's prior understanding of the phenomenon; rather, the researcher's perspective became a part of a hermeneutic circle that includes both the researcher's and participants' respective perspectives to form an understanding of the meaning behind a phenomenon (Lopez & Willis, 2004). Derico (2017) contrasted the two methodologies by their overall position of the subject being researched. In hermeneutic phenomenology the focus "should be on the meaning of being a human in the world versus focusing on the phenomenon" (Derico, 2017, p. E7). Also, in hermeneutic phenomenology, the phenomenon must be understood prior to it being interpreted by its subjects, meaning more than a description is required in this methodology (Derico, 2017). In hermeneutic phenomenology, individuals can not distance themselves from the world and therefore the subjectivity of humans is not the main

focus but rather the interpretation and implications of what individuals say about their daily experiences (Lopez & Willis, 2004).

The purpose of this study, however, was to understand the essence as described by the participants themselves, and not to examine the actions of the participants, but to explore and describe the experience as it is in the present conscious. For this reason, Heideggerian hermeneutics was not employed as its goal did not serve to answer the research question in a descriptive form.

3.3.2 Essences. Essences are important to phenomenology in that they give understanding to a phenomenon. Streubert & Carpenter (2011) state that essences are the basic unit of understanding. Essences are identified through an analysis of individual lived experiences. In this study, the basic units of understanding were the experiences of the nurses, which included feelings of inadequate cultural knowledge and skill, difficult communication in the form of language barriers, and limited knowledge of cultural nuances, as well as attributes nurses showcased while working with ethnically diverse populations. The description of all these experiences identifies the units of understanding that then are used to describe the phenomenon in question. The basic units are also known as eidetic structures (Lopez & Willis, 2004). The experiences of individuals as a form of study, despite being subjective at this point in history, was Husserl's goal for phenomenology. Although this was a shift away from empirical knowledge and a battle between objectivity and subjectivity, "Husserl believed that subjective information should be important to scientists seeking to understand human motivation because human actions are influenced by what people perceive to be real" (p. 727). Nurses' experiences will be valued and explored through their respective lenses. Through the description of personal encounters, rich information can be brought forth and used to understand the cultural,

environmental, and situational influences on the impacts of care through nurses' lived experiences of the nurse-client relationship.

With the philosophy that human consciousness shapes experiences and influences the perceptions of individuals, Husserl felt that in order to be genuinely knowledgeable and free from predispositions of personal experience, a reductionist approach must be employed (Holub, 1995). This approach is known as bracketing, which involves the conscious awareness of biases, thoughts, preconceptions, and personal experiences that can and would influence thinking or description of a situation (Rodgers, 2005). The goal of bracketing is to produce an unbiased, true description of an event, circumstance, or knowledge in the purest form. This is the essence of descriptive phenomenology: an untainted depiction of what is. In this study, bracketing was achieved by first assessing my own biases and recording them on a personal voice recorder to be played back later, before the analysis phase, so that I might recognize my pre-assumptions before addressing the data collected. My pre-conceived ideas about cultural competence in the workplace was not to be the focus of the study, but was instead to be set aside by the review of my assumptions during the analysis phase, and reflection on how my assumptions could influence the analysis before writing. With recognition of my pre-conceived notions, the nurses' voices through the interview process were true to their true description of the phenomenon, rather than representing my thoughts. This step allowed for me to be able to truly illuminate the voices of the nurses.

The use of Husserl's descriptive phenomenology would provide a rigorous description of the essence of cultural competence among community healthcare nurses. The intended research goals of understanding and describing cultural competence are better suited for descriptive phenomenology than that of hermeneutics, which focuses on interpretation (Rodger, 2005).

Hermeneutics, although a form of phenomenology, focuses on uncovering the concealed meaning of phenomena, which is not the purpose of this study (Streubert & Carpenter, 2011). Rather, the purpose of the study was to formulate a description that can serve as a basis for understanding the phenomenon of cultural competence as understood by public health nurses as foundational knowledge, because this population is not studied well in the literature to date.

3.4 Trustworthiness of Data

Descriptive phenomenological methodology includes ensuring data is trustworthy and credible. In order to ensure that the data collected was an accurate summary of the findings, they were sent to the participants after analysis to member-check the information. Member-checking is employed to ensure the participants' true voices were understood by the researcher. E-mails with a summary of themes and findings were sent to each participant individually by the researcher. Participants were asked to review and validate the themes found in the analysis. Participants were also given the opportunity to add any further comments or findings they may have felt necessary Results of member-checking validated the themes presented in this thesis. Participants agreed to the units and themes and did not add any further comments to the researcher post interview. Bracketing by the researcher was also employed to deter any influence and assumption regarding the data.

3.5 Research Process

3.5.1 Entry into research site. The three research sites were outpatient clinics that serve large ethnically diverse patient populations. These clinics were chosen because they serve mostly ethnic minorities in the most ethnically populated area of the city. With ethics approval obtained from the university's Conjoint Health Research Ethics Board (CHREB), posters and information regarding the study (see Appendix B) were circulated by managers at the sites after the approval

from management at the respective sites. The researcher's contact information was provided on the poster for nurses to voluntarily contact the researcher for participation, along with information about the proposed study.

3.5.2 Sampling. Participation at the selected sites was voluntary, and a purposive sampling method was used to recruit participants. Purposive sampling is a non-probability or expert sample, where participants have a relation or knowledge of the concept being studied (Palys, 2018). Snowball sampling was also used as a result of the participants informing their colleagues of the intended study. The participants were registered community health nurses, aged 25 to 57, with levels of experience ranging from one year to twenty-six years. However, due to only one nurse having one year of experience and the other six nurses having over ten years' experience, it was difficult to accurately compare the years of experience to thoughts on cultural competence in this study. The participants were made aware that their involvement would not affect their work. A sample size of n=7 was obtained from these sites. Adequacy of the sample size was guided by the expertness of the participants and their ability to articulate their experience. Recruitment was stopped when data saturation (when no new major information was identified) was reached with seven participants.

3.5.3 Inclusion criteria. Inclusion criteria were consenting, English-speaking registered nurses (bachelor's degree nurse) working at one of the selected sites that were chosen based on geographical areas wherein the clinics mainly serve ethnically diverse communities. The participants also had to have a minimum of one year of working experience.

3.5.4 Exclusion criteria. Exclusion criteria were any person who did not meet the inclusion criteria.

3.5.5 Data collection. Data was collected through in-depth semi-structured interviews lasting 45 to 60 minutes. The interviews were audio-taped using a digital audio recorder. Questions were open-ended with guiding questions on the experiences of caring for ethnically diverse patients. Questions were asked that allowed for nurses to elaborate on their experiences working with diverse populations. The questions were open-ended, focusing on describing the nature of work that the participants did and how their experiences were understood to them to form an understanding of their lived experience. The purpose of asking about their experiences was that it gave the nurses liberty to reflect and discuss all areas of their work that they found exemplified the nature of their work with diverse ethnic patients. Questions pertaining to the secondary questions of cultural competence education were asked to gather information on the current knowledge and the use of available resources for registered nurses. Questions pertaining to the challenges participants faced in their practice served as a guide for the researcher to propose areas for further research, and also where education could best be implemented or created to benefit and support registered nurses in their practice with ethnically diverse patients. Lastly, questions pertaining to recommendations of education were asked to provide the researcher with a rich description of what the participants would find most helpful in their practice to best prepare them to work in cross-cultural situations (Appendix C). In order to ensure clear descriptions were obtained for each area, the researcher asked for clarification and examples from participants' experiences to illustrate their characterization of the question asked. Demographic questions were asked for classification and context. Varying levels of experience yielded unique experiences regarding cross-cultural situations; higher levels of experience tended to lead to more examples, as the nurses have had more exposure to diverse patients.

The interviews were held at mutually agreed-upon locations between the interviewer and participant with ensured privacy measures (i.e. outside participants' places of work). The interviews began with introductions and an explanation of the purpose of the interview and research, followed by the signing of consent forms (Appendix D). The participants were made aware that the interview would be recorded, and permission was obtained. The participants were assured that information will remain confidential and their identity would remain anonymous with the use of a pseudonym. The open-ended questions were used as a guide to allow participants to offer rich descriptions of their experiences. When major concepts had been uncovered and the participants felt they had shared their experiences in detail, the interview concluded by asking the participants if they would like to add any further comments.

3.5.6 Data analysis. The interviews were transcribed verbatim and checked for accuracy by the replaying of the audio recordings by the researcher. Data collection and data analysis happened concurrently. Colazzi (1978) methods for data analysis were used. Organization of data in terms of demographics (i.e. work setting, years of experience, age, ethnicity, etc.) was completed to provide descriptive statistics of the sample. In order to provide accurate qualitative analysis, the seven steps of Colazzi (1978) data analysis were used, beginning with my reading and re-reading of each transcript to acquire a sense of familiarity. Following this step, the significant statements pertaining to the nurses' experiences, such as how they feel working with diverse populations or what they think constitutes culturally competent nursing practice, were extracted and put into a separate Word document organized into seven sections, one for each participant. The significant statements were re-read by the researcher, and organized into themes according to common ideas shared from the data. Thirdly, the formulation of meaning through the extraction of descriptive words that defined attributes and situations from the significant

statements was made, with careful attention to ensure words were not interpreted through my own understanding so that the descriptions were true to the participants. The fourth step required organization of the significant statements into themes. Five main themes were identified: lived experience, opportunities and benefits, challenges and barriers, supportive training, and, lastly, recommendations. All themes were analyzed in direct relation to culture. This step was completed using a table of organized excerpts from the transcripts. An exhaustive description of the phenomenon of cultural competence in care was created through the themes and statements extracted from the transcripts. Step six of Colaizzi's (1978) method stipulates the reduction of the description of the phenomenon to an essential structure, which is defined as a "statement of identification of the fundamental structure of the phenomenon" (Sanders, 2003, p. 300). Once the final description was made, the final step occurred, which involved e-mailing the participants a document with a description of the lived experience in relations to cultural competence in practice, and obtaining critique and validation from the participants. During the analysis, bracketing by the researcher was done by using voice journaling of personal thoughts and feelings about the findings. Journaling was initially completed after each interview. The researcher would express thoughts and feelings about how the interview took place and general overarching perceptions of the interview. For example, the researcher would reflect as to whether the participants had been familiar with concepts of cultural competence, and how that may influence their thoughts and feelings about the subject. Thoughts and general assumptions were noted and written in the researcher's assumptions section of this thesis.

3.6 Ethical Consideration

Approval of this study was been obtained through the Conjoint Health Research Ethics Board (CHREB) at the University of Calgary, along with operational approval from Alberta

Health Services at each respective site. Ethical consideration for this project included maintaining confidentiality. To ensure confidentiality, all audio-recording and transcripts were kept on a secure, password-protected drive. Consent forms containing the personal information of the participants was filed in a locked cabinet by the supervisor of the study at the University of Calgary for five years, as per University of Calgary policy. The supervisor and the researcher were the only personnel with access to the consent forms with participants' personal contact information. Confidentiality of participants was ensured through the use of pseudonyms in all written text. Consent was obtained in writing after full disclosure of the study, including known risks and benefits to the participants. After the specified five years or completion of the project, documents would be shredded by the researcher and disposed of on campus. In the event of publication, the researcher would ensure to maintain the confidentiality and anonymity of participants. The researcher would use pseudonyms, and would not list names of participating sites in the event of publication. In addition, the researcher would not use quotations that may identify the participant or site locations. Although participants had the right to ask questions about the study and withdraw from it at any time, they were informed that once their data had been coded and analyzed it could no longer be removed.

3.7 Conclusion

To conclude, descriptive phenomenology is the methodology that is meant to describe a phenomenon. Descriptive phenomenology, founded by Edmund Husserl, uses methods such as bracketing of the researcher's assumptions and biases, and aims to explore how objects, ideas, or phenomena are viewed in the conscious. The purpose of this study is to explore the lived experience of nurses working with ethnically diverse patient populations in relation to cultural competence. In order to best answer my research question, a clear, untainted description of the

nurses' experience was required, and, therefore, descriptive phenomenology was used as its purpose is best suited to accurately telling the story of the nurses' experience without my opinion overshadowing their thoughts and feelings. Colazzi's method is a step-by-step method used to orchestrate the research process, with the influence of the theoretical perspective of Campinha-Bacote to guide the design of the question which would let the researcher to compose a description that encompassed the basic units of understanding of the participants.

CHAPTER FOUR: Results

This chapter will discuss the findings of this study to answer the research questions: What are the lived experiences of nurses with respect to cultural competence? What are the challenges and barriers that nurses experience while working within culturally diverse care settings? Do nurses feel adequately trained to care for culturally diverse patients? Are there educational resources that nurses feel are necessary to help them best serve ethnically diverse populations? The results will highlight and provide context for understanding the nurses' lived experiences of working with ethnoculturally diverse patient populations through descriptive analysis of study participants' in-depth interviews. To answer the main research questions, the results of the study will be presented with a description of the essence of the lived experience of nurses in relation to cultural competence. The secondary research questions will be answered with the participants descriptions of the following core units: understanding of culture, challenges, and the desire to be culturally competent; these areas of the study also serve to represent the nurses' lived experience as a whole. Reference to how the units affect the nurse-patient dynamic will be highlighted throughout the chapter in order to demonstrate impacts on nursing care. During the interview process, participants used the terms *patient* and *client* interchangeably, and, therefore, the terms will be used interchangeably throughout the chapter. Throughout this chapter the terms *immigrant, newcomers,* and *refugees* will be used interchangeably, as well. Prior to the units being discussed, demographic data will be presented to give the reader context and insight into the participants' perspectives.

4.1 Demographic Results

Demographic data was collected during the interview process by asking demographic questions. Results of the participants' demographic data are displayed in Table 1 and were used

to understand the context in which the participants work, as well as their exposure to culturally diverse populations.

Table 1.

Demographics			
		(n)	**Percent**
Age			
	18-30 years	**1**	**14%**
	31-40 years	**2**	**29%**
	41-50 years	**3**	**43%**
	51-60 years	**1**	**14%**
Gender			
	Female	**7**	**100%**
	Male	**0**	**0%**
Ethnicity			
	Caucasian	**4**	**57%**
	South Asian	**1**	**14%**
	Southeast Asian	**2**	**29%**
Years of Experience			
	0-10 years	**1**	**14%**
	11-20 years	**4**	**57%**
	20+years	**2**	**29%**
Area of Practice			

	Urban	**6**	**86%**
	Rural	**1**	**14%**
Highest Education Completed			
	Bachelor's Degree	**6**	**86%**
	Master's Degree	**1**	**14%**

Seven currently practicing registered nurses aged 25 to 57 years old participated in the study. All of the participants spoke English and were female. Each participant attended an accredited Canadian university, and obtained a bachelor's degree in nursing. One participant was currently enrolled in a master's program, while another had a completed master's degree. All participants were nurses with active registration who worked in a community setting as a public health nurse; one worked in a rural setting, and the remaining six worked in an urban city setting. The nurses of South and Southeast Asian decent described personal experiences they or their families may have had being from a family of immigrants, and spoke more personally about how it feels to be an immigrant compared to the Caucasian nurses. The years of experience of the nurses dictated how many experiences and encounters they may have had; however, all nurses were able to recall encounters with ethnic patients and to share their experiences clearly. Two of the participants were currently in educator roles in their health setting, and five were staff nurses. The demographic data provided context to show the landscape of the nurses' practice to gain understanding and meaning of the phenomenon cultural competence.

In this chapter, I will report the findings from the interviews, including the essence of the lived experience in relation to cultural competence. I will demonstrate how the nurse participants understand culture, culturally competent care in practice; the attributes of a culturally competent

nurse; challenges; power imbalances and finally the participants desire and readiness to be culturally competent.

4.2 The Essence of the Lived Experience in Relation to Cultural Competence

The essence of the lived experience of registered nurses in relation to cultural competence is one full of reward and hard work. Nurses proudly strive to understand their patients' challenges both while recognizing the limitations, such as in the area of cultural knowledge, that they have in their work environment, and while playing the role of an educator to their patients.

The essence of the lived experience of the participants highlights their beliefs, attitudes, and actions as nurses who are working with ethnically diverse clients, thereby showcasing how the nurse-client relationship impacts the quality of the delivery of nursing care (McCabe, 2004). To grasp the essence of a subject means to understand the meaning of the subject in relation to what is in the conscious. In this study, the nurse participants' relationship to their culturally diverse patients was studied in the conscious thought of the nurses to bring forth the essence, or meaning, of the phenomenon of cultural competence. Cultural competence to the nurse participants is a multicomponent skill that nurses possess to best care for the dynamic nature of their ethnic patient population. In the nurses' view, being culturally competent is a necessity so as not to alienate or intentionally or unintentionally mistreat patients. The phenomenon of cultural competence is not overtly stressed in the workplace to nurses, and, thus, may not always be recognized as a vital area in nursing practice at face value. However, nurses do recognize the importance of cultural competence to their practice and how it affects the nurse-patient relationship, which, in turn, has an effect on the healthcare outcomes and health behaviours of their patients.

Nurses experience cultural competence through the encounters they have with their patients, as expressed through three overarching perceptions that describe their experiences. These constructs are units of understanding that stood out in the interview process as common areas that the nurses felt impacted their practice with respect to working with culturally diverse patients: understanding patients and their challenges, awareness of limitations in the workplace, and, lastly, the nurse's role as an educator. These units will be discussed in further detail in relation to culture and cultural competence in practice.

4.2.1 Understanding the patient and patient challenges. The participants expressed great pleasure in working with ethnically diverse patients. Clinical Nurse 4 said, "It's been a wonderful experience for me," when speaking about her work. She stated that she has learned greatly about diverse populations through encounters which disprove the stereotypes that she has come across in the workplace:

> I was pleasantly surprised . . . you just hear different cultural beliefs get passed on between nurses . . . we all have stereotypes that we deal with in the workplace. Some of them being that East Indian women tend to be more vocal and needy during labour or may not be able to get an epidural because her husband won't let her, or if there is a male present during the labour, it will be a difficult labour if you were to stereotype. But then you go into their home and it's a completely different experience. Usually there is lots of family there and the East Indian woman herself usually is not difficult and very accepting to the home care that she gets.

Stereotypes initially hindered the nurse's understanding of the patient; however, through experience, the nurses were able to appreciate the patients' individuality, shifting their focus to the positive attributes of the patients.

Learning and understanding ethnically diverse populations fostered personal growth among the participants. An illustration of personal growth is stated by Clinical Nurse 1, who expressed her appreciation for working with culturally diverse patients, as it promoted her knowledge of different cultures while helping to increase her patients' knowledge of the healthcare system. She stated, "I see working with different ethnicities as a benefit. I am learning a lot about them and I have the ability help them learn more about our health system, so that they can best take care of themselves." Moreover, Clinical Nurse 2 described how her personal growth has had implications for and benefited her practice: "When you have personal growth in your nursing practice you use it in your work. For me it has allowed me to better teach the patient and I can better relate to them."

An in-depth understanding of the patient allowed the participants to have insight into the challenges that their patients face, including isolation and being misunderstood. For example, through her nursing experience, Clinical Nurse 5 found that newcomers often were isolated when coming to Canada and were in need of connections within the community to build a supportive network. She explained how the supportive community group helped build these connections:

> A big part of our [support] group is to connect people, because a lot of the newcomers are very isolated when they first come here. When they do come to group, they find people from their country. So, it is a really good way to build a network of support.

Some participants recognized that ethnically diverse patients sometimes felt misunderstood and mistreated by healthcare providers. Clinical Nurse 3 highlighted the dialogue she had with a client who felt misunderstood when encountering the healthcare system:

> They just say to me, I don't even know why I go to seek help, because, they [healthcare providers] treat me like garbage, or they don't listen to what I have to

say, and they just don't get it… It just makes me so sad.

The recognition of the clients' barriers caused the participants to focus on relational practice to best serve their patients, and to build strong nurse-patient relationships. Clinical Nurse 1, being a first-generation Canadian, showed empathy through understanding the challenges facing new immigrants in order to build a strong nurse-patient relationship, and to best nurture and provide effective nursing care:

> Just hearing about my parents' struggles of coming to a new country, not knowing any English, not having any money, and seeing how hard they work . . . really opened my eyes . . . I try to do the best I can. I never try and make appointments rushed. If there is something that the patients didn't understand or something that they are upset about, I really try to understand where they are coming from and what their perspective is in order to help.

Nurses are often the frontline healthcare practitioner for immigrants who are accessing the healthcare system. Therefore, it is expected that nurses can direct immigrants to the appropriate areas of service they require. To be able to serve their patients effectively, they must be able to understand and meet the patient's needs as identified by the patient. Clinical Nurse 1 shed light on how understanding patients' concerns can uncover what their specific needs may be:

> There are a lot of studies on medication adherence and we tell patients one thing and wonder why they just don't do it. There can be a lot of reasons behind compliance, maybe they can't afford to, or they have other concerns that are way above your medical concerns, so it is important to look at the big picture and seeing what is important to patient as well to providing holistic care, because your job is to do the best you can for the patients. I think

> to do that you need to understand what is important to them and how you can best help them, because often we think we know what is best for them.

Being inquisitive was found to be one of the participants' strengths. Six out of seven participants (86% of the study's participants) expressed that they rely on their patients as resources. Often, the patients would provide the nurse with in-depth insight into a culture. For example, Clinical Nurse 4 expressed how she learned about the thoughts of a patient with critical maternal health issues:

> We have a woman on our program right now that was offered a termination of pregnancy. The prognosis for the baby is not good. She's East Indian and she's deeply religious . . . So, I asked her the last time, I said, "Do you like us coming out to see you? . . . Does it reassure you?" She said "No, not really." . . . I said, "Is it because you feel the baby moving?" and she said "Yes." I really think she has a very much, what will be will be attitude, and it's not in my hands, it's in God's hands. So, putting that idea into where they're coming helps you understand their decisions. I've worked with Filipino nurses before and East Indian nurses and they'll often tell you having a sick child or losing a baby is just a part of life. In their culture, if one was to have a baby die within a few hours or have a negative outcome, that outcome was supposed to happen.

Asking specific questions served as a reliable way to extract pertinent health information, and to grow an understanding of the patient's health-related decisions in relation to culture. Furthermore, through her experience, the nurse developed a greater understanding of her patient, and she promoted the nurse-client relationship to support the patient's choice.

Understanding patients' personal stories helps them to integrate into Canadian society, and is one of many strategies nurse participants used. Using appointment time to explore and

understand the patient's concerns is the first step in helping to support or solve their concerns. Clinical Nurse 6 shared her experience of helping newcomers to understand and adapt to their new environment:

> So, if the patient need is understanding nutrition, that is where I focus my energy. When they tell me, I just moved here and nothing that I would normally buy in my native country are here, then that's what I focus on. My goal is helping them understand—showing them to buy food at this market to make the food that they would normally make in their home country. Or I would assess if the food they would normally make is nutritionally appropriate according to our recommendations and help them to integrate their culture into their daily practice here in Canada, because it looks different from home for them.

To summarize, understanding or attempting to understand the patient and the patient's challenges is an important part of the lived experience of the nurse participants in relations to cultural competency. Recognition of patients' barriers, such as isolation and feeling misunderstood by healthcare professionals, allows participants to promote and facilitate an environment in which patients feel welcomed and cared for. A welcome environment is achieved by asking questions and having patience with diverse clients to best allow them to express themselves. The goal of understanding is to facilitate a better nurse-patient relationship in order to best deliver nursing care. Understanding is beneficial in the nurse-client dynamic; however, there are limitations to the nurse-client relationship which will be discussed in the next section and further along in the challenges section of the results.

4.2.2 Recognizing limitations. The participants recognized that they have limitations when working with ethnically diverse clients. Lack of cultural knowledge and time constraints were noted to be significant limitations in practice. Several participants indicated that they were

aware of their own limitations, largely related to cultural differences, while working with culturally diverse groups. When meeting a patient for the first time, a sense of uneasiness due the lack of cultural knowledge was expressed by Clinical Nurse 4, who recognized her limitations and expressed her desire to know more about different cultures and subcultures so that she would feel better prepared to provide good nursing care:

> I wish I had more cultural knowledge of the differences between Muslim women and Sikh women and all the different subcultures or similar cultures of people from similar geographic areas, because you really do not know where they are from or what they identify with by looking at them and the last thing I want to do is offend them.

Clinical Nurse 4 also expressed that her lack of knowledge on cultural matters such as religion would result in her not knowing what to say to the patient in practice:

> I just don't know what to say, especially with regards to a patient's religion. I don't know what to say to them or how frank to be with them. It is something that I struggle with when I don't know or understand where they draw their beliefs from.

The participants recognized the inability to know everything about every culture; however, their recognition of the limitations does not discourage them from wanting to learn more about new cultures. Gaining knowledge of culture instills confidence and readiness to deliver better nursing care, as pointed out by Clinical Nurse 1:

> I don't have a lot of knowledge about other cultures or a lot of experience in this field of cultural competency, but I think, like any other challenges, you should try and explore the challenge and learn to not be judgmental, but instead be open-minded and that will take you far.

Regarding the limitation of time, it is important to know that the nurses have an allotted time in which they must complete an appointment, which includes health history, addressing patient concerns, and medication review. Clinical Nurse 1 described her workday below:

> I typically have 45 minutes to an hour with a patient for an appointment. I see where there may be knowledge gaps and then I help fill in those gaps and answer questions that the patient may have. Time, however, is definitely a big factor, because of the use of language line and having a three-way conversation with an interpreter it can make the appointment longer.

Working with ethnoculturally diverse populations demands more time to ensure that language translation has occurred to guarantee patients' understanding. In cases where the allotted time for an appointment is not sufficient, further action is out of the participants' control, leaving participants wishing they could have more time with the patients' individual visits to ensure adequate care is provided. Clinical Nurse 5 spoke about how her intake assessments are not always sufficient for gathering background knowledge on a personal level:

> It's difficult because, when we do our one-on-one intake assessment with people, it is usually just a one-time introduction to do an assessment to find out what the patient needs are. After the assessment we are seeing the patients at group sessions where there are 45 to 50 women, which makes it difficult if there is a personal issue one may have, but do not feel comfortable sharing.

Clinical Nurse 5 recognized that her inability to see her patients beyond the first meeting may be limiting for the patient, who may feel uncomfortable sharing in the large group setting. Clinical Nurse 7 shared her experience of a home visit where she felt constrained after reaching the two allowed visits with the client:

> I had to visit a Syrian refugee family recently, and I think that the health teaching was really important, because the SIDS (Sudden Infant Death Syndrome) factors were terrible, and they couldn't use their car seat. They received two visits from us, then we were told we should not go back anymore. During the first visit, there was a maternal health issue and on the second visit we tried to do some psychosocial and financial referrals, along with the health teaching and the car seat teaching . . . but we could not finish. I think they really need it. I tried to advocate to go back again, but the decision was out of my hands.

The participants' awareness of both their own limitations and those limitations which are out of their control impacts the delivery of care in positive and negative ways. Nurses' awareness of their own limitations, such as lack of cultural knowledge, motivated them to explore and ask questions to best grow their understanding and knowledge. The goal of growth from their limitations motivates participants to find culturally safe and appropriate ways to effectively educate their patients, and to deliver quality nursing care. The next section will discuss the participants in the role of educator to their patients.

4.2.3 Role of educator. All the participants felt that they had the duty to educate their patients within their scope of practice. However, participants expressed that even with education, patient compliance was an issue. These nurses realized that their role is to provide information, and to ensure patients understand the information, but what patients do with the information is not their responsibility. When issues of compliance happened in practice, nurses learned not to pass judgment, which might strain the nurse-client relationship. Clinical Nurse 2 expressed how she understands her role as an educator:

> I am not here to change them; the onus is on them to change behaviours that can hurt their health. My job is to give them information and hope they make a choice for the better. I

document that I have taught them but truly it is up to the patient to do as they wish. It is all about self-management.

For some participants, the education they provide helps to break down stigmas and beliefs that may prevent newcomers from seeking healthcare in Canada. Regarding tuberculosis (TB), for example, Clinical Nurse 6 expressed how large the stigma attached to the disease is in many countries; many newcomers may feel ostracized if they are found to have the disease here in Canada. Her education regarding how TB is perceived and treated in Canada helped break down the barriers these patients are facing:

> There is a big stigma associated with TB. [Patients] understand that we're not going to kick them out of Canada just because they have tuberculosis. That's a huge barrier, but once they understand that they are here, and they are Canadian and this is a service that we offer them. The only difference between the service that we offer here and the service that maybe was offered in their home country was that ours is free, and we demand compliance. It is not always free in their home country. If they have active disease, they must be treated, and they must comply. If they don't then we can enforce the Public Health Act. Which we rarely ever have to, so once we convince them that they are not in jeopardy of being kicked out of Canada or losing their job . . . Once we get over all those stigmas and barriers that they assume then we start them on treatment . . . we develop very close relationships with the clients.

Providing education on Canadian practices breaks down fears caused by the patient's lack of knowledge about their new environment and health care services. The educational role of Clinical Nurse 3 enabled for her to advocate for newcomers to Canada as her role exposes her to many different cultural backgrounds that allow for her to learn about thoughts and beliefs of her

patients. With exposure to diverse patients over time, she has come to learn that it is important for her to be sensitive to the needs of her patient population. Her experiences with patients go beyond solely her patients' health, but also how her patients exist within the healthcare system as her role introduced a lot of families to the healthcare system. Her role included educating patients, as well as connecting new immigrants with local healthcare services. The educational role strengthens the nurse-client relationship and builds capacity in a community where new immigrants must adapt to the Canadian healthcare system. Her experience of educating patients about health also prompted her to advocate for high-needs newcomers, who struggle to navigate the Canadian health care system. Having patients and members of the community trust her is a sign of her being culturally competent and sensitive to the needs of her patient population. Her experience sheds light on the overwhelming need for culturally appropriate healthcare services for newcomers:

> I have people calling me to say, "Nurse I saw somebody here and they don't have a family doctor yet and there such and such going on. Should they come to the newcomer clinic?" I was the gatekeeper, the nurse who was running the newcomer clinic. And then we would get them in to see the doctor and then they would do their assessment on them. [We] use the evidence-based guidelines for our newcomers to Canada and go through several screenings as well as a social history and all the medical history.

Being an advocate and providing culturally relevant education and guidance helped form positive nurse-client relationships and build clients' capacity to deal with health issues. Introducing newcomers to the healthcare system, educating them about it and about specific health issues, and giving them a safe place to ask questions and to receive trustworthy information is an aspect of this nurse participant's experience of cultural competency.

Advocacy and education are gratefully appreciated by patients, as well. Clinical Nurse 3 recalled the warm reaction she received from a patient who was an English language learner, and who needed an explanation of a necessary procedure. The patient's response put into perspective how important connecting with ethnically diverse patients is in providing excellent culturally competent nursing care:

> There was a young guy that was going into the operating room, terrified, and did not know what was going on. He knew that he had to have surgery, but they were trying to explain to him the details of his condition. So, we used the Language Line and, sat with him, and explained to him what was going on and he was so grateful. I remember maybe six weeks later I saw him at Safeway, and he lifts his shirt up right between the potato chips and the popcorn saying, "You help me! You help me!" He had this huge scar from the surgery. You're certainly not looking for that and I certainly didn't expect that, but to know that you've helped somebody in that way. It's really nice. It feels good.

Using cultural knowledge and desire to connect with patients for better nurse-patient relationships is the essence of cultural competency. Clinical Nurse 3 found that when she was able to connect with her patients through open conversation that included asking what was important to the patient, and what their views were of what it meant to be healthy.

Participants communicated that they often experience professional satisfaction when they see the positive impacts of being culturally competent in their work. Aside from having positive experiences and learning about different cultures, the nurses took pride in making a positive difference in their patients' health experience through education and advocacy.

The reflection of personal satisfaction was identified as personal growth for the participants. Personal growth through exposure to new cultures promoted the nurses' confidence

in working with different cultural worldviews and provided understanding of how health can be viewed through the lens of the patient. Personal growth further affected the nurses' own practice by improving how nurses related to patients as described by Clinical Nurse 2:

> I have learned a lot and my self-esteem has developed because like as I said, the more experience I have the more I learn and then feel more capable of talking to a patient who is of a diverse background.

Moreover, Clinical Nurse 2 found that her fluency in her native language increased:

> Also, my Filipino language has developed being a first-generation Canadian. In the beginning I wasn't very good at the language, but I was able to speak well enough to get by. Now I'm proficient. [laughter] I'm very good at speaking Tagalog now that people don't even realize that I was born here. They think I was born in the Philippines!

In their cross-cultural work, one nurse participant experienced personal growth through developing an enhanced understanding of cultural variations in family dynamics. This personal growth was of benefit to the nurse participant and allowed her to be more competent as a healthcare provider, as mentioned by Clinical Nurse 4: :

> Working with diverse patients gives you a different perspective on your own life and how you lead it . . . cultures that really value their family and their elders is something that I have taken away from my work experiences. I find, as more and more time goes on, in Western culture, we tend to view our seniors' population as one that has less use. I would like to see Western culture more connected, seeing the difference has broadened my perspective and that's been a benefit to me.

The participants' lived experience included challenges as well as rewards. Understanding their patients' stories by asking questions and showing interest in their patients' healthcare

decisions were a major aspect of the lived experience of cultural competency of the participants. Personal growth, education, and advocacy for their patients are all part of why they feel providing competent care is important. The participants are heartfelt and compassionate in the care that they give, and they strive to do the best for all patients and families who come into their respective areas of work, and at the same time they recognize the cultural aspects of their patients, such as language and beliefs, and incorporate them into their care. When providing care, the participants wanted to consider the cultures of their patients in order to best serve them in a holistic manner. To do that, culture must be explored. The next section will discuss participants' understanding of culture, and how culture can affect nursing care.

4.3 How Nurses Understand Culture

This section will discuss the conceptualization of culture and how culturally competent care is understood and demonstrated by the participants in this study. The participants felt that understanding the impact of culture on their patients' healthcare perspective and experiences was essential. From their presepectives, patients' cultural beliefs and values are important elements in their lives and healthcare practices. In order to provide effective nursing care, nurses need to fully understand a person in a holistic manner; thus, contextual and cultural understanding of patients that influence their healthcare decision-making process should be considered. Nurses' understanding of their patients' cultural beliefs and attitudes gives them perspective on their patients' priorities and health-related decisions, and it provides a starting point from which to have a focused conversation. The participants of this study were from a variety of cultural backgrounds, and they defined culture in similar yet divergent ways. The data analysis indicated that the participants conceptualized culture in relation to ethnicity, language, and innate characteristics; behaviours and attitudes; and, foods and traditions. A simple, overarching

description was given by Clinical Nurse 7, who stated, “Culture includes religion, people’s priorities, language and behaviours. It [culture] is how people see and make sense of the world.”

4.3.1 Ethnicity, language, and innate characteristics. The participants associated the term “culture” with the innate characteristics of an individual, or something that a person is born with. According to Clinical Nurse 2, “Culture is your root,” the basis from and foundation on which people identify themselves. Although the term “root” is a simple statement, the meaning of it should not be taken for granted. Merriam-Webster (n.d.) defines “root” as “something that is an origin or source (as of a condition or quality).” Arguably, therefore, “culture” means something that is an origin, and the definition in relation to this study would mean that culture means the origin of a person. This is a powerful statement, as it puts culture at the centre of everything that makes people who they are.

Nurses believed that a fundamental characteristic of a person when they are born includes their ethnicity. As expressed by Clinical Nurse 6, “Culture is a person’s ethnicity, where a person is born, because sometimes where you’re born dictates cultural practices.” Location of birth can dictate practices such as the first language one will learn to speak or the values one will find important. According to Clinical Nurse 5, culture is “the values and beliefs that you are born with and that your family teaches you.” These characteristics then translate into what one can consider to be “a person’s background,” suggested Clinical Nurse 4. The point of emphasis is that innate features are what individuals do not have control over and cannot choose; rather, they are the features that a person is born with, such as skin colour, mother tongue-language, and country of heritage. These beliefs put into perspective the nurses’ level of cultural awareness. How nurses perceive or understand culture is a reflection of their understanding and knowledge of the cultures they are serving. For the purpose of this study, there were no definitive or correct

responses to the questions asked during the interview. Instead, the purpose was for nurses to share their thoughts and feelings to illuminate their current understanding of culture. In this particular instance, having a sense of cultural awareness is a part of the Campinha-Bacote's (2002) Process of Cultural Competence in the Delivery of Healthcare Services Model and, thus, it can be said that that nurses are on the journey of cultural competence as the model suggests. Innate characteristics are features that a person or group would identify with at a very young age. Ethnicity and shared common beliefs would then influence or shape behaviours, and what a person finds valuable. As stated by Clinical Nurse 6:

> A person's thoughts and beliefs including the traditions that they believe in such as the holidays a person celebrates and what someone does with their family on and during their holiday and sacred time. Those would be traditions which represents how a person grew up and their learned values.

In the participants' view, culture is something that is visible and tangible, and something that can be traced back through history, lineage, or root. Outward appearance reflects ethnicity, or the inherited traits that represent "everything that makes you who you are" (Clinical Nurse 6).

Three of seven participants (43% of the participants) also mentioned during the interviews that they noticed that their patients recognized the nurse's ethnicity, and would relate to and establish rapport when the patient and the nurse had the same ethnicity. This relation, whereby patients and nurses share the understanding and principles of a culture, illustrates how important having diversity in the workforce is to relate with a variety cultural groups. This was seen in the analysis of the ethnic nurses; for example, Clinical Nurse 1 stated, "I am Vietnamese and I can speak Vietnamese so that's been really helpful with my patients relating to me in my work." Clinical Nurse 2 also found her ethnicity to be beneficial for patients who identified with her:

> I work in certain clinics with a large Filipino population… when I have a Filipino patient I speak the language and the Filipino patients appreciate it. Me, being from the same cultural background as the patient they feel I understand them better, and they are happier because they can talk to me freely in their language as opposed to if they were talking to another [person from another] culture.

The understanding of culture as an innate and fundamental part of an individual is only a portion of what the participants collectively defined as "culture." The nurse's familiarity with cultural practices and norms serves to her advantage as she already has an understanding of what is culturally accepted, which she describes simply as better understanding her patients. Her understanding is then used as a catalyst to have open dialogue centered on cultural understanding. Having a diverse nursing workforce starts with having diversity in nursing schools and in the workplace, highlighting the need for diversity admissions and hiring processes. Participants expanded the term "culture" beyond an individualistic view to encompass attitudes and behaviours of an individual and a group. The next section will explore how nurse participants understand culture as made up of attitudes and behaviours.

4.3.2 Behaviours and attitudes. Some participants expanded their conceptualization of culture beyond visible ethnicity and innate features. Participants viewed culture from a broader perspective to include shared behaviours, attitudes, and beliefs, as explained by Clinical Nurse 3:

> A simple explanation would be that culture is just shared behaviours. It could be a large group of people; it could be a small group of people . . . and you can belong to several different cultures. You can be a skateboarder. It's not just ethnocultural. Culture is some form of shared behaviours; meaning you can belong to several cultures and subcultures. It

> is something that identifies you or something you identify with other people that all have in common, or similarities. That is an attitude that impacts your choices and your behaviours.

In her description, Clinical Nurse 3 expressed that a person belonging to an ethnocultural group (e.g. Spanish) does not limit that person only to Spanish norms. A person may identify as Spanish, but also identify as a skateboarder, which is not inclusive of all Spanish-speaking individuals. Therefore, a person can identify with an ethnic culture while also identifying with another subculture which has no connection to the former. This means that one person can belong to many different cultures through the basis of sharing commonalities of all sorts with another group of people. For example, Clinical Nurse 4 referred to the difference in behaviours between Canadians and Americans when entering a person's home. It is common knowledge that both Canada and the United States are considered western in culture but having that in common does not mean Canadians and Americans share the same practices. According to Clinical Nurse 4:

> Canadian culture is something that some people have a difficult time describing because it's kind of bland, but at the same time, we have a culture. When you go into people's homes, is when you realize the cultural differences. When I lived in the United States, even though it is also a western culture, it's very different. For example, you don't take your shoes off when you go into someone's home in Texas, and when you do they would always know you're Canadian. It is that small behaviours that let you see the subtle nuance differences.

Furthermore, participants classified culture as a broad concept that can have many sub-categories, meaning that there could be a broad cultural group with many different subgroups. Being culturally competent in practice requires nurses to understand that subgroups exist within

cultural groups, and, therefore, assumptions cannot be made about an entire group without taking into consideration the unique aspects a cultural group may have. Thus, a culture can have commonalities and differences at the same time, as explained by Clinical Nurse 3:

> Culture is just some form of shared behaviours you can belong to several cultures and subcultures. It is just something that identifies you or you identify with other people that all have in common, or similarities. That is an attitude that impacts your choices and your behaviours.

Behaviours can be taught or adapted over time. Participants felt that individuals and families migrating to a new country, such as Canada, want to learn about and adapt to the culture of their new environment, while merging it with what they already know from their countries and cultures of origin to form a blended culture. As described by Clinical Nurse 5:

> Most of [the clients] for us in the northeast are new immigrants. So, they're coming in thinking 'what's it like having a baby here [in Canada]?' And so, we're trying to, talk about what's normal here in Canada. What you can expect, and then find out what their expectations are. Most of these people want to fit in, they want to be Canadian. And they want to do things the way we do things.

However, behaviours, attitudes, and beliefs can be changed to reflect the host society, as Clinical Nurse 6 insisted:

> But I still have my own culture that was with me and part of that was my Indian ethnicity, but part of that was also my Canadian culture of where I grew up, the food I like to eat, the language I speak. My culture went with me, but I tried to broaden it—if I said that my only culture was Indian, or half Indian. That would be really boring to me, it would really limit who I am.

For the participants, culture is inextricably linked to perspective. An individual's perspective can include beliefs and attitudes which coincide with definition of culture in sociology (Horevitz, Lawson & Chow, 2013). Clinical Nurse 7 described culture as an understanding of the world through a person's perception and intrinsic beliefs. Moreover, the participants classified culture in terms of the patient's perspective of health. This identification of health is in line with Kleinman's Model of Explanatory Health and Illness (1978). What a patient identified as being of good health had to do with what the patient valued. For example, some patients viewed themselves as healthy if they had a roof over their heads and their children were fed and taken care of. Many felt they were healthy if they had quality time to spend with their families, as family was an important factor in how they viewed themselves. Clinical Nurse 3 shared the thoughts on her patients' view of how family interactions influence health:

> A lot of the times I will ask them, 'What does it mean to you to be healthy?' Some of them will say being able to have a family meal together. Some of them talk about their experiences in the refugee camps and that for them to be able to share a family meal is important to them.

In her example, the past hardships of the patient are often used as a reference point for what is considered to be good health. The attitudes and beliefs which make up culture showcase that quality family time is important in their culture, as it represents good health.

Culture has an influence on the way a person views the world. . Clinical Nurse 7 describes culture as "The frame through which people view the world and their health, [or] the worldview [that] includes religion, people's priorities, language, and the way a person looks at the world." Important personal values, such as religious beliefs and attitudes, influence identity decision making. Religion, as a part of a person's culture, can greatly influence health choices. For

instance, the termination of pregnancies due to poor prognosis may not be initiated or viewed as an option by a patient who is deeply religious, as it contradicts their faith. Instead, their worldview is to accept and embrace the situation as it happens, and not to try to change the outcome.

To summarize, participants defined culture as the attitudes and behaviours possessed by an individual or a group; how a person views the world can reflect the culture to which they belong. Identifying with more than one culture is a norm which shows that an individual has the capacity to be multifaceted. Having common shared practices allows for people to identify with and relate to one other. Nurses' understanding that shared behaviours within a culture can shed light onto their patients' health decisions is important. Understanding aids them in knowing how best to support health decisions in a manner that is inclusive and respectful of their patients' cultures, whether it be a major decision regarding medical intervention or a simple choice such as food. The relationship between behaviours and attitudes in a culture and food choices will be discussed in the next section.

4.3.3 Foods and traditions. Forty-three percent of the participants felt that the food choices patients make are closely related to culture. From the participants' perspective, various cultures have staple foods that are traditionally consumed. For example, Clinical Nurse 1 explained the prevalence of the consumption of noodles in Vietnamese culture, and how that consumption can affect patient health:

> I am familiar with Vietnamese food, and with Vietnamese food there is a lot of rice and noodles. So, when I see patients who tell me, "Oh I only have a bowl of noodles," I show them a portion that the Canadian Food Guide would recommend and ask how does that compare to a bowl of noodles that you are having. The bowl they refer to only has noodles

> in it such as pho. I know pho is all noodles and a few pieces of meat in soup. So that is where the talk about carbs and how it affects their health comes in and they realize, "Oh okay, that is a lot of noodles."

Cultural dishes are often associated with countries of origin; generally speaking, cultural dishes are comprised of and directly related to the food that is grown in a particular region. The participants believe that food directly corresponds with a person's culture. Clinical Nurse 6 used herself as an example, stating, "Part of my culture is Indian, and I love Indian food." Moreover, she expressed that when she moved to a new region, she broadened her culture by eating the local food: "When I lived in Costa Rica, I tried to embrace the Costa Rican culture even though I wasn't Costa Rican. I tried to eat the type of foods that Costa Ricans would eat." It was her belief that submersing oneself in a culture includes eating the food that comes from that culture.

Traditions are selective and personal, as are the foods eaten by cultural groups, and this makes diet and tradition a personal representation of an individual. The idea of personal representation was supported by Clinical Nurse 2, who described the significance of food by stating, "My thoughts and beliefs, coming from where I come from. My Filipino culture. Our thoughts and beliefs including traditions and food. Our culture is represented by what our traditional foods are."

Moreover, Clinical Nurse 5 found her patients to be warm and inviting when sharing their cultural dishes. These dishes are used to showcase the patient's culture, and to share it with the nurse, with the main point of building a stronger nurse-client relationship. The generosity Clinical Nurse 5 has experienced has led her to develop a new appreciation for other cultures through cuisine:

> I've learned so much about all the different cultures. And amazing food things, which has given me an appreciation of the different foods that are out there. People want to give food when you come into their home

The link between food and identity is recognized by the participants. Staple foods that patients eat are reflective of their cultural heritage, making it important for the nurses to incorporate those foods into conversations with clients about health and nutritional practice. Clinical Nurse 2 stated, "South Asian food such as curry and chapatti I've learned about and other foods my patients eat, so then I can talk to them about their food," expressing her understanding of the importance of incorporating culturally relevant topics into her care. Knowing the types of foods a patient eats can give the nurse information on whether patients are eating each food group according to the recommendations of the Canadian Food Guide. Nurses will be better equipped for talking to patients about food choices if they have a good understanding of various foods from the cultures with which they work. Clinical Nurse 1 suggested that she does her best to try and teach about food and nutrition, but sometimes, it is up to the patient to integrate western foods with their cultural foods:

> I give the patients general western examples of food. . . . If I'm seeing a person that is Vietnamese for example I use the examples of white bread or roti. So, I don't know a lot, but I do know a few small examples that would fit in the carb category that would affect their blood sugars. I might not give specific examples related to their culture, but I'll speak about starches, bread, or potatoes. The more common food groups, and then from that the patient can try to relate it to what they are eating.

From the participants' perspective, the types of food patients eat have a direct impact on their health. Nurses with knowledge of various cultural foods will be better equipped to relate to patients, and to have focused conversations regarding food choices that can impact health.

The participants feel that food choices are important to a person's identity, and, therefore, are a representation of their culture. As nurses, there is a duty to understand patients in a holistic manner, which includes culture and food choices. Understanding food choices can help to promote the nurse-client relationship; when nurses are more knowledgeable about cultural foods, they can better explain to patients how their food choices affect their health. Being able to take information provided by a patient and translate it into practice is an example of how cultural competence manifests in nursing practice. The next section will discuss how the understanding of culture is translated into culturally competent care.

4.4 Culturally Competent Care in Practice

It is imperative that nurses have an understanding of how their patients' culture influences their patients' healthcare needs. Recognition of cultural influences to health should also be addressed and cared for with respect to patients' culture. Respect and understanding of culture translates into the care nurses provide, and the outcome is effective patient care. The participants recognized that cultural norms from the patient's country of origin may not be the same as Canadian norms, resulting in some frustration for the patient trying to adapt to their new environment. In recognizing their patients' struggles with the unfamiliarity of Canadian cultural norms, nurses can adjust how they present information to their patients to best explain different cultural practices in Canada. Understanding that there are differences and then finding practical solutions while being respectful of the patient's culture is the basis of providing culturally

competent care in practice. It serves to improve patient care without threatening the patient's current culture. This is eloquently described by Clinical Nurse 6:

> I think as a health care worker, cultural competence doesn't mean that you must know everything about every single culture, because that's impossible. If maybe after you've been a nurse for 99 years travel and worked all over the world, you might have a better idea of every culture that exists [laughter], but I don't think that's possible. I think what cultural competence means is being able to practice in a way that is sensitive to somebody's cultural practices. And to, first, recognize they [the patient's cultural values] exist.

When becoming culturally competent, Clinical Nurse 6 recommended that nurses look at the patient's unique story, which encompasses cultural beliefs and values of health, and use that information to provide care that is tailored to the patient's specific needs:

> So, yes you need to understand the social determinants of health, but you need to go further than that. You need to understand that everybody has a story and that they are unique. And if you want to be a good and competent nurse, you need to remember that.

A patient's behaviour can be related to their unique story and past experiences. Experiences shape how people view the world, and they affect how people react in certain situations. Clinical Nurse 1 recognized a cultural nuance of her patients who expected prescriptions every time they visited a doctor's office, possibly because that was a familiar experience for them in the past. She recognized the behaviour of her patients, and reacted by providing specific education on proper self-care behaviours that the patients could implement without a prescription:

> I've seen patients who say back in their home country, no matter what the concern is, they would go see the doctor. Their doctor would then give them the prescription and they would take it home to be filled. We've been seeing patients here where something as little as a cold the patient would be expecting a prescription when they see the doctor. This is where I explain that there is not always a need for a prescription. I tell them about how-to do-good hand hygiene and the importance of drinking lots of fluids and resting.

Using open-ended questions to ask participants about their culture is seen as a sign of respect. Patients sharing stories and expectations of healthcare in their native countries can enable nurses to be more educated on cultural norms, and inform cultural knowledge understanding in nursing practice. Using open-ended questions was important to develop an understanding of the participants and to inform nurse participants' cultural competence, as Clinical Nurse 7 described:

> Not making judgments about a person's culture, but instead asking them about their culture and incorporating culture into their care. By asking open-ended questions about what they believe and incorporating their beliefs and cultural references into your care, you respect their culture and help them at the same time.

Providing a safe place where patients feel comfortable expressing their beliefs without judgment can help build rapport between the nurse and the patient, thus enhancing a helping relationship.

Taking the time to learn and to engage the patient in conversation to further understand their perspectives was also seen as an aspect of cultural competence in practice. Clinical Nurse 4 learned about the history of First Nations in Canada that has led to a lack of trust in the healthcare system through a presentation she attended in the past:

> It was a 20 or 30-minute presentation of the history of First Nations, and where some of their biases come from… in the 1960s some of the kids were taken from homes and were made to go to regular school. So, there is a lot of built-in conflict . . . Regarding their views on healthcare they don't ideally want to seek western medicine. They would much rather manage things with their own healer or healers.

Clinical Nurse 4 used what she learned in the presentation and applied it to her practice when working with a First Nations patient. Through her education, she learned that it is not uncommon for First Nations peoples to be less willing to divulge information to healthcare providers. The issue of lack of trust outside the First Nations community was a barrier to the nurse-patient relationship. Consequently, Clinical Nurse 4, recognizing the barrier, took the time to make the patient feel comfortable, and to explain to her that she was not going to be hurt or taken advantage of based on her culture. In her description, Clinical Nurse 4 highlighted that having the time to converse one-on-one in a non-intimidating setting also helped break down the barrier of mistrust:

> We had a First Nations woman on our program for six weeks and in that time frame, I think we shattered a lot of her negative beliefs of what the government is going to do to her! When you have to sit there and do the non-stress test you find things to talk about. So, I explained to her that we were not going to come in and take anything away from her or make her feel isolated. Sometimes being one-on-one with that person can make them more willing to talk to you.

Being culturally competent in practice meant that nurses could relate to the patient, ask for suggestions, and allow input so that the patient felt included in the process.

Clinical Nurse 3 referred to relational practice as a fundamental way of best caring for patients in a culturally competent way:

> There are so many different cultures. When it comes to this idea of relational practice, the hardest thing, I think, for people to do is to allow the power to shift back to that patient so that they can make the ultimate decision [regarding their care]. So, if you hold people in unconditional warm regard from the very beginning, it's easier for you to listen to their story, find out what their lived experience is then work with them to find out what some suggestions they might have. Or where do we go from here? What could work for you? And then allow the power to shift back to the patient.

To some participants, understanding what to do and how to provide effective care when differences arise is what it means to be culturally competent and to practice in a respectful manner. When asked what her understanding of cultural competency was, Clinical Nurse 1 stated:

> There are a lot of different factors competency is, I find, being really good at something. "Cultural" is diversity, backgrounds, and ethnicity. There are a lot of different cultures out there and a lot of diversity. I think cultural competency is the top [umbrella term] and under it would be communication skills, empathy, compassion, and all those characteristics as well. It is not just necessarily being able to speak the person's language but being able to work with someone that doesn't speak your language.

In summary, the participants described cultural competence in practice as incorporating the client's thoughts and beliefs into the patient's care, through a recognition of cultural beliefs and by making it a part of the conversations nurses have with their patients. The goal is to provide

the patient with effective nursing care, while also being respectful of the patient's culture. Actively thinking about culture while caring for ethnically diverse patients requires the nurse to understand the patient and to exhibit culturally sensitive attributes. The following section will discuss the attributes that participants found necessary in order to be a culturally competent nurse.

4.5 Attributes of a Culturally Competent Nurse

The participants' conceptualization of a culturally competent nurse encompassed a multitude of attributes which enabled nurses to effectively work with and advocate for their patients. According to nurse participants, a culturally competent nurse has the following attributes: (a) patience and effort, (b) understanding and open-mindedness, and (c) empathy and sympathy.

4.5.1 Patience and effort. Taking the time to get to know a client or spending the extra time to delve further into an issue was said to build true rapport, and to affect positively the nature of the nurse-client relationship. Clinical Nurse 1 reported that she finds joy in her nursing work when she feels she can connect with her patients. Exhibiting patience allows patients to express their issues and to ask questions without feeling rushed or neglected. Moreover, a nurse who is patient allows for an open dialogue that can expose knowledge gaps the patient may have, thereby providing the opportunity for direct education, as per Clinical Nurse 1:

> The reason I really enjoy my job is that I have time to spend with patients in terms of education as compared to when they go to see their physician. Most of the time they see their physician for five to ten minutes, get a prescription and they are out the door. That's why it's good when I get to see patients because I typically have 45 minutes to an hour with them for an initial appointment. So, I really get to know them, and see where

> education might be missing or lacking, and I then help fill in those gaps and answer questions that they may have.

Having patients with a language barrier is a challenge for nurses. With the barrier of language, a culturally competent nurse is one who is willing to take the time to find ways to explain information in the way the patient will best understand. These efforts in helping patients ensure high-quality care while leaving patients feeling appreciated, as explained by Clinical Nurse 7:

> I believe that due to the language barriers patients have to deal with, they don't get as much information. So, if you have an opportunity to take time and explain thoroughly it is beneficial for the patient and it feels good to be helping a population that is affected harder because of barriers.

Having patience and making effort to understand patients' concerns can prevent reoccurring visits for the same issue. Clinical Nurse 3 stressed this point and suggested that if patients do not understand the education being given to them, their issues will not improve. Reoccurring visits to the clinic for the same concern illustrate the failure to properly deliver care to patients in a form that they can understand. These reoccurring visits cause a burden of cost on the healthcare system, asserted Clinical Nurse 3:

> People must take a breath and take the time to look at what kind of tools can we use, how do we understand this person. You don't just rush them through and say oh well, I think they understood and go on to the next person, because that person is going to keep coming back and possibly get sicker because they don't know how to take their medications, they aren't taking medications properly, or they don't understand the symptoms. So over time, I have realized that the health service provider has a much bigger role.

The participants suggest that patience and effort are foundational attributes required to be culturally competent, as they allow for patients to be heard and to feel validated. Having an open mind and a willingness to understand the patient were also viewed as important attributes of a culturally competent nurse.

4.5.2 Understanding and open-mindedness. Having an open mind promotes conversation, and through conversation, nurses learn more about their patients, which builds understanding. The participants expressed that both having an open mind and understanding the patient were needed to ensure a non-judgmental attitude in working effectively with ethnoculturally diverse clients. Patients who feel judged may access the health care system less frequently in the future. When discussing the factors that make a healthcare provider culturally competent, Clinical Nurse 3 highlighted how being close-minded can have a negative impact on patients' future encounters with the healthcare system:

> At some point in time they [patients] are going to be ready to make a change, whatever that change may be, and if they feel judged, they are not coming back [to seek health services]. They may end up going somewhere else, or they might not access healthcare services for a long time.

Clinical Nurse 2 found it beneficial to have an open mind regarding how culture influences patients' behaviour. She developed an appreciation for her patients' diverse cultures, and how important elements of culture, such as food, are to them in greater detail:

> The South Asian population really enjoy roti and chapatti, a cultural dish that is like a large flat bread. I see that they eat big portions, three at a time, but that's too much for the blood sugars of a diabetic patient. However, understanding that eating this type of food is a part of their culture, I keep an open mind and try to work with them on how to modify eating

habits. I understand that I can't just tell them to stop eating their cultural food, as it is a part of their staple food.

Clinical Nurse 5 recognized that she had existing biases and was only able to look past her previous beliefs when she took the time to open up and listen to understand her patients. The willingness to be open minded and to change one's perspective, according to Clinical Nurse 5, is a sign of growing cultural competency in nursing practice:

> I have to say that working in the northeast for the last 25 years and being exposed to many different cultures has opened my eyes. Initially, there were some cultures that I used to think, "Oh, they're treating the women so badly because they value males over females, babies especially." But, then when you sit down and start talking to people and learning about their background I've appreciated what their beliefs are.

Being able to communicate with the patient and to understand what the patient is saying is paramount in developing trusting nurse-patient relationships. When discussing understanding languages, Clinical Nurse 6 simply stated that "language is always one of the biggest barriers in nursing when you work with ethnoculturally diverse populations." Thus, to truly recognize what their patients' needs are as healthcare providers, nurses need to be able to understand what their patients are telling them. At times, the patient may not speak English fluently, causing some setbacks in the conversation. The nurses, realizing that they are not always confident in what the patient is telling them, then take extra steps, making an effort to understand in order to provide effective care. Clinical Nurse 3 described her experience working with communication barriers and how she overcame such barriers:

> Do I understand what it is that they're trying to tell me? Even . . . [in some cases] English is their fifth language. They probably speak at least two or three, English being one of

> them. I don't always really understand the accent. I'm certainly getting better because I'm used to hearing it now—and I feel more comfortable saying, "Can you help me understand that? I'm not sure that I'm understanding you." I think that I was trying to be polite before, thinking that I understood, so now I just say, "I don't get it. Can you help me understand this?"

Without effective communication, patients risk not being heard, as per Clinical Nurse 5: "And when someone feels like they can't be heard? That their concern, or their fear, isn't being heard and understood? That doesn't feel very good. That's not going to help them." Language Line is an interpretive resource available to all the participants. Language Line is an over-the-phone service whereby nurses ask for an interpreter who speaks the language of their patient so that the nurse can communicate effectively with the patient in the patient's native language. The medical interpreter ensures that correct information is being shared and understood.

Language Line is a resource used by the participants to reduce possible misunderstandings and the fear of not being able to express concerns on the patient's part. There is a sense of relief with Language Line, as it is a much-needed tool in the work performed by nurses. The service allows for nurses to communicate in situations that otherwise would be difficult due to language barriers. Clinical Nurse 1 described the need for and use of communication aides:

> The patients that I see are either newly arrived in Canada or have been here no longer than two years. Pretty much all the patients that I see I must use the Language Line. It's a telephone translation service and that's what we use to help with the conversation. Most of the patients are taking ESL classes, but definitely, we still need to use the Language Line to help with translation.

Understanding the patient's level of comfort is an astute observation that the nurses must make and incorporate into their practice. Clinical Nurse 5 recognized her patients' varying levels of comfort, and understands that having familiar people who share the same culture or language connected to and supporting each other promotes a sense of community:

> Patients living with low income and also a language barrier come to Canada for a new life, but because they don't have the language or the education, they really lack confidence to come out and kind of participate in their [Canadian] culture, in their new place and so I think it really helps that we have people speaking their language that can invite them to come to group. So that they start learning more and connecting with other people.

Understanding what the patient may be feeling is a form of empathy, which will be discussed more in depth in the next section.

4.5.3 Empathy and sympathy. Being empathetic requires the participants to put themselves in their patients' shoes in order truly to understand the patients' experiences. Empathy is a driving factor in providing culturally competent care, as it allows the participants to take a step back and understand the struggles that impact their patients' lives. Clinical Nurse 1 spoke about the experiences of her immigrant family regarding the barriers immigrants face. The experiences and hardships of her family have led her not to want immigrants to struggle when coming to a new country, and, accordingly, she strives to make patient experiences with the healthcare system less cold and uninviting:

> Hearing about my parents' struggles of coming to a new country—not knowing any English, not having any money and seeing how hard they had to work—really opened my eyes to every time you see a patient. I really try to do the best I can. I never try to make their appointments rushed. If there is something that they didn't understand or something that they are

upset about I really try to understand where they are coming from and what their perspective is on the issue. Not necessarily to tell them that they're wrong or this is how you do it. I just tell them I see where you're coming from.

Clinical Nurse 5 spoke of mistreatment of patients by other healthcare providers because of language barriers. During the interview, her demeanour suggested that she felt a level of unjust treatment towards culturally diverse patients. She shared her experience by saying:

> Over the many years that I've worked, to see some people caring for their patients from a different country. They don't speak the language [English], and so they can't communicate well, so then the [healthcare provider] thinks, "Well, they don't know anything. Or they're not very smart," because they can't communicate. Instead of taking the time to use the Language Line and find out how this person is doing and what their questions are, they are judging them, which is unfair and inexcusable. I believe you can actually care for non-English speaking immigrants at the same level as anyone and not treat them like a second-class citizen just because they are not able to communicate with you.

She sympathized with her patients and knew that she would not want to be treated negatively if she were not able to speak English. Consequently, reflecting on those experiences has informed her practice and highlights her experience with cultural competency, driving her to use available resources to engage her patients and break down barriers by advocating for patients who may not be able to advocate for themselves.

To the participants, open-mindedness, sympathy and empathy, and patience and understanding make up the attributes of culturally competent healthcare providers in the workplace, where the goal is to facilitate positive interactions for patients utilizing healthcare services. On the nature of cultural competency, Clinical Nurse 1 stated, "I think it's an awareness

that there are many different beliefs and values that people hold. And I think ‘competence’ just means that you’re willing to accept that people have different values and different beliefs than you do.”

Acceptance of diverse cultures broadens a nurse’s worldview, and being able to see health from different perspectives is the result of knowing that culture can impact health behaviours and attitudes.

Nurses’ recognition of cultural difference allows for cultural care to be valued. A nurse’s interpretation of understanding the patient and meeting the patient where they are holds great bearing. As Clinical Nurse 6 pointed out, “We’re not meeting their [the clients] needs effectively if we’re not culturally aware.”

All of these attributes make up an ideal of what it is to be culturally competent in the workplace, and to establish better rapport to facilitate positive interactions for patients coming into the healthcare system. Being aware of cultural difference is the first step in cultural competency, as per Clinical Nurse 5:

> I think cultural competence is an awareness that there are many different beliefs and values that people hold. And I think “competence” just means that you’re willing to accept that people have different values and different beliefs than you do.

When there are contradicting beliefs and values between the patient and the nurse, challenges can arise which affect the nurse-patient relationship. Challenges within the ethnically diverse population are numerous, and the next section will discuss the challenges participants found while working with ethnically diverse patients.

4.6 Challenges

This section will discuss the challenges participants described while working with patients of ethnoculturally diverse backgrounds. Participants identified many challenges, which have been grouped into the following categories: lack of formal education, limited understanding of cultural nuances, language barrier, and power imbalances and assumptions. Each of these findings will be discussed in more detail below.

4.6.1 Lack of formal and informal cultural competency education. One challenge faced by the participants was the lack of formal education, such as workshops or seminars provided by their employers, focusing on cultural competency. Participants shared that they are not required or mandated to have specified cultural competency education in order to work in their field, despite the high immigrant population. Clinical Nurse 1 described the lack of education she has regarding cultural competency:

In terms of workplace-provided education, I haven't had any formal training in cultural competency. This job is more so a learning-on-the-go kind of thing. All the little tips and tricks I have I've learned on the job.

The "learn-as-you-go" style relies heavily on personal experience and exposure to various cultures. The learn-as-you-go style forces nurses to recognize whether cultural differences are present, and then to cause them to adapt the care to respect their patients' culture. For some nurses, stark cultural difference is not always present and familiarity with their patient's culture can help build easy rapport. In the case of Clinical Nurse 2, she felt fortunate to speak the language of her clients, allowing for rapport to be formed easily and for conversations to be had more easily because she understood her clients' culture:

> No, it's more of a "learn as you go" at work but I am fortunate I know the language of some of my clients who share the same ethnicity as me [making rapport and dialogue more easily had], but for other cultures it's just a "learn as you go."

Being fortunate to speak the language may help in circumstances where the nurse and the client share the same ethnicity, but in the participants' practice, being of the same ethnicity with the patient is not always the case. This can leave some nurses feeling unprepared to work in cross-cultural situations, highlighting the need for training in relational practice in cross-cultural situations. Ideally, employer sponsored education with specific focus on the client population would be appreciated. The necessity of employer-sponsored training was supported by Clinical Nurse 6, who stated, "I think that you can't expect that people will just come into the workforce being culturally competent. Therefore, the need for mandatory employer training is necessary."

Participants noted that there was relatively limited employer-funded cultural competence education that is easily accessible to nurses. As well, participants felt that the culture of their workplaces did not place sufficient value on cultural competence education for staff. Participants felt that with the apparent lack of value around cultural competency education in the workplace, staff were less likely to pursue cultural competency education. Participants felt that lack of emphasis on cultural competence in the workplace leads nurses to disregard the importance of cultural competency in practice, and, therefore, not to make time to learn more about the cultural competence outside of their other required duties. As put into perspective by Clinical Nurse 3:

> Some areas are a lot more open to having cultural education and information available, and nurses have taken it upon themselves to learn more about culture and health. I understand that the staff is busy at work, having many mandated things to do. Anything that relates to diversity work, cultural competency, cultural safety is not something that has been adapted

> by people in senior positions, who are in the position to say all staff should seek cultural and diversity training. Senior positions have not made the process of getting education accommodating. Management has not offered to bring in relief staff so that staff can take three hours to go to a diversity seminar or workshop. It is not evident that management will make sure that all the staff gets this sort of training. The importance of the education has not been adopted from management so, even if are people interested, it is difficult for them to get the time to go.

Furthermore, participants rarely recalled having specific cultural competence education in nursing school; Clinical Nurse 6 expressed, “I don’t think that we come out of nursing school prepared.” In terms of education in the workplace, findings suggested that there are resources available; however, they are difficult to find, inconvenient, or too general in nature, which is not appealing to the participants. This lack of education forces the participants to rely mainly on personal experience; as per Clinical Nurse 2: “I know we took like Alberta Health Services diversity course, but it’s very general and it’s not enough. So that is why I think experience plays a large role, but I wish there was more education.”

Participants also described the few workshops available to be too generic, and they did not get at the fundamental and essential skills related to culture in healthcare. The courses did not provide what nurses would want to know about how culture affects the health of their patients, leaving them feeling discouraged in their learning. Regarding the workshop she attended, Clinical Nurse 7 said:

> I had it in mind that it would be really great to learn about different cultural beliefs about TB, because we’ve seen a lot of patients from different cultures greatly affected by TB. Knowing about the different cultural beliefs would give us nurses an idea of where the

> patients are coming from. However, that idea was very much discouraged in that class. I didn't understand why. [The class facilitator believed that] you can't assume that every person from the Philippines believes the same thing about TB, and you should talk to that person about what they believe. But it would be nice to know what people were coming from.

The participants have had different exposures and past experiences with different cultures, which gives some insight into their understanding of cultural norms. However, because knowing about every single culture is impractical and impossible for the nurses and because of the lack of cultural competence education, there are inevitable knowledge gaps. The participants expressed that these gaps were a motivating factor in wanting to learn about culturally relevant issues, practices, and norms in order to best understand their patients' perspectives, and to nurture the nurse-client relationship. When asked about cultural education for staff, Clinical Nurse 5 said, "I don't think that we are doing enough to educate all health staff," clearly asserting that there is a knowledge gap that should be addressed.

Lack of knowledge and education forces the participants to be resourceful, and always to be learning while working. Obtaining information from patients was considered invaluable and much appreciated, but participants expressed feelings of uncertainty and a sense of unpreparedness to work in cross-cultural situations, as they had received no cultural competency training specifically related to their work. In particular, they felt unprepared when they were uncertain of who they were meeting on home visits; according to Clinical Nurse 4, "We see African women, and again, you don't really know if they're, like, the French African or not?"

Participants felt that cultural competency education would help form a basis of understanding on cultural nuances and norms, as well as improve awareness of non-verbal

communication. Cultural competency education would allow the participants to anticipate behaviours and health-related choices, and it could be also be used as a reference guide when working with diverse patients. Participants found that not having a baseline understanding of their patients' cultures led to difficulty in building rapport and trust among their patients.

4.6.2 Limited understanding of cultural nuances. Due to their limited understanding of cultural norms and nuances, participants reported finding themselves in awkward situations where their inability to understand a patient's or family member's body language and behaviours might result in a misunderstanding, with one party thinking the other is being rude. Clinical Nurse 4 voiced concerns about not wanting to present as arrogant or rude when working closely with patients and their families. She compared two different cultures with different responses to her being in their home:

> When you go into someone's house, the last thing I want to do is offend anybody. In my experience on a home visit to an East Indian patient's home, the grandparents are present, and they do not speak English at all, and their body language seems suspect of me, and I don't know if that's just a cultural thing. I don't know what it is. They never talk to me and they never smile, whereas if you go into an Asian woman's home. Where the grandparents, again don't speak English, they're usually smiling and they're nodding and they're like, very accepting.

It is clear she is unsure whether the behaviours towards her are culturally related, and this experience highlights the differences of non-verbal communication among South-Asian and Asian homes respectively. Regardless, not knowing why a family member is behaving in a certain way towards the healthcare provider may cause some uncertainty and discomfort for the nurse. The patient and family not being of a mainstream culture causes for more of a challenge

for the nurse in predicting what is deemed culturally acceptable. If healthcare providers are aware that common attitudes and behaviours, such as not smiling or having a closed demeanour, are related to the particular culture that their patient and/or family belongs to and not to a patient or family being offended by the healthcare provider's actions, it would lessen the worry of the nurse, as she can be assured she has not offended anyone.

Conflicting beliefs of the nurse and of the patient can hinder the nurse-client relationship. Understanding common cultural beliefs may allow nurses to find ways to support their patients by being aware of their biases. Awareness of bias is recognized as an important step to practicing and delivering safe, quality nursing, as explained by Clinical Nurse 3:

> Everybody has biases and stereotypes. It is how we make sense of the world. It is important that you be aware of it, and how it impacts the care that you give. It doesn't matter what your role is at Alberta Health Services, whether you're in finance, nursing or in the lab. At some point in time you're going to encounter somebody who's different than yourself and you need to be able to work with them.

Being aware of biases allows healthcare providers to set their thoughts and beliefs aside in order to focus on the thoughts and beliefs of the patient, thereby allowing the patient's concerns to be the focus without judgment.

Clinical Nurse 7 spoke of an experience during which her professional nursing knowledge on health practices were opposite to those of her patient. Her experience is an example of the challenges healthcare providers face when their nursing knowledge and the patient's cultural nuances and beliefs do not align:

> In my home visits I notice that everyone seems to think the baby is very cold, so they feel they must wrap the baby up, and that's different than the SIDS teaching that we would

> give. Also, the topic of formula feeding is a huge issue. Some patients believe that they don't have milk right after birth, or that colostrum is not good for the baby. So, I always feel at a disadvantage when it comes to addressing certain beliefs and behaviours, because I don't really know the cultural beliefs that they have. And of course, I'm not in a position to counteract them, and say, "Oh, your cultural beliefs are not based on science." But then my teaching is in opposition to what they're doing, and I want to support them practicing their culture when it relates to their new baby.

Cultural competency education would have aided Clinical Nurse 7 in this situation by providing communication strategies to best address the cultural differences of the nurse and family, and to find supportive ways to best provide health education while respecting the patient's culture.

All participants felt that understanding the patient's experience is beneficial, as it allows the nurse to view health and healthcare practice through the eyes of the patient. When the participants shared cultural similarities with their patients, as discussed before, they believed their patients appreciated them and would share freely. In contrast, not being able to identify with the culture of the patient may cause the nurse to face a void in understanding patient challenges. Limited understanding can result in inability to recognize patients' needs. Clinical Nurse 7 reflected upon the difference between herself and her patients, and how not having the same lived experience may unintentionally lead to not recognizing or focusing on the patient needs:

> I just haven't faced [the hardship some of my patients have faced] being decently educated, from a middle-class background, English speaking. I just haven't encountered a lot of the barriers they have, and I think I, in a quiet moment I can sit and reflect on how hard that must be for other people, but I haven't really lived it . . . In the rush, to get things done,

> you can overlook the challenges that they must be feeling. Maybe it's emotional, but because I haven't lived those challenges, it's easier for me to overlook [not intentionally] but because I haven't experienced it.

To reiterate, nurses having limited cultural understanding of patients' cultures can hinder the nurse-client relationship, as it can result in lack of recognition of patient challenges and the significance of culture on their patients' health. The participants' comments about patients encountering barriers is insightful, as is the recognition that these barriers result in difficulty for patients navigating the healthcare system. In particular, the barrier of language, which is a crucial part of understanding, is a challenge. The next section will look into the topic of language barriers and how they affect health.

4.6.3 Language barrier. There are thousands of languages in the world, and the participants recognize that they will come across patients on a daily basis who do not have the ability to communicate with them in English. One of the most stated and apparent barriers in working with diverse populations is the language barrier between the participants and their patients. According to the participants, the inability to communicate effectively with patients results in difficult or challenging appointments. The language barrier keeps the patient guarded and does not always allow for pertinent information to be communicated, resulting in decreased rapport and the inability to share sensitive topics that may be important to the care being provided. The challenge that is the inability to communicate effectively was highlighted by Clinical Nurse 4:

> If there's a language barrier we'd say everything we want to say at the visit. But then we don't get to go into just small talk, where you sometimes get to pull out information that you wouldn't normally, so there tends to be less, therefore, less building of a rapport and

where they feel safe to ask me questions—or what if she was a victim of abuse, for example.

The language barrier issue can be ameliorated by using language resources, both written and oral. Although these resources are appreciated, they come with challenges for the participants, which will be described below.

4.6.3.1 verbal language resources and time constraints. Language Line is an over-the-telephone interpretive service that offers several different languages to healthcare providers during face-to-face patient interactions. Ease of use is clear; according to Clinical Nurse 1, "Language Line is a really easy service to use. You just dial a number and the operator will ask you what language you want, and they will find someone who speaks that language." The difficulty comes when the participants are pressed for time during appointments, as a three-way conversation is now taking place. This means that all questions, discussion, and answers are going through the telephone interpreter. As stated by Clinical Nurse 1, "Time is definitely a big challenge, because of the use of Language Line and having to have a three-way conversation." The nurse asks a question and waits for it to be interpreted to the patient; the patient then responds by speaking to the interpreter, and then, finally, the interpreter translates the responses back to the nurse in English.

Patients sometimes take offence to the use of Language Line and refuse the service for their appointment. According to Clinical Nurse 3, patients who felt that they spoke English well enough to carry on a basic conversation declined the service or were offended when she wanted to use the service for quality assurance purposes. Patients refusing to use the Language Line Service left her in a bind, because she did not want to offend the patient and ruin their rapport. However, she knew that having a medical interpreter would best help facilitate the conversation.

She, at times, had a hard time discerning accents and understanding phrases her patients were saying, even though they were speaking English. Clinical Nurse 3 shared her experience, stating:

> I was early to adopt the use of Language Line, and a couple of times had people say, "Well, I speak English." You know? And, so that was that's always interesting. That people feel insulted that I would want to use Language Line. And I try and explain that it's more so to be able to provide the best care. I need to be able to understand what it is that they're telling me, and I sometimes find that difficult.

The rejection of Language Line for the use of family members is a common issue some participants faced. Request to use a family member as an interpreter made some participants uneasy, as it goes against the workplace policy of using a certified medical interpreter for ensured accuracy. The insistence further strained the building of rapport while the participants sought to work in accordance with organizational policy. Clinical Nurse 7 shared the challenges she faces using Language Line with family involvement:

> Using interpreters, that's another whole issue. Family versus the Language Line. Well, a lot of people decline the Language Line and they want to use their family. And especially now, our policy is for us to get more firm and not allow family interpreters, which I understand and support. However, when patients insist in using their families it's awkward and intense. It should be, you should use the Language Line, but a lot of people, the clients aren't wanting to . . . they want to use someone that they know and trust as an interpreter.

Regarding selecting a Language Line interpreter, participants do not have a choice as to who they will speak to when they phone into the service. In most cases, not selecting an interpreter is not an issue, but among certain ethnocultural groups, as made starkly clear by

Clinical Nurse 5, it is not culturally acceptable to speak to a male about female reproductive issues. Therefore, if a female interpreter is not available, the nurse knows that prevalent information will simply not be divulged. Inadequate information has caused a great challenge in providing care and can be frustrating, especially for the participants whose area of practice is maternal/women's health, where all female health information is relevant and pertinent to the care that is being planned and provided. According to Clinical Nurse 5:

> Sometimes we have to use Language Line and that is really difficult to work with. Some of the cultures that we work with wouldn't speak to a man about these things [reproductive health]. I mean we're talking about sexuality or pregnancy. So, having a male interpreter can be awkward for the woman. And I feel like she's not going to tell us really what's happening, but often there are no options for a female interpreter. I've tried to do it [request for female interpreter] and no luck, it's goes to whoever gets the call at that time. So that's difficult. And it's really hard to be speaking through a machine to someone.

The experience of Clinical Nurse 5 speaks to the need for culturally competent ways to service women and women's health issues that respect the privacy and dignity of women. Increased availability of female interpreters in women's health clinics would help ease such tensions and respect the patient's culture.

4.6.3.2 Written resources and literacy. There are mixed reviews on the quality and use of written resources such as pamphlets and handouts. Clinical Nurse 2 found written material in her area of practice not practical for predominantly non-English speaking patients; she said, "I try not to use written material a lot, because it is in English . . . [instead] I use a lot of pictures and try to not give many handouts." She has found other resources, such as Language Line, to be

more useful, and she has relied on her conversations with patients to extract information and to provide education in a more personal manner.

There were a limited number of written resources in various languages, and the addition of more languages would be welcomed by the participants, as they recognize the need for resources that their patients can understand more easily when English is not their first language. Clinical Nurse 1 indicated that she would appreciate more written resources, saying, “For our English-speaking patients, we have a lot of handouts in English; but I find that there are not a lot of handouts in other languages. So, if there could be more resources that are in other languages that would be really helpful.”

Written resources translated into multiple languages are valued as they provide education in the native languages of the patients for greater understanding. When there are written resources both nurse and patient can use, the participants felt reassured that the patient had a reference to go back when appointments were over. Clinical Nurse 7 stated:

> We had a breast-feeding handout that was translated into the five or six top languages. . . the pamphlet is a double check [for the patient]. The patient may think they understood what the nurse said, but then go home and read the information to make sure they understand.

Patients using pamphlets for verification of information is only valuable when literacy is not an issue. Caring for patients with low levels of literacy is a reality for the participants. Therefore, the participants suggested that because low literacy rates are common among their patient population, written material is not the most beneficial, as there is no certainty that written resources will be read. Clinical Nurse 7 stated:

> I'm aware that literacy is an issue that you should take into consideration. I know, it has happened a lot with older women from India. I'll try and give them resources in their language, and either the son or someone else will tell me she can't read. So, I know that sometimes literacy is a problem. I try and do my best health teaching first, but people usually seem pretty happy to receive something that's in their own language.

The recognition of literacy levels among various cultures was an important step to having awareness as the nurse. Clinical Nurse 7's recognition of differing education levels among Canadians and other countries led her to adapt her teaching style to best provide education that her patient could understand. Supplementing the education with written documentation for the family to review with the patient was also appreciated.

To summarize, language barriers are a significant challenge for the participants, as language affects how they are able to deliver information. There are resources such as Language Line available, and while the service is appreciated, it adds to the length of the appointment. Written resources are often made available in the workplace to help educate patients. Written resources are appreciated by patients who can read them, but were of less value with populations with low literacy rates. Language barriers contribute to how well a patient can participate in and control their healthcare plans through the discussion had with their healthcare providers. It is important that patients are able to have some control and power in their care, but due to language barriers causing a decreased ability to express and articulate concerns about healthcare, an imbalance of power can be created. Power imbalances will be discussed in the next section.

4.7 Power Imbalances and Assumptions

The participants insightfully recognized the power imbalances that occur between the nurse and the client. For some participants, being an educated and well-spoken Caucasian person

was found to be intimidating for the patient, and possibly prevented them from feeling comfortable enough to share their opinions, especially if they were coming from a country where respecting people of authority is paramount. With experience, some participants were able to recognize the imbalance and to break down these barriers by speaking with patients and allowing them to feel heard. Clinical Nurse 3 emphasized the finding of power imbalances:

> I think being a white English-speaking woman with an education, you don't realize how intimidating that can be to people. I never thought about myself that way until somebody pointed it out to me. Patients have come to you because they need something from you. There's a power imbalance there. So, if you hold people in unconditional warm regard from the very beginning, it's easier for you to listen to their story, find out what their lived experience is, work with them, find out some suggestions on where do we go from here? What could work for you? And then allow the power to shift back to the patient

On the contrary, one non-white participant had an unfortunate experience where a Caucasian patient discredited her nursing work because she is a visible minority. Although the unfortunate experience is an isolated incident in the study, it is highlighted due to its relevance regarding how a person can perceive another and act based on stereotypical assumptions and cultural differences among individuals. There is a grim reality that in some countries, not being Caucasian is viewed as being inferior. The belief is historically rooted and can be linked back to colonialism. A person viewing an entire ethnicity and giving it a value or rank is dehumanizing and hurtful. A poor assessment of the nurse can hinder the nurse-client relationship, as it does not allow for rapport to occur. While Clinical Nurse 6 shared her story, she seemed hurt and frustrated by her experience, showcasing how the patient's behaviour can also affect the nurse.

Clinical Nurse 6 described her perception of patients that are doubtful of her ability to provide quality nursing care, simply because she is of a different ethnicity:

> They assume that I'm not going to give them good service because I won't understand them [and their experience] because they're Caucasian and I'm not . . . [That way of thinking] affects how I'm able to deliver services to them, mostly in a negative way. It makes barriers when people don't understand the difference.

In her experience, a patient being doubtful of the healthcare provider may lead to the patient not respecting and accepting the education the nurse is providing, which negatively impacts both the nurse-patient relationship and health outcomes. When the credibility of the healthcare provider is questioned, the patient may lose respect for the nurse, and this loss of respect might impact how they receive education provided. The participant was concerned that the patient would not respect the education she provided, and which was meant to help the patient.

Respecting authority is an ingrained value in many countries around the world. Obedience and respect being a core value in a patient's culture may deter patients from expressing themselves in health-related situations in order to avoid being considered disrespectful. Clinical Nurse 2 found that some patients she worked with valued the importance of authority; however, at times, the respect for authority perpetuated the power imbalance between healthcare provider and patient. As explained by the participants, the respect for authority might result in fear to share thoughts or concerns with their doctors. Clinical Nurse 2 highlighted the common behaviour she has noticed with her immigrant patients:

> They [immigrant patients] are afraid to speak up to the Caucasian or other cultures. They see the doctors as the main person so, whatever the doctor says is what goes. The doctors have the most important opinion and they believe they are just supposed to listen.

Nurses with cultural knowledge and awareness of the belief can encourage patients to take a role in their healthcare by asking them what they feel is important in their care.

To conclude, participants described many challenges when it came to working with ethnically diverse populations. Language barrier, literacy rates, and lack of cultural knowledge and nuance, along with power imbalances between healthcare providers and patients, impact how effectively care can be provided. Through the challenges, the participants suggested methods to incorporate and respect culture while providing care. The attitudes of the participants showcase their willingness and desire to be culturally competent in the workplace. The following section will discuss the readiness to be culturally competent.

4.8 Readiness to be Culturally Competent

A great strength among the participants in this study was their obvious desire to know more about the cultures of the patients for whom they care, and how to provide culturally competent care. All of the participants were devoted nurses who faced challenges in their practice related to cultural differences (e.g. language barrier, understanding cultural nuances, and lack of cultural knowledge). Despite the apparent challenges, the participants remain resourceful in seeking out methods to best assist them in caring for their patients. The following section will look at the strengths of the participants in three sections: active learners, resourcefulness, and desire to care.

4.8.1 Active learners. All of the participants expressed the willingness to attend cultural education sessions, if given the opportunity. Some had already attended culturally focused seminars and cultural workshops prior to their interview of their own volition. The participants recognized the impact education has on the care they provide, and, thus, would feel more confident and better prepared to work in cross-cultural situations if they were to be given specific

cultural education that pertained to their work area. Clinical Nurse 4 recalled a seminar on First Nations populations that she attended and found to be very beneficial. The knowledge she obtained from the seminar was beneficial, and she expressed that having seminars on different cultures would assist healthcare providers in forming a good understanding of their patients' perspective:

> I would love to be more competent. I attended a 20 or 30-minute presentation, I learned so much about the history and perspectives of First Nations and where they're coming from. I think we [as nurses] would like to have the key points that would be great to know in our practice such as when they nod their head or if they look away, it is not a sign of being rude, but rather of respect. Knowing specific behaviours like that would make me more competent.

The participants expressed that if there were opportunities to attend cultural education sessions, they would be willing to attend. However, what is currently available is limited in terms of number, and the available sessions can be difficult to find. Clinical Nurse 3 stated, "there really isn't a lot of formalized education that is easy to get at it."

Clinical Nurse 4 expressed that cultural education would be welcomed in the workplace, as it would help the nurse-patient relationship. She stated, "I think that most nurses would welcome cultural competency education because it would make their job easier and remove some of the barriers that they feel they come into."

The participants actively searched for cultural education to increase their cultural knowledge. Taking the initiative to learn about other cultures demonstrates the participants' desire to provide better patient care. Although the number of workshops is limited, the participants still find ways to expand their knowledge on different cultures. Clinical Nurse 6

recognizes the importance of cultural education in her practice, and takes measures to ensure she is well-informed and able to relate to her patients:

> Any formal education I've done has been of my own personal volition, because I've worked in areas of nursing where there's diverse cultural populations, [and] I've felt the need to understand it better. So, I've done readings it's also part of my graduate studies, I've taken some courses, and the ones that are offered through Alberta Health Services.

In order to provide better patient care, the participants will have to be resourceful in finding various avenues to gather information to increase knowledge. The topic of resourcefulness will be discussed in the next section.

4.8.2 Resourcefulness. The participants are very resourceful in their practice. Their use of what they have available to best educate themselves and their patients was evident. For example, some demonstrated their resourcefulness by asking co-workers for their expertise on familiar cultures. The participants and fellow practitioners share personal experiences to help build a knowledge of cultural norms and beliefs within different cultural groups, as described by Clinical Nurse 2:

> We have our colleagues, we have a team, and we meet once a month and one of the topics that we discuss is culture. One of our areas of focus is to share our culture with each other to increase our knowledge.

Sharing amongst peers builds a safe space to speak openly about experiences without the fear of judgement. To the participants, having a safe space is an ideal way to speak about experiences and to share information amongst peers to better build patient relationships. Clinical Nurse 3 expressed the importance of sharing with colleagues by highlighting the challenges that nurses may face when working with culturally diverse patients:

> Some examples of things nurses would say are: “I really have trouble working with so-and-so or with this group of people because I don’t understand them,” or “I don’t understand what they’re saying,” or “I don’t understand why they choose to do what they do.” Or “I really struggle because I do not believe what they believe and it’s hard for me to relate.” So, we need those opportunities to express that with other people so that we can troubleshoot how are we going to deal with them the next time they come in the door. It’s all about growth. It’s not about blaming somebody. It’s not about saying “you’re not good at this.” It’s all about growth and providing patient-centred care.

Using peers as resources to discuss cross-cultural situations is beneficial when the opportunity is available. For some participants, resources are not always readily available, but the passion for nursing care drives them to create resources for patients and other staff when they see the need. Creating resources to help patients leaves the nurse with a feeling of satisfaction and sense of worth. Clinical Nurse 7 found a way to bring various translated reading material to her clinic through working with other organizations:

> I came from postpartum where we had these great “Best Beginnings” books that were in all these different languages. So, I was used having them when I came across a client that I found difficult to communicate with verbally, you could give them one of these books. And I loved those. So, when I went to this clinic and found out that all their resources were in English, I said this is unacceptable. This is the most diverse group of patients I’ve ever come across, and you can’t only have English resources. So, I worked with Toronto Public Health and I got some translated reading material for the patients and nurses. I was so proud of myself.

Another resourceful action the participants took was speaking directly to the patient and using the patient as a resource. Clinical Nurse 4 said, “I also use the patient as a resource. Like, as you develop a rapport with people, you can ask them questions.” To understand some of the underpinnings of a culture, direct questions sometimes need to be asked to evaluate patients’ actions and decisions regarding health-related issues. Being resourceful and asking honest questions shed light on a very personal practice of another culture, according to Clinical Nurse 4:

> I’ve had East Indian women that don’t tell their other children that she’s pregnant. And this woman was quite far along, and I said, “Well– How – how do you keep this . . . why do you do that?” And she said just in case something happens with the baby, they don’t want to have children grieve for that child. And I’m thinking to myself, you learn those things just straight from them. But that’s honestly where I get most of my information now is from the actual patient . . . I mean it’s not a bad place to get it.

The resourcefulness of the participants is beneficial not only for them, but also for their colleagues with whom they can share their experiences and who can then apply them in practice.

4.8.3 Desire for more education. The participants used resources within their workplaces, such presentations held by staff, to increase their cultural knowledge as mentioned in the previous section. They also advocated for and expressed their desire for more education: “I would love a cultural day… I would love to be more competent,” stated Clinical Nurse 4. Education that is tailored to their respective areas of practice is what was most commonly lauded as beneficial. Clinical Nurse 2 listed specific topics that she felt would be beneficial, as they would better equip her to work effectively in cross-cultural situations:

> I would like to see something like that presentation the doctor presented about the culture. Discussing what food they eat, what they like to do for exercise, their lifestyle and how

> they manage health along with some statistics about chronic disease in that population. I would like to see more education on that because if you learn more about the culture then you are better equipped to meet with the patient.

Not all requests for education were as specific, but from the participants' responses, it was gathered that a general, concrete knowledge about cultures that are prevalent in their areas of work would serve the participants well in their practice. Some participants expressed that the courses they attended in the past gave them some insight into other cultures, and they felt that more courses would help improve the cultural competency of everyone in the organization as a whole to improve patient care. As stated by Clinical Nurse 5:

> Diversity liaisons . . . do presentations for nurses and different health care professionals that I think they are awesome. Like, we need to do those for everybody. It's more of a generalized discussion about cultural diversity and how we can be sensitive to people's beliefs. So, it's helpful. I think that we honestly should have more courses like that.

Having learned information through past cultural courses was appreciated, but some of the participants felt that concrete skills and tangible tools needed to work with ethnically diverse populations should be added to future courses. The participants felt that teaching concrete skills would make for better learning and provide practical ways to deal with cultural diversity in the workplace. According to Clinical Nurse 7:

> I feel like that one course I took, I understand why it's important that, they took away that, 'Oh, you can't think you're caring for someone who's diverse as like this.' But the philosophy of the person that was teaching the class was kind of moving more towards cultural safety, and not thinking because someone belongs to a cultural group acts that you know everything about them . . . Diversity is a lot of different things; it's not just people

> throughout the different ethnic groups. And so, it [the course] tried to disavow you of a lot of stereotypes you might have had, but it didn't give you a lot of skills about how to deal, or tangible skills that I felt like I could use.

4.9 Conclusion

The purpose of this study is to understand the lived experiences of registered nurses working in heavily multicultural areas. The essence of cultural competence in relation to nursing practice is an aptitude that allows for nurses to work effectively, compassionately, and respectfully with patients of diverse ethnic backgrounds. Cultural competence in nursing care, according to the participants, should be exhibited by possessing attributes that facilitate the nurse-patient relationship in relation to culture. The findings from this study highlighted the nurses' experience to be diverse in nature, mainly consisting of the benefits of learning about new cultures and developing an appreciation for ethnic diversity. The nurses' lived experiences also include challenges that affect patient care. Language barriers and differing worldviews may cause rifts between nurses and patients. However, nurses with culturally competent attributes—such as empathy and open-mindedness, along with the recognition of biases—can help facilitate the nurse-patient relationship and exhibit what they describe as cultural competence.

Understanding culture through the perspective of the patient was found to be a beneficial tool, as it allowed for patients to take control of their health. Cultural competence education is viewed as important, but there is a lack of available workshops for participants to attend. Improvements to the number of and access to workshops would be appreciated by the participants, along with content tailored towards building relational skills. To conclude, the participants are willing to take the steps to become more culturally competent through education

and seminars tailored to their area of practice. The participants are devoted nurses doing the best with what they have to educate and help the patients and families with which they work.

CHAPTER FIVE: Discussion and Recommendations

5.1 Introduction

The findings of this study represent the essence of the lived experiences of registered nurses working with multicultural populations. Their experiences highlight the need for cultural competence education in nursing school, as well as in the workforce. Through detailed descriptions of experiences, the insight of the nurses into the various challenges faced when working with diverse populations and the need to adapt and care for patients while being respectful of culture represent a wholesome picture of the experiences of registered nurses with respect to cultural competency. This chapter will discuss the findings of this study through reflection and comparisons to the literature. Since there are few research studies specifically focused on the lived experience of public health nurses working with ethnically diverse populations with respect to cultural competency, findings from this study can serve as foundational knowledge of nurses' experiences in order to create educational programs that support nurses in their work. This chapter will be divided into the following sections: the essence of cultural competence through the lived experience, how nurses understand culture, how nurses understand cultural competence, cultural competence in practice, and challenges, as well as implications for nursing practice, nursing education, and nursing research, respectively.

5.2 The Essence of Cultural Competence Through Lived Experience

In this study, the lived experience of the nurses working in culturally diverse settings yielded three main units: understanding patients and patient challenges, recognizing the nurses' limitations, and, lastly, nurses in the role of educators. The three units will be highlighted, and the lived experience will be compared to literature and practice standards for similarities and differences.

5.2.1 Understanding patients and patient challenges. Nurses recognize that there are imminent barriers immigrant patients face when encountering the healthcare system. These barriers can include language, limited understanding of Canadian health practices and norms, and feelings of isolation (Rawlings-Anderson, 2001). Watts et al. (2018) found that nurses recognize that their minority patients face the inherent challenges of language, and the subsequent difficultly in understanding medical information being provided for them to make an informed decision about their health. The limited understanding of the patient can cause ethnic minorities not to have "their information needs met in the same way as non-minority patients" (p. 4). Not only is less information shared, but patients feel misunderstood by their healthcare team. In a case study by Reznik, Cooper, MacDonald, Benador & Lemire (2001), a mother of a child with end-stage renal failure felt misunderstood, and at times, disrespected by her child's healthcare team. The healthcare team did not make the effort to understand the patient's cultural views on health and the healing of her child's illness. The idea of not being heard was central to what the participants in this study experienced, as well. Nurses felt that their patients were sometimes feeling unheard, and through reflection, the nurses expressed that in health crises, not being heard truly caused patients to feel alienated. The feeling of alienation of the patients has a negative outcome on the patients' health, as the nurses felt it resulted in decreased information sharing, which, in turn, decreased rapport and communication, and hindered the establishment of trust. My findings, like those of Reznik et al. (2001) and as seen through the nurses' perspectives, were that patients' inability to participate in or contribute to their healthcare plan resulted in decreased rapport with and trust in the healthcare team.

My study focused on the nurses' perspectives of cultural competency, and through their perspectives, I have learned how the nurses believed their patients may feel misunderstood, and,

at times, not valued while encountering the healthcare system. The feeling of being misunderstood is a common theme in the literature, which highlights the need for healthcare providers and patients to have sense of understanding between one another. Kleinman's Explanatory Model, developed in 1978, has been used as a beacon for teaching cultural competence to physicians and healthcare providers. The Explanatory Model implores the use of open-ended questions that focus on how the patient perceives their illness, such as: *why do you think your illness is presenting in this manner?* Or, *what do you believe is the cause?* These types of questions open a dialogue that allows the patient to discuss more freely their disease process in a context that they understand, using their own words, and, as a result, they allow for the healthcare provider to understand the context of the illness from the patient's perspective. In my study, the participants, through the process of asking questions pertaining to health beliefs, exemplified Kleinman's model. The nurses' desire to understand their patients was their main guiding principle, and, as such, they used open-ended questions, recognizing that open-ended questions were culturally appropriate and helped to build a picture of their patients' stories with consideration of their unique challenges.

The understanding of patients' unique stories includes their challenges and the ability to recognize patient barriers. Learning how to recognize patient barriers requires healthcare professionals to be adequately educated on the cultural health beliefs and values of their patient populations in order to be prepared to work in cross-cultural situations. Reznik et al. (2001) found that increasing the healthcare providers' understanding of patients' inherent challenges and beliefs, and using a certified transcultural nurse, was effective in increasing both patients' input into their healthcare plan and their satisfaction. Increasing provider understanding of patient challenges can serve as an example of the steps that can be taken to increase cultural

competence among nursing staff to improve health outcomes and strengthen rapport. Currently, there are no programs to certify nurses as *Transcultural Nurse Specialists* in Calgary. Transcultural Nurse Specialist are master or doctoral nurses educated in the field of transcultural nursing whose knowledge of nursing care concepts is derived heavily from anthropology. Their leadership role includes being educators, expert clinicians, and researchers in the area of transcultural nursing, forming knowledge to enhance the discipline of health in relation to culture (Leininger,1989). Implementing programs that grow the area of transcultural nursing and employing transcultural nurse specialists as educators in the community can serve as a beacon of knowledge for community health nurses to use as a resource to help problem solve situations that may arise in cross-cultural situations.

5.2.2 Recognizing nurse's limitations. Specific feelings that exemplify the lived experience of community health nurses focused on the nurses' feelings of inadequacy with regards to cultural education, and how the lack of knowledge makes the nurses feel uncomfortable working in cross-cultural situations (Debesay, Harslof, Rechel & Vike, 2014)**.** Nurses strive to provide the highest quality of care when working within the complexities of their environments (language barriers and socio-economic challenges); however, while providing care, the nurses' own limitations sometimes become apparent. Personal limitations included lack of cultural knowledge required to comfortably address health issues related to culture. For example, issues can arise in addressing co-sleeping with an infant and its relation to SIDS when, culturally, a family's belief system finds co-sleeping acceptable. Stiffler, Ayres, Fauvergue, and Cullen (2018) aim to increase cultural knowledge among nurses as to why African-American mothers are less likely to follow safer sleeping practices, and instead continue to partake in co-sleeping. The nurses in this study expressed limited cultural knowledge on beliefs and cultural

health practices, but also a desire to have increased familiarity with their patients' health needs in relation to culture. Increasing knowledge and fostering an open conversation about the beliefs and common practices within different cultures can help healthcare providers understand the factors that influence the populations for which they care. Having knowledge about common beliefs will allow nurses to inquire further, and to form a greater understanding to best educate and provide alternatives methods that can be mutually agreed upon with respect to culture.

Organizational constraints of time allotted for visits or interviews were limiting with regards to how much information and help could be provided per visit. In my personal experience shadowing public health nurses prior to this research study, I saw firsthand the importance of every minute of a meeting. With the required use of Language Line and visual aids to help focus conversations, nurses dedicated every moment to ensuring they could understand what their patients were telling them.

Having the ability to know every detail about every culture is deemed by the nurses to be an unrealistic expectation to have of oneself. Recognizing that there is not an expectation of knowing everything, but rather of having some pertinent information as a starting or reference point was important (Kersey-Matusiak, 2012). The results of the study illustrated that the nurse participants' decreased cultural knowledge and cultural skills made addressing cultural topics difficult. For this reason, the nurses felt that having salient points of information was the starting point to having in-depth conversations with their patients. However, the risk of using reference points as means of categorizing a culture leads to the potential of stereotyping and prejudice. Cortis (2000) sees the use of simplifying common behaviours as the norm as detrimental to a culture, causing the culture to be viewed in a caricatured form which does not showcase the true essence of a group.

However, having reference points or important “need-to-knows” about a culture was one of the desires of the participants. Without having guided information, the nurses feel at a loss and unsure about how to approach cultural encounters. For instance, the subject of mannerisms, such as looking people in the eye and the use of touch, are approached with hesitation due to the fear of offending patients or families. Debesay et al. (2014) also found that nurses feel uneasy working in cross-cultural situations due to their limited knowledge of cultural appropriateness. The validation of limited knowledge leading to uneasiness is a reason for providing cultural competence education that provides pertinent information on skills to use when working with a culture, such as understanding body language and non-verbal cues, for nurses to feel adequately prepared to step into cross-cultural situations.

5.2.3 Educators. The role of education is a valued source of pride for the nurses in this study. Their prime role is to educate the public about good health practices, and to best prepare their patients for success in managing their care. Being the educator is a standard of practice and a key component of nursing (CARNA, 2013). Along with being educators, public health nurses were represented as being versatile advocates and credible individuals, according to Joyce, O'Brien, Belew-LaDue, Dorjee, and Smith (2015)**.** In contrast to my study, these public health nurses were not mentioned to be working in highly ethnically diverse areas; however, some parallels could be drawn regarding how the nurses view themselves in their public health practice. Nurses value the education they provide and express how versatile they need to be in their daily practice to assure their patients’ needs are addressed and their questions are answered. As seen in the study of Joyce et al. (2015), nurses find themselves adjusting their teaching to the needs of their clients, and value the versatility trait as one that allowed them to connect to their patients. Versatility was described as the ability to adapt to the needs of the patients. For

example, Clinical Nurse 6 mentioned that she would prepare for her visits with an outline of topics to discuss, but if the patient had needs in another area, she would then focus on the needs of the patient for best nursing practice. Being able to adapt and "go with the flow" made her feel more competent as a nurse, as she put the needs of her patients first.

While being able to adapt to various situations and to tailor education to patients, the nurses also described that through conversation with their patients, they found knowledge gaps which led them to advocate for more support for their patients, and to provide more education to fit the needs of the client. Advocacy is seen as an important role of the value a nurse adds to healthcare team (Joyce et al. 2015). The lived experience for nurses included being protective of their patients through advocating for best care or services.

The lived experience of public health nurses in this study brings to light shared beliefs and practices that every nurse may experience at some point in their nursing practice. In general, there is a lack of specific knowledge in lived experiences of public health nurses working in heavily multicultural areas; as such, more research is needed in this area to further establish a basis of understanding and foundation about the ways in which nurses need to go about caring for their multi-cultural patients. A method of understanding the nurses' lived experience would need to include how nurses understand culture and how culture impacts health.

5.3 How Nurses Described Culture

The participants understood culture as a way of life in which individuals define themselves. Throughout the interviews, participants spoke of culture in terms of attributes and in relation to cultural practices and nuances. Food and cultural attributes were areas that nurses highlighted when describing their own culture and those of their patients.

5.3.1 Attributes. Culture is described by the participants in many ways. Most notably was the initial conflation of ethnicity with culture, and the suggestion that the ethnic make-up of a person represents their culture. Culture was also described by the nurse participants as the innate characteristics, influences, behaviours, and beliefs of an individual or group. In the literature, culture has been related to behaviours and beliefs (Groves, 2010; Markus & Kitayama 1991; Reznik et al., 2001). Culture is viewed as a marker that differentiates groups in the anthropological sense. The participants' responses parallel the findings of Grant & Luxford (2011) which define culture as shared characteristics such as customs, traditions, and worldview. Showcasing the commonalities of a group of individuals is a representation of who they are, or their essence. This essence, according to the Merriam-Webster (n.d) dictionary, is "the properties or attributes by means of which something can be placed in its proper class or identified as being what it is," or, simply, the attributes that make a person who they are. Rawlings-Anderson (2001) separates ethnicity from race, stating that ethnicity represents the shared values between groups, and not necessarily the colour of one's skin, which would only reflect one's race. The participants did not distinguish between ethnicity and race, but instead used the two terms interchangeably.

Reznik et al. (2001) suggested an alternative to the notion that culture is inherited by saying that culture is learned through formal teaching, and not environment. The participants of this study seemed to believe culture can be learned through a person's environment and through teaching. As in the case for Clinical Nurse 4 who demonstrated that children are a great example of how families teach their young how to view the world through morals and values, and through learning how to relate to other individuals. In her experience, the environmental exposure to

grandparents had a significant influence regarding how the child socialized with other elderly individuals outside the home.

However, when asked about culture, the participants acknowledged the innate characteristics and attributes such as race and language, which they believe affect how their patients related to them. For example, both Clinical Nurses 2 and 4 shared stories of how patients positively or negatively interacted with them based on their appearance and ability to speak their language, respectively. Moreover, the three nurses from ethnic minorities (South Asian and Southeast Asian) referred to their own culture to highlight the attributes that they found influenced themselves, while the four Caucasian nurses highlighted what made the ethnic patients different, possibly highlighting the nurses experience of how they see the world. In my findings, the three ethnic-minority nurses recognized cultural difference through a personal lens as compared to the four Caucasian nurses. This finding could suggest that ethnic-minority nurses are in a position of empathy and understanding of the challenges that patients of diverse backgrounds face because they have been exposed to those same challenges, and this may increase their ability to provide culturally competent care through understanding.

Grant & Luxford (2011) found that healthcare professionals describe culture as something someone else has, and not something they have. Grant & Luxford (2011) highlighted that when nurses explain the term “culture,” they use an “us versus them” connotation, insinuating that they themselves are not the one with a culture. This was in correlation to the findings of my study with the Caucasian nurses. One Caucasian participant was cognizant of the tendency not to consider being Canadian as culture, while the other Caucasian nurses did not delve into detail regarding the makings of Canadian culture, but did describe the cultural attributes of their patients in a manner that showcased the differences between them and their patient. Describing

culture in a dichotomy of “us versus them” did not strike me as intentional, but it may serve to validate the point that there are apparent differences between individuals from various countries, as well as an unconscious bias that the nurses held. Inherent biases can be blinding if a person is not aware that they exist, which the nurses in the study underscored. The awareness of biases is in line with Campinha-Bacote’s (2002) *The Process Of Cultural Competence In The Delivery Of Healthcare Services* construct of cultural awareness, which suggests that in order for a healthcare professional to be aware of and support the needs of their clients, they first must be able to acknowledge their biases so as not to impose their cultural beliefs on the beliefs of other cultures. This was highlighted in the experience of Clinical Nurse 7, who felt uneasy because her beliefs regarding safe sleeping habits for children did not coincide with those of the family with which she was working. She was aware that her beliefs did not align with those of the family, but this awareness posed a challenge, as she was not well equipped to discuss the matter in a culturally sensitive way. This showcases that while acknowledging biases is important for nurses, having the skills to address them and to come to a common understanding is equally important in providing culturally competent care.

5.3.2 Foods. Dietary patterns in cultural groups are of use to nurses caring for patients holistically. For example, nurses managing diabetes and hypertension should be aware of the diets of their patients to properly address any areas of concerns (i.e. sodium or sugar intake). When addressing the foods patients consumer, nurses should be able to discuss food choices respectfully, and try to incorporate foods from cultural groups as a sign of cultural competency. The nurses in this study acknowledged food as being a part of a person’s culture, suggesting that certain dishes serve to illustrate a person’s culture. The recognition of food and cultural dishes was relevant to the care the nurses provided, as it helped to guide their understanding of what is

important to the patient. For example, a person from India might value foods such as chapati and roti, or a person from Vietnam might hold strong value and appreciation for rice. Staple foods were described by the nurses as a representation of an ethnic group. However, simply implying that rice is only important to a culture because they consume it in large quantities can be viewed as simplistic, and it does not communicate the importance of the food to that society. Fischler (1988) states that "food is central to our sense of identity" (p. 275), and through anthropological research, further explains the complexity of the relationship between food and self. He states that what a person incorporates into their diet speaks to socio-economic factors as well as cultural factors. Nurses having a knowledge base of their patients' diets and also the availability to access cultural foods speaks to their cultural competence. For instance, certain foods or delicacies that are associated with individuals of a certain social class may not be affordable to individuals of a lower socio-economic status, thus explaining the likelihood of certain foods being consumed by different social classes.

In my study, the participants did not refer to the social class of their patients when they described the foods their patients eat. However, the foods they did describe were generally readily available in their patients' home countries and could be viewed as staple foods for nourishments. When staple foods are not readily available, newcomers face the challenge of finding their familiar cultural foods. According to Popovic-Lipovac & Strasser (2015), newcomer health declines in the years post-migration to Canada due to the inability to access known foods, and consequent increase in refined and processed food or fast food. Healthcare providers who have cultural knowledge about ethnic dishes and familiarity with their patients' cultural communities can provide information about where certain cultural groups gather (for

example, Chinatown), which can help patients build a community and find familiar food items they would eat in their native countries.

Obtaining native food in a foreign country can also be costly. This may result in finding alternative items to make dishes or settling for what is available, not what is most nutritious. Therefore, understanding the general food practices and native foods that grow geographically in patients' native countries can serve as a starting point for understanding patients' food choices. In relation to the health of a diabetic patient, food choices are imperative to good health, and, therefore, should be discussed. Understanding food choices can also lead to greater understanding what is of value to patients, and it can bring insight into the practices that are important to patients. Having culturally focused workshops that delve into the cultural significance of food is beneficial to healthcare providers' knowledge in providing best care for best patient outcomes.

5.4 How Nurses Understand Cultural Competence

The participants' understanding of what is means to be culturally competent focused on their ability as healthcare providers to work effectively with patients of ethnicities different from their own. While Debesay et al. (2014) and Slade, Thomas-Connor & Tsao (2008) acknowledge that cultural competence is a process, the participants in my study viewed cultural competence as an action: either you are, or you are not. Varying levels of exposure to cultural competence education may be the reason for the narrowing view of what it means to be culturally competent. Campinha-Bacote (1999) states that cultural competence is "the process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of a client (individual, family, or community)" (p. 203).

However, understanding that cultural competence as an ongoing process rather than a destination was not something that seemed apparent to the nurses. Instead, during the interviews, participants' responses to cultural competence focused on actions that were either seen as competent or incompetent. Nursing education and practice standards are presented in such a fashion that most are answered with "yes" or "no." For example, CARNA Nursing Practice Standard (2013) indicator 1.4 states that "The nurse practices competently," while indicator 2.7 states that "The nurse applies nursing knowledge and skill in providing safe, competent, ethical care and service." The statements are very much polarized statements that are to be answered with either yes or no. Using the nursing practice standards as a guiding principle may have influenced the nurses' understanding of cultural competence, as the practice standards do not speak to the process of being or maintaining competence, but rather insinuate that being competent is something that a person does or does not do. Further education on the term cultural competence and what it means in practice needs to be explain in further detail for nurses to understand the process of cultural competence in order for the view of competence as a destination to be discredited.

In my research, the actual term "cultural competence" did not always come to mind when speaking about how to give effective care in relation to a patient's culture. However, terms related to the subject, such as cultural safety, cultural sensitivity, respect, and compassion, were mentioned by participants. Participants listed the attributes that they felt were required in order to be culturally competent as patience, understanding, empathy, sympathy, and open-mindedness. Although the terms are broad, they are reflected in the literature. Smith (2013) states that culturally competent nurses are healthcare professionals that believe that everyone should have fair and equal access to healthcare, respect individual cultural uniqueness, and exhibit

empathetic, patient-centered care. Like Kleinman's Explanatory Model, Smith (2013) also states that culturally competent nurses should consider how culture plays a role in defining and understanding patients' health and illness.

Kersey-Matusiak (2012) found there are varying definitions of cultural competence, but the three main themes which take precedence in most recognized definitions are skills, attitude, and knowledge. From my findings, the theme of knowledge was most prevalent in the nurses' interviews. The nurses highlighted the knowledge base that they had obtained over the years. The knowledge they acquired was used in subsequent patient situations and built upon by engaging with patients of other cultures to help build their skill. The recognized definitions will be discussed in more detail below.

5.4.1 Cultural knowledge. To be effective and competent, healthcare providers should have cultural knowledge about themselves as well as their patients. The knowledge they obtain about themselves serves to recognize and reflect implicit biases they might have. This is seen in the cultural awareness construct of Campinha-Bacote (2002), where self-reflection can help a healthcare provider recognize biases before imposing their beliefs onto their patients. During the interviews, the nurses self-reflected on how their families and past experiences have shaped the way they practice. Being self-aware was very important to the nurses, as self-awareness guides their practice by recognizing there are differences in how nurses and patients may think about health-related issues. For example, taking cholesterol medication is considered the correct and responsible thing to do by the nurse, but for the patient, managing chronic disease with diet and exercise is believed to be a more acceptable and less invasive method. In the patient's culture, taking medication for each symptom may be frowned upon. Nurses must be aware of the actions and inactions of their patients in order to decrease conflict and to increase dialogue that will

foster the nurse-patient relationship. In this study, it was apparent that the nurses have a strong understanding that they cannot change a person's attitude or belief system, and because of this awareness, it was clear that cultural knowledge was important for them to build their nursing practice and to increase positive interactions with their patients.

5.4.2 Cultural skill. Having culturally competent skills allows for healthcare providers to accurately assess patients in a cultural context (Campinha-Bacote, 2002; Sneesby, Satchell, Good, & Van der Riet, 2011). To accurately assess patients in a culturally sensitive way, healthcare providers are to use communication skills to ensure clients can speak and obtain information in a language they understand (Kersey-Matusiak, 2012). Pertinent cultural information includes beliefs on health and illness, as well as cultural beliefs and practices about health and illness. Specific skills are represented vaguely in the literature, aside from using cultural assessment tools. However, even with cultural assessment tools, there are issues of not naming which ones or expressing the validity of the tools, not to mention the availability of the tools to all nurses. Clinical Nurse 3 made note of the importance of having a self-assessment tool for nurses to use as a foundation, but none of the nurses made reference to a specific cultural assessment tool to measure cultural competence. Wilson (2010) found that there is limited knowledge of specific skills that contribute to cultural competency, yet cultural competence models outline that cultural skills are necessary. Comparatively, in this study, nurses asked for specific skills to increase their nursing knowledge and to advance their nursing practice, as they felt current workshops available to them are lacking in this area. Debesay et al. (2014) found that nurses in Norway "lacked organizational support and in view of the documented lack of opportunities for the development of skills in Norwegian home care" (p. 2114), which is similar to the finding in my study that nurses feel organizational support for cultural competence

education is not at the forefront. This finding may be reason to conclude that there is a lack of participation in culturally sensitive training. Organizational support should include allotted paid time off for nurses to attend culturally competent education that delivers specific skills for nurses to work effectively in cross-cultural situations.

5.4.3 Attitudes. The attitudes of a healthcare professional towards ethnically diverse patients have a direct impact on the care they will provide. To be in the process of cultural competence, healthcare providers must have positive attitudes towards open-mindedness and co-operation to be able to work with cultural difference (Kersey-Matusiak, 2012). Interestingly, the nurses in this study described attributes that they believed made healthcare providers culturally competent. The majority of the attributes described are attitudes an individual must possess. Care and compassion are the pinnacle of the art of nursing, and there is no exception when speaking about cultural competency. However, cultural skills are necessary to provide culturally competent care. Possessing such qualities sparks a cultural desire, which is defined by Campinha-Bacote (2002) as the catalyst the starts the process of cultural competence in healthcare. It is evident in the interview process that the nurses genuinely care for their patients, and they want to help educate them the best way they know how. The desire to fulfil patient needs, especially for patients who experience barriers, is a motivating factor in the quality nursing work they provide. Having genuine interest in patients is shown to increase the amount of time spent with healthcare providers and higher patient satisfaction with care provided (Castro & Ruiz, 2009). With positive encounters and increased time spent speaking about health issues, trust and rapport are solidified, and patients are more likely to comply with healthcare plans and to contribute to them, as well (Reznik et al, 2001).

5.5 Cultural Competence in Practice

Cultural competence work has its roots in anthropology through the work of Dr. Madeleine Leininger, which focuses on the holistic care of individuals. Since her seminal works that focus on the preservation of cultural in relation to health, culturally sensitive, culturally congruent, and culturally competent care have been increased (Cortis, 2000; Debesay et al., 2014; Grant & Luxford, 2011). The healthcare providers' impact on providing healthcare in a manner that will not threaten the patient's culture is essential to Dr. Leininger's work. The underlying notion of treating individuals and families with respect, irrespective of cultural background, showcases nurses' desire to be culturally competent as per Campinha-Bacote (2002).

Showcasing cultural competence in practice would constitute having the appropriate attitude, knowledge, and skills to work effectively with diverse populations. In this study, the participants demonstrated how they view cultural competence in practice through cultural assessments of their patients, which they complete by asking questions that pertained to their patients' culture. Although the nurses mentioned assessments, there appeared to be no formal systematic assessment used amongst the participants; rather, the nurses used informal questions to gain more cultural knowledge. The information received from the patients was of value in understanding the patients' views of health in the context of culture. For instance, a nurse asking her patients what constitutes their idea of being in good health and the patient responding with being able to have meals together with their families, was a cultural representation of health to for patient. For other cultures, the limited sharing of news about loss or illness in a family is a representation of how the family may view how health and illness affects all members of a family. Once the views of the patient were made clear, nurses would respect their wishes to best support their views of health for patients and their families. Culturally sensitive information is

shared more readily when the patients feel comfortable and perceive a genuine sense of healthcare provider interest (Castro & Ruiz, 2009). Not only is this a step towards cultural competence on the healthcare providers' part, but Kersey-Matusiak (2012) suggests that cultural safety is enhanced, protecting vulnerable populations who may not be represented as the majority.

The participants expressed that, at times, nurses feel the burden of responsibility to be fully accommodating to the cultural needs of a patient with no onus on the patient to be accommodating to the healthcare system. Nurses felt that as the professional practitioner in the nurse-patient dynamic, it was their responsibility to ensure their patients were taken care of when in their care. This meant providing information and resources to their patients who lacked knowledge or awareness about where to seek information. The CARNA Nursing Practice Standard (2013) indicator 2.2 states that "The nurse uses appropriate information and resources that enhance client care and the achievement of desired client outcomes," while indicator 3.3 states that "The nurse ensures that their relationships with clients are therapeutic and professional." Based on these standards, one could argue that the responsibility to use evidence-based practice to achieve the most desirable outcome for the patient in a therapeutic and professional manner would be on the nurse. This means that as a form of professional responsibility, the nurses should be practicing in a manner that accommodates for the cultural needs of the patient. There is a lack of research on the responsibility of patients to understand the a healthcare system, and whether they feel it is required of them. The comparison between nurse and patient perceptions of understanding the healthcare system could serve as an area for further research.

Differing views of healthcare providers and patients have been documented by Akhavan & Karlsen (2013), whose study focused on the experiences of both patients born in Sweden and those foreign to Sweden in comparison to the experience of doctors caring for them. The findings suggest there are starkly differing views between patients and physician. Physicians addressed the apparent challenges of working with foreign-born patients in relation to language and communication, as well as expectations of the healthcare system. Healthcare providers felt foreign-born patients expect similar care to that of their home countries regarding receiving prescriptions. Regardless of suggested plans, physicians found that foreign-born patients expect medication, and those unmet expectations meant decreased levels of satisfaction of care were felt on the patients' part. This was congruent with the findings in this study, showcasing that there are cultural views of health that patients maintain. The difference in views is seen as inadequate care by the patients, and for some of the healthcare providers, this behaviour is seen as exaggerating illness. In situations where these misunderstandings occur, the presence of culturally competent nurse to educate patients on the methods of delivery of healthcare is important. Explaining to patients what is expected in their treatment and why would be beneficial in bridging the gap of understanding between patients and foreign healthcare systems. Misunderstandings of both patients and the healthcare system perpetuate an environment where trust cannot be built, as each party views the other in a negative fashion. Moreover, the lack of understanding between healthcare providers and patients makes patients more vulnerable, as a distinct power imbalance is present. Physicians prescribe medication according to their medical knowledge and their understanding of a patient's illness; therefore, if their interpretation is that a patient is exaggerating or not being truthful, under-prescribing can occur (Akhavan & Karlsen, 2013). This can create vulnerabilities for minority patients, as well as further health disparities

(Villeneuve, 2002). The need for cultural training on health views and behaviours for clinicians is a step forward in decreasing healthcare disparities among ethnic minorities, as it fosters understanding and open-mindedness in healthcare.

Cultural value systems and beliefs are sensitive subjects that are, at times, uncomfortable to discuss. In my research, there was discussion of the need and desire for cultural competence training that focused on providing communication skills for healthcare workers to assist them in facilitating difficult discussions about cultural-specific issues. Healthcare providers fear being labelled as culturally incompetent, or worse, racist, so they refrain from speaking too openly about cultural beliefs of others so as not to appear insensitive. Cortis (2000) states that healthcare providers find learning about other cultures forces them to reflect on their own culture, and to face their inherent biases, which is uncomfortable and at times difficult. The participants who had limited to no formal cultural competency training felt that opportunities to speak about cultural competence and culture needed to be in a safe, judgement-free environment, where they will not risk being labeled as insensitive or racist in order for nurses and their peers to feel comfortable. Clinical Nurse 7 spoke about the environment of a cultural education session, and found that facilitator not very open-minded, causing for it to be difficult to express thoughts and feelings within the session. Moreover, the participants' desire to have a safe place for discussion among peers of challenges faced when working with ethnically diverse populations was seen to be one that would increase nursing knowledge and personal growth. The participants believed that reflecting with their peers would be beneficial, as they would more easily relate to one another because stories shared could be on a more personal level as opposed to having generic case-study examples to discuss. Organizational implementation of self-development amongst

staff would be beneficial to discussing sensitive cultural topics, and it would also show staff that the organization is supportive of their cultural enrichment and learning.

How to be culturally competent and to work effectively with cultures other than one's own is an on-going process in practice; therefore, complacency should be avoided with regards to cultural competence. While complacency was not deliberately discussed, the nurses in this study were not complacent. The sample were all nurses who wanted to do better in their practice, showcasing to learn about cultural competence in nursing care and to be culturally competent. Nurses spoke about the experiences they have had in their nursing careers that have shaped the way they practice. In particular, Clinical Nurse 3 stressed the need for unconditional warm regard for patients as a starting point for open-mindedness and dialogue with respect to cultural beliefs, as she felt that open communication was the foundational skill that allowed for her to have conversations about culture and health. According to Campinha-Bacote (2002), competence is not an obtainable end-goal, but rather a life-long journey in practice, by which every encounter will shape the knowledge and awareness of the healthcare provider to strive for greater competence with each successive cultural encounter. When the nurses reflected and focused on how to best practice in cross-cultural situations, they appeared to take on the responsibility in the nurse-patient relationship of accommodating patients who have cultural barriers, mainly language barriers. The use of phrases such as *taking the extra time, asking more questions*, and *being patient* were all examples of the nurses taking responsibility for how to they can affect the nurse-patient relationship in a positive manner. The nurses felt their approach to care was based on the cultural needs of their patients (i.e. religion and language) to best understand the patients' point of view, which can also be considered patient-centered care. The College of Nurses of Ontario (2018) recognizes culturally sensitive care a component of patient-centered care, and

states that nurses are to "strive to enhance their ability to provide patient-centered care by reflecting on how their and the patient's culture's, values, and beliefs impact the nurse-patient relationship." Understanding that the cultural values of a patient are important to the nurse-patient relationship nurses must be educated and supported with skills to address cultural issues in practice.

The participants expressed a desire to learn cultural skills, mainly verbal and non-verbal communication skills, in order to best understand their patients and to help them make culturally safe healthcare decisions. Nurses expressed the challenge of limited resources readily available to them, and they suggested the following to best support nurses: organizational education provided through inviting formats, such as lunch-and-learns or paid professional days, would be beneficial for the growth of cultural knowledge and awareness, as the desire for cultural education is apparent among the participants. Workshops that focus on specific and tangible cultural assessment skills would help ease nurses' anxiety regarding potentially disrespecting ethnic minorities. In addition, these workshops will educate nurses on how to extract pertinent information that will build a strong nurse-patient relationship and allow nurses to create open dialogue between patients and the healthcare system to decrease the disparities and challenges faced by minority patients.

Organizational cultural competence should be apparent to foster a culture in the workplace that values cultural diversity and safe practice. Organizational adaptation of culturally competent concepts and structures need to be implemented. According to Ngo (2008) "a culturally competent organization holds cultural diversity in high regard, and integrates cultural diversity into all aspects of its structures and functions" (Ngo, 2008, p. 46). This would include achieving

cultural diversity and competence at the board and management level, through governance and policy initiatives, and through the delivery of healthcare services.

5.6 Challenges

The majority of the literature on cultural competence in healthcare practice focuses on the challenges that healthcare providers face while working with ethnic minority patients (Akhavan & Karlsen, 2013; Debesay et al. 2014; Joyce et al. 2015). There is no question that the findings of this study are in line with the challenges that healthcare providers encounter globally when working with minority patients. Challenges are faced daily by the participants of this study, mainly due to language barriers and limited cultural awareness and knowledge. That language barriers are a significant challenge identified in this study is, unsurprisingly, confirmed in the literature as the most recognized barrier, but along with language comes general communication issues and non-verbal communication.

5.6.1 Language barrier. Studies show that language barriers are an on-going challenge for nurses working with ethnically diverse populations (Michaelsen, Krasnik, Nielsen, Norredam, & Torres, 2004; Akhavan & Karlsen, 2013). In Canada, increasing immigration is diversifying the population, and nurses are readily meeting an array of cultures different from their own. New immigrants accessing healthcare may not be fluent in English or even have basic conversational language required to ask questions comfortably in medical situations, resulting in decreased communication between patients and healthcare providers. Poureslami, Rootman, Doyle-Waters, Nimmon, & FitzGerald (2011) found that newcomers to Canada found their physicians' communication to be closed off and uninviting for more questions, and, moreover, information pertaining to their illness was presented in English and in a confusing manner which patients admitted decreased their likelihood to comply with physicians' orders.

The use of language resources such as Language Line to interpret conversations is seen by the participants in this study as beneficial and necessary in the daily practice of culturally competent healthcare providers. The use of interpretive services was identified as having benefits and drawbacks. In situations where understanding would otherwise not be established, interpretive services act as a cultural tool that allows communication and builds a connection between the healthcare provider and the patient. Medically trained interpreters are viewed not only as translators, but also as mediators who have are to understand the healthcare norms while also understanding nuances of the patient's culture if they are from the same country (Arias-Murcia & Lopez-Diaz, 2013). The added understanding of the medical interpreter is referred to as cultural brokerage, whereby the interpreter is meant to "clarify meanings, modify communication patterns and explain social norms and features of the medical system" (p.417). Clinical Nurse 5 made mention of the benefit of having a physical interpreter accompany nurses during visits with patients. The interpreter, usually from the same or similar cultural background as the patient, can assess and address the non-verbal communication happening during the visits. This is a form of cultural brokerage with benefits of education for nurses and decreased misunderstanding of social cues between nurse and patient. The interpreter enhances the cultural encounter, and their own knowledge of cultural norms can be used as knowledge to help educate the nurse or patient. However, Poureslami, Rootman, Doyle-Waters, Nimmon, and FitzGerald (2011) contradict the idea that using an interpreter is a simple fix for culturally competent care by stating that "translation should not be viewed as a simple solution to making information culturally appropriate" (p. 340), because interpreters are not physicians. Therefore, although their understanding may be like that of the patient, they are not licensed medical professionals. The view of interpreters imposing their beliefs on the patient or nurse was not seen in my study.

Rather, interpreters were held in high regard by the participants for the service they provide, even while the mode of interpretation during clinic visits was not considered to be the most effective by some of the participants.

Language Line, the over-the-phone interpretive service, is what is used within Alberta Health Services. According to the participants, Language Line is not free to use for private clinics, which may be cause for concern as there are numerous clinics outside of the Alberta Health Services umbrella. The use of Language Line was deemed easy, but the challenge occurs when using Language Line for sensitive information that is not culturally appropriate to speak about with the opposite sex, such as reproductive health issues in Muslim women. My findings suggest that nurses are aware that female patients will withhold information if the interpreter is male. Yet, while nurses are aware that having a male interpreter in a conversation about female reproductive health is considered taboo, under the current structure of Language Line, there is no way to request male or female interpreters for cultural sensitivity reasons, thereby decreasing the amount of information shared. A mechanism to request male or female interpreters should be made available for culturally sensitive subjects to ensure that patients feel comfortable and able to share the health concerns that can affect their plan of care, and to avoid increasing disparities by not addressing healthcare concerns.

5.6.2 Time. When working with language barriers, the issue of having inadequate time was highlighted by most of the participants. Simply stated, working with ethnic patients who have language barriers takes more time, especially if the healthcare provider is going through the necessary channels to provide effective care (Language Line, pictures, speaking slowly, offering time to ask questions, etc.). Akhavan & Karlsen (2013) found that physicians have noted that foreign-born patients require more time to express their concerns, and that adding the use of an

interpreter meant appointments were longer. Consequently, some physicians believe that treating foreign-born patients is not cost-effective, saying, “Communication and time is money” (p. 90). Such thinking may be a precursor to undervaluing foreign-born patients as human beings, and not taking the extra time to ensure that all the patients’ needs are met. In contrast, in my study, nurses found that the appointments with patients requiring translators did take a lot of time, but they were not willing to rush through appointments. Nurses did not feel the need to rush patients. Language Line, which costs money, is still used and if it is not used by nurses it seems to be for the sake of money, not for the sake of time.

The patient load for a physician relative to a nurse is generally greater, and that could explain the views of some physicians; also, the fee-for-service pay structure for physicians may also come into play. At the end of the day, rushing through patient care in primary care to save money will only cost more in the long run, as patients who do not feel cared for often turn to emergency services (Akhavan & Karlsen, 2013). Burdening emergency rooms with issues that can be addressed in primary care should be avoided, as it has the potential to increases wait times and to create stress on the healthcare system. The recognition of allocating time in primary care to accommodate for language barriers and cultural concerns can potentially decrease healthcare costs and wait times for patients seeking urgent care.

Considering lengthening appointment times for areas heavily populated with patients who have language barriers would allow for patients not to feel rushed or unheard. Increasing time to account for the use of interpretive services would also be beneficial for healthcare providers, who often feel pressed for time. Having more time, nurses would foster culturally competent care through the use interpretive resources and spend more time using communication skills to perform in-depth cultural assessments.

5.6.3 Cultural knowledge and cultural norms. What is culturally appropriate for the majority of a population does not always hold true for ethnic minorities. Nurses in my study found that they are at a disadvantage when understanding the cultural norms and behaviours that would be considered appropriate when working in cross-cultural situations. The disadvantage is mainly due to their lack of cultural knowledge regarding various cultures. As a result, nurses found themselves feeling uneasy, and not culturally competent or skilled when working with ethnic minorities, despite their best efforts not to offend their patients. This showcases the need for increased cultural competence education in the workforce. Debesay et al. (2014) addresses a similar finding of uneasiness and discomfort in addressing areas of culture and religion with ethnic minority patients. When sacred behaviours and beliefs have an impact on health-related issues, nurses do not feel comfortable addressing or contradicting patients' beliefs out of fear of disrespecting their patients; this was in correlation to the findings in my study. Nurses feel that it is not their place to combat the belief system of their patients, as it may cause further alienation of the client.

Patients often feel that healthcare providers have limited cultural knowledge and need to be more aware of the beliefs of the patients for whom they care (Akhavan & Karlsen, 2013). Nurses also find that they lack cultural knowledge, but they note that they have the desire to learn more about cultural norms (Eche & Aronowitz, 2017). Cultural knowledge and skill are seen to be less developed in undergraduate nurses compared to graduate nurses (Mareno & Hart, 2014). The lack of cultural knowledge may be the reason nurses would rather avoid discussing sensitive subjects with which they do not feel prepared to deal. If patients sense this lack of preparedness, it may hurt the patient-nurse relationship, and decrease information-sharing and trust, which puts minority patients at risk of health disparities. Education and increasing cultural knowledge for

nurses is important to nursing development. Research in various ethnic communities can serve as a basis of information through which nurses can gain an understanding of prominent cultural norms. Communication skills will help nurses delve into topics in a culturally sensitive manner. It is always important to remember that although cultures do have similarities, a one-size-fits-all attitude will only further marginalize vulnerable populations.

5.7 Summary

The lived experiences of the nurses in this study showcase the common challenges faced by healthcare providers working with ethnically diverse patient populations. Language barriers and inadequate cultural knowledge can hinder the nurse-patient relationship. Through the challenges, nurses continue to strive to provide the best care, using the resources they have available to them, such as Language Line. However, more support is needed. Increased, mandated cultural education in the form of workshops, lunch-and-learns, and seminars would be beneficial to nurses' growth. Organizational support, whereby cultural competence education is viewed as a valuable and important requirement, will help perpetuate the need to learn more about the cultures with which nurses work.

This research has showcased that nurses' desire to be more culturally competent is present. Nurses would like to serve their patients and communities effectively to improve health outcomes and empower their patients. This research supports the need for increased knowledge and skill training for registered nurses working with ethnically diverse patients, as it would allow for the nurses to feel competent and better equipped to address cross-cultural situations.

5.8 Implications

5.8.1 Implications for nursing practice. Addressing cultural competence in practice is recognized as a positive way to address healthcare disparities, increase patient satisfaction, and,

in turn, increase patient participation in care (Castro & Ruiz, 2009). Supporting cultural competence education in nursing practice is vital to create a supportive, holistic healthcare system that recognizes health inequities and aims to dismantle stereotypes of patients, and to view them in their own individuality (Villeneuve, 2002). The Canadian Nurses' Association's (2010) position statement on cultural competence states:

> that cultural competence is 'a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals, and enables…[them] to work effectively in cross-cultural situations.' It is a component of quality practice environments that leads to improved health outcomes for clients, nurses and systems. Practice environments that are conducive to safety and quality reflect cultural diversity.

This position states that policies should come together to increase the effectiveness of cross-cultural situations to best achieve health outcomes. The CNA (2010) is promoting cultural competence in nursing practice, which now leaves the onus of implementation on the organizations who employ nurses in practice. Policies that mandate continuing cultural competence education for nursing will increase nurses' knowledge base and cultural awareness, which, in the findings of this study, proved to be an area nurses felt gave them uneasiness and where they would like to improve.

Based on the results of this study, it is clear that nurses working with minority patients should advocate for more learning to build their nursing practice. It is important for nurses to recognize cultural differences, not only amongst cultural groups, but also within their own ranks, as stereotyping can occur when individuality is not appreciated (Maddalena, 2009). Practice guidelines and position statements serve as ways of representing the importance of cultural competence in nursing education. The same sentiment was communicated by the

participating nurses in the study. The perceived importance of being culturally competent to best serve and care for their patients supersedes the challenges that the nurses face in their lived experiences.

5.8.2 Implications for nursing education. Nursing education has long suggested diversifying the profession of nursing in order to help build a workforce with diversified life experiences and worldview (Maddalena, 2009; Villeneuve, 2002). Having a diverse workforce would suggest that undergraduate nursing programs must also be diversified. Participants in the study had a hard time recalling any cultural education they had received in nursing school to prepare them for the workforce. The majority of the participants stated that they did not have any formal training prior to becoming a nurse, and they said they felt as though nursing students, while in school, are a very captive audience, allowing them to absorb important information to better prepare them for when they enter the workforce. The training when entering the workforce, however, was not in-depth, nor did it centre on skills that would equip nurses to speak about cross-cultural situations. The nurses expressed that education was not culturally focused when starting at their current places of work.

The Entry-to-Practice Competencies for the Registered Nurses Profession (2013) references culture in nursing care in Competency 6, “Demonstrates leadership in client care by promoting healthy and culturally safe practice environments,” and in Competency 42, “Negotiates priorities of care and desired outcomes with clients, demonstrating cultural safety, and considering the influence of positional power relationships.” The mention of culture in direct practice highlights the importance of education on culturally relevant topics to best fulfil the competencies at the entry level of nursing practice. Nurses in this study demonstrated leadership through allocating appropriate avenues to best help their patients after recognizing a challenge

the patient may have. For instance, nurses recognize that understanding of the treatment plans is of concern due to language barriers, and thus use available resources to address this issue and best remedy it for safe practice. Moreover, nurses negotiate care by allowing the patients to be a part of their care through discussion. Dietary practices for diabetic patients are negotiated with an understanding of cultural foods that the patient eats and has access to, thereby promoting culturally safe care for the patient and cultural competence for the nurse who is addressing cultural factors that affect the patient. The result of the study demonstrated that nurses did not feel ready to practice with culture in mind at the entry level of their practice, nor did they always feel prepared to do so even after several years of practicing. This highlights a void and a need for education at entry level to practice, baccalaureate nursing programs.

Integrating cultural competence education in undergraduate education has been seen to improve student self-awareness, increase awareness of racial privileges, and decrease negative racial attitudes towards minorities (Colvin-Burque. Zugazaga, & Davis-Maye, 2007). This illustrates that the use of models that promote self-awareness and skills to work in cross-cultural situations is beneficial to building well-rounded students, and is effective in promoting early cultural competence. Also, research has shown that cultural competence education increases cultural competence outcomes in student, however without continuing education, overtime, cultural competence declines in students. Therefore the need for on-going education is imperative to increased cultural competence for students who will then enter the workforce. Adapting a framework in undergraduate nursing can serve to promote cultural competence before nurses start in the workforce. Incorporating methods of critical self-reflection for students, after cultural encounters in the form of journal writing as well as having open class discussions on concepts of culture in nursing are formats that promote cultural competence. Providing a safe

space where students can discuss their experiences, challenges and the uncomfortable feelings they may experience could all be examples of cultural competence education for students. It is important for students to have exposure to cross-cultural situations to better adapt and grow their confidence as future culturally competent practicing nurses.

Once nurses are in the workforce, it is essential for them to have opportunities to grow in their nursing practice. Continuing education for nurses in the workforce is critical to support proficient nurses who feel prepared and equipped to work in cross-cultural situations. With varying levels of education and perceptions cultural competence of nurses currently in the workforce, it is highly recommended to have ongoing cultural competence education to address cultural differences between nurse and patients. Current continuing education within Alberta Health Services can be found through the internal webpages. At this time, cultural education is not a mandatory continuing competency, which highlights the organizational undervaluing of cultural competence education. Nurses must make accommodations with their employers to attend sessions, instead of employer allotting time off to take diversity workshops. Although the education that is currently being provided is appreciated, increased tangible skills regarding how to discuss difficult topics related to culture and belief systems should be integrated.

Workshops held by Alberta Health Services that invite staff to share their personal experiences among peers would be beneficial to foster a supportive environment. Moreover, ensuring that critical reflection on part of the nurses can be done through the workshops could serve as a tool for personal growth in nursing practice. Open-ended questions and dialogue should be encouraged to allow for nurses to delve into cultural concepts that may be uncomfortable to deal with while working. Communication workshops with focus on cultural skill that provide tangible talking points for nurses to use in the workplace would serve as a

benefit to nurses in practice. Through this study it was seen that nurses are familiar with the idea of cultural safety and sensitivity, however nurses are not well educated on the definition of cultural competence, leaving a void in complete understanding of culturally competent concepts. Concepts should be viewed at an organizational level and then presented to staff in an organized succinct manner. The evaluation of current educational workshops would help serve as a tool to measure effectiveness, and to assess where modifications should be made to current courses. Recognizing that cultural competence education is necessary and welcomed in nursing practice should serve as a reason for further research in the area of cultural competence education to ensure nurses are being educated in a standardized method that is grounded in evidence-based knowledge.

5.8.3 Implications for nursing research. There is much discussion of cultural competence in the literature; however, specific research in cultural competence education for nurses working in heavily diverse areas needs be increased for greater understanding of educational needs. The goal of this research is to serve as a foundational understanding of the challenges and concerns nurses have in practice in order to educate policy makers and educators with regards to the need for tailored education to build the practice of nursing. Research that builds strong nurses strengthens both the healthcare system and the patients for which it cares, thereby decreasing health disparities. Due to this study being focused on the nurses' lived experience, further research detailing the lived experience of patients' views of cultural competence in healthcare would be beneficial for comparison and addition to nursing practice. Moreover, research within cultural communities can serve as additional areas of knowledge regarding beliefs and values for cultural associations in the city. Longitudinal studies following the implementation of cultural competence education in nursing research can serve as a way of assessing and monitoring the

effectiveness of cultural competence education for nurses in Alberta. Culture is a construct that is understood to have influence on health, studies that aim to understand which areas of health culture influences most could be beneficial for focused education. Also examining the relationship of culture to social poverty and health equity in pateints can shed light on the importance of the understing of culture not only on an individual level but also on an organizatonal level to combat health disparities related to culture. Further studies that examine the lived experience of nurses in teirtieary healthcare settings could also be benefical to the overall understanding of nurses experience in relation to culutral competence in the workforce.

5.9 Limitations to the Study

The main limitation of this study was the small sample size of n=7. Participation was voluntary, and participants could withdraw at any time. The study inclusion criteria only called for registered nurses, not licensed professional nurses or nurse practitioners, which may have affected sample size, as well. Feedback from recruitment was that the nature of the topic of cultural competency is difficult and uncomfortable for some nurses to speak about, as the idea of cultural competence was intimidating, and nurses did not want to be labelled as incompetent; this led some to refrain from participating. The education of the nurses who participated can also be viewed as a limitation. Six out of seven participants graduated from nursing school over ten years ago; when topics of culture and cultural competence may have not been at the forefront of their education and when Alberta's population was less diverse. Also, the focus of this study was to gain understanding from the nurse's perspective which is at an individual level, not on an organizational level. Understanding the organizational structure in greater detail, would serve to benefit understanding of how cultural competence education can be implemented for nurses and other healthcare professionals. Further research on organizational structure and its influence

would be beneficial to view the phenomenon of cultural competence in healthcare on a larger scale. The findings of this study were favorable to the implementation of more continuing education for practicing registered nurses. Due to the nature of the study, participants who have interest in cultural safety and the development of cultural education for nurses would have more affinity to participate, leaving a void in understanding nurses who may think contrary to cultural competence education.

5.10 Conclusion

To conclude, the combination of my personal and professional experiences has sparked my interest in the area of cultural competence in healthcare. Being a first-generation Canadian, who has viewed the challenges ethnic minorities face in Canada while being a Registered Nurse has incited my interest in cultural competence education for nurses caring for ethnically diverse populations. As a researcher, my position has allowed for me to view concepts and areas of how cultural competence is understood by nurses in the community healthcare settings. This has also opened my eyes to see other areas that may have influence on cultural competence in healthcare, specifically the organizational structure of health and educational institutions. Managing Canada's increase in diversity would require for organizational support of nurses through continuing structured education, both in nursing school and in the workplace. Policy implementation that fosters a sense of importance around concepts of cultural competence would serve to increase the awareness and importance of cultural competence concepts in healthcare.

Increased diversity in the general population is being reflected in the healthcare system, and with this increase, there are more apparent health disparities among minority patients (Villeneuve, 2002). Nurses are the frontline workers in the healthcare system, and they deal with the daily challenges of working with ethnically diverse patients. The nurses' lived experience

working in community healthcare with diverse ethnic patient populations serves as basis of understanding of the rewards and challenges faced by any nurse working with ethnically diverse patients. There is no mandatory cultural education provided to nurses to adequately address cultural issues affecting the care they provide. Structured cultural competence education can serve as a model to standardize education for all nurses, starting in undergraduate nursing education, with the goal of increasing cultural knowledge and awareness amongst the profession of nursing to best support patients, and to increase patient outcomes in an equitable fashion that recognizes the barriers minority patients face by addressing their needs accordingly. Moreover, to support education for nurses organizational change and research

I would hope the findings of this research study be considered when creating and implementing cultural competence education for nursing students and nurses in the workplace. Recognizing that nurses would like more education is reason to include nurses in the formation of a curriculum that would best serve nurses, and which considers the need for increased education on cultural skill, knowledge and communication. Nurses have a difficult and rewarding profession caring for all individuals who come into their care regardless of race, sex, or culture, and support that would facilitate best nursing practice should not be taken for granted.

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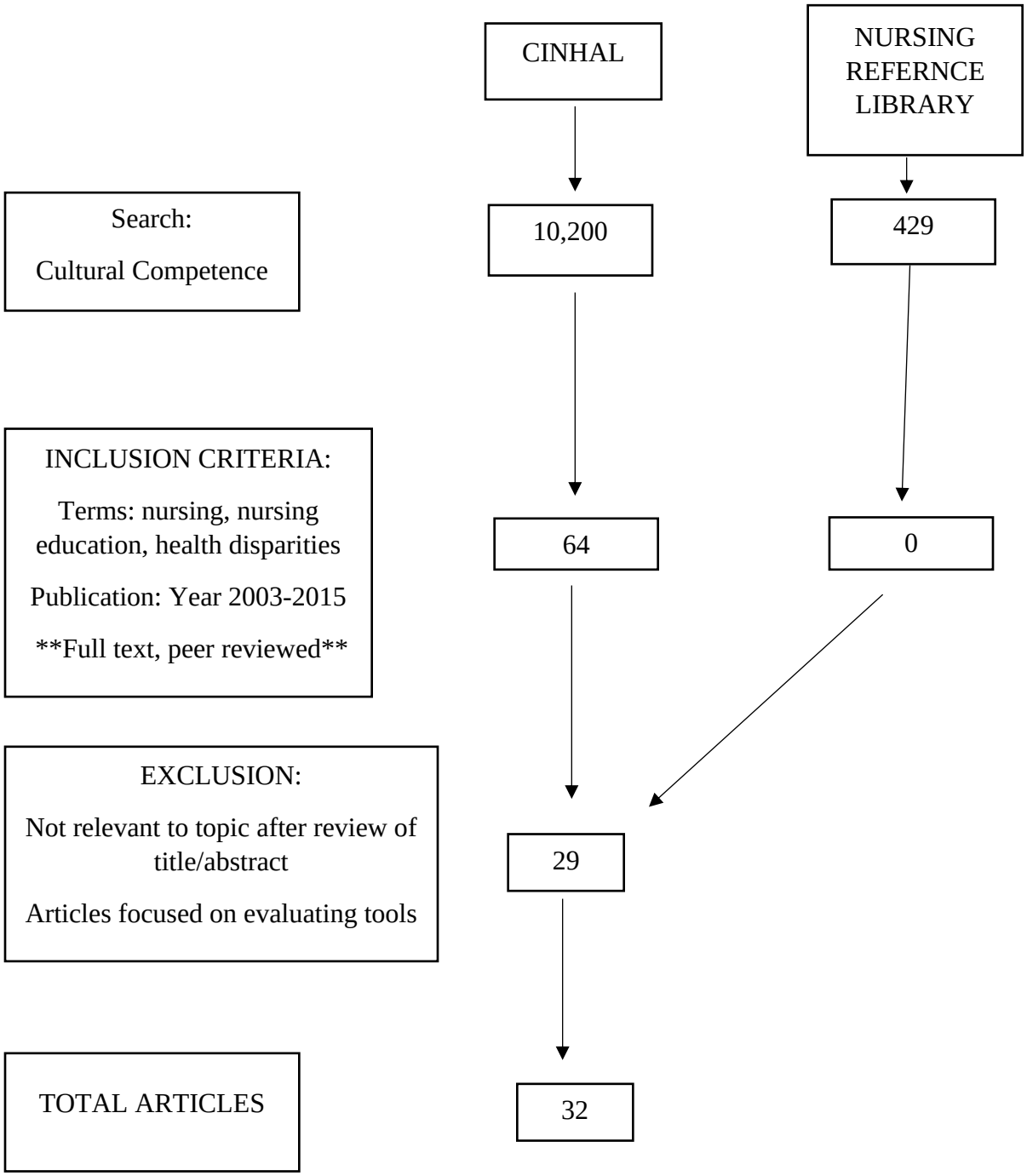
Appendix A

PRISMA Flow Diagram



Appendix B

UNIVERSITY OF CALGARY

Culture in Nursing...Cultural Competence...Cultural Diversity...What does it mean to you?

Looking for Registered Nurses to share their experiences caring for and working with patients of diverse cultural backgrounds?

Who: Registered Nurses working in Community Healthcare Centres

What: Participate in 45 minutes to 1-hour one-to-one interview

Where and When: Mutually agreed upon time and place at your convenience

Why: Your participation will help build a greater understanding of the experiences of nurses caring for patients/clients of diverse ethnicities and help form education to best serve nurses

If interested please contact:
Evelyn Anokye BN RN (MN Student)
University of Calgary

Supervisor:
Tam Donnelly RN, PhD
Professor, Faculty of Nursing, University of Calgary

This study has been approved by the University of Calgary Conjoint Health Research Ethics Board.

Appendix C

Interview Guide

Demographics

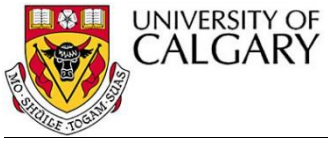
1. Where did you do your training?
2. How many years of nursing experience do you have?
3. What area do you currently work in?
4. What areas have you worked in the past?
5. How would you describe your cultural background/ ethnicity?
6. Would you mind telling me your age?

Interview Questions

1. Can you give me some examples of your day to day experiences working with patients or population with diverse cultural background?
2. How would you describe some of the challenges you have faced in working with patients or population with diverse cultural background?
3. How would you describe the opportunities/benefits you have experienced in working with patients or population with diverse cultural background?
4. How would you describe what (knowledge, skills, attitudes or behaviours) you feel is a required to work with patients or population with diverse cultural background?
5. What education have you received in order to work with patients or population with diverse cultural background?
6. What form of nursing/cultural competency education did you received?
7. How would you describe the availability of educational opportunities on the subject of caring for patients or population with diverse cultural background?
8. What is your understanding of the term “cultural competence”?

9. Describe how the culture of your client might influence your practice?
10. Describe how your culture affects your practice?
11. Describe how your knowledge of different cultures and of cultural competency affects your practice
12. How could education foster better nursing care for patients or population with diverse cultural background?
13. Any further comments or additions?

Appendix D



Consent Form for Subjects Participating in Qualitative Interview

Title: Understanding Cultural Competence through Registered Nurses in Community Health Care Settings

Sponsor: Unfunded

Principal Investigator:

Dr. Tam Donnelly

Professor, Faculty of Nursing, University of Calgary

Researcher:

Evelyn A. Anokye-Owusu, BN, RN

Graduate Student, University of Calgary

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

Background

You are invited to take part in this study because you are an English-speaking Registered Nurse working in a community healthcare setting that serves a large population of ethnically diverse patients/clients. In this interview, we would like to talk about your experiences in with working with ethnically diverse patients/ clients and any form of education and resources you have received to provide care. The information you provide in this interview will offer information about things that have helped or not helped you provide care to diverse patient/client populations. This will help to identify ways of improving education to registered nurses about providing culturally sensitive care to diverse populations in Calgary and area.

What is the Purpose of the Study?

This research study aims to explore the experience of nurses working with culturally diverse patients in Alberta to better understand what barriers and challenges they may face, as well as what resources help them. **What would I have to do?**

If you agree to participate in this interview, you will be one of approximately 10 people participating in the study. You will be asked to participate in a sit-down one-to-one interview

lasting approximately 45 minutes to 1 hour. During the interview, the following things will happen:

1. You will be interviewed by the study investigator.

2. You will be asked 10-15 open ended questions about your experiences working within your work setting. You will be able to respond to these questions with as much detail as you like.

3. The interview will be recorded and later transcribed for purposes of study.

What are the Risks?

There are no specific risks to you participating in this interview. The information collected in this interview will inform health care educators about the need of cultural education for Registered Nurses. Minimal personal information will be collected from you when interviewed. All personal information will be kept confidential. After the interview process, the recorded information will be transcribed, coded and stored on a secure drive. The interview documents will be stored in a locked cabinet within a locked office. Only the researcher and supervisor involved with this project will have access to your interview.

Will I benefit if I take part?

If you agree to participate in this study, there may or may not be a direct benefit to you. Your participation in this study will help inform educators of needs of Registered Nurses and help refine or develop new educational approaches to providing culturally based care for patients/clients.

Do I have to participate?

Your participation in this study is voluntary. You are free to refuse to take part or to withdraw at any time until data has been collected and interpreted. At this point, your information will not be able to be extracted from data; however, confidentiality will still be maintained.

Will I be paid for participating, or do I have to pay for anything?

Your participation in this study is voluntary. You will not be given financial reimbursement (money) for participating in the study. You will not have to pay for anything. There is no direct cost to participating in the study.

Will my records be kept private?

All information obtained during the interview will be held in strict confidence. No names or identifying information will be used in any publication or presentations. No information identifying you will be transferred outside the investigators in this study or the study location. However, the University of Calgary Conjoint Health Research Ethics Board will have access to the records.

The pseudonym I suggest for myself is:

_____

Signatures

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. If you have further questions concerning matters related to this research, please contact:

If you have any questions concerning your rights as a possible participant in this research, please contact the Chair of the Conjoint Health Research Ethics Board, University of Calgary, at 403-220-7990.

Participant's Name	Signature and Date
Investigator/Delegate's Name	Signature and Date
Witness' Name	Signature and Date

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

A signed copy of this consent form has been given to you to keep for your records and reference.

Appendix E

Entry to Research Site E-mail Script

To: Public Health Managers,

Hello, my name is Evelyn Anokye, and I am a student at The University of Calgary with a research focus on cultural competence and mainly understanding cultural competence in Registered Nurses. This research is part of my work towards my Masters Degree in Nursing at the University of Calgary. For my thesis I plan to interview nurses who have exposure to many clients/patients from diverse ethnic backgrounds to describe these challenges. I am looking to recruit ten Registered Nurses working within community healthcare settings and am contacting you to see if you and your staff would be interested in participating. Should you and your staff agree, participants will be asked to complete a one-to-one interview (which should take about 45-60 minutes), at a time that is most convenient for them. The interview involves questions of nurse's knowledge and experiences working with diverse patients/clients. Nurses will have complete latitude to choose whether or not to participate in the research. Confidentiality and anonymity will be kept for all participants.

Please feel free to contact me by phone or email with any questions or concerns regarding my project.

I look forward to hearing from you,

Evelyn Anokye BN RN University of Calgary Master of Nursing Student