2022

Nurses' Perceptions of Culturally Competent Care at the Bedside

Judith Cox
Walden University

Walden University

College of Nursing

This is to certify that the doctoral dissertation by

Judith A. Cox

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Janice Long, Committee Chairperson, Nursing Faculty
Dr. Kelly Fisher, Committee Member, Nursing Faculty
Dr. Mirella Brooks, University Reviewer, Nursing Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2022

Abstract

Nurses' Perceptions of Culturally Competent Care at the Bedside

by

Judith A. Cox

MSN, Walden University, 2015

RN, Mid Michigan Community College, 2008

LPN, Mid Michigan Community College, 2007

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Nursing

Walden University

August 2022

Abstract

The population served by health care systems in the United States is widely diversified, which requires nurses to be culturally competent in their care practices. However, studies have shown that nurses do not consistently deliver culturally competent care. This basic qualitative study was designed to explore nurses' perceptions of cultural competence at the bedside to understand what is needed to improve cultural competency practices. Campinha-Bacote's conceptual framework for cultural competency was used to guide this study that included face-to-face, videoconference interviews using semi structured and open-ended questions from 13 voluntary, acute care bedside nurses. Interviews were audio recorded and uploaded to NVivo software for transcription. Saldana's first and second cycle manual coding and code weaving were used to identify themes with NVivo software used for organization and verification. Results revealed five themes:(a) cultural knowledge, (b) self-awareness, (c) barriers to cultural competency, (d) educational process, and (e) current culturally competent practices. All five themes aligned with the constructs of Campinha-Bacote's cultural competence model. The findings of this study may promote positive social change by identifying strategies for cultural competency improvement at the bedside and in nurses' delivery of care. Recommendations for future studies include quantitative or qualitative studies that identify tools and education to improve nurses' knowledge and skills in delivering culturally competent care.

Nurses' Perceptions of Culturally Competent Care at the Bedside

by

Judith A. Cox

MSN, Walden University, 2015

RN, Mid Michigan Community College, 2008

LPN, Mid Michigan Community College, 2007

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Nursing

Walden University

August 2022

Dedication

I want to dedicate this dissertation to my grandmother, Sandy, who was my biggest supporter through my educational endeavors. My grandmother did not live long enough to see me accomplish this goal, but I have felt her encouragement and love from heaven, especially when it seemed I would never reach my end goal. Thank you for your love and support. I hope I make you proud.

Acknowledgments

I have been blessed with a great support system of family, friends, and friends who are now considered family. My father, Joe, has instilled in me a strong work ethic, which has kept me going through this long process. My mother, Kim, has the biggest heart and has always encouraged me to use mine to see things from other peoples' perspective, which has led me to the topic I chose to study. My sister, Jessica, has grandiose visions of who I am as a person, and I strive to be that woman for her every day. I would like to recognize my loved ones, there are a lot of them, not mentioned above for their constant love, endless words of encouragement, understanding, and patience; I would not have made it this far without you. I would also like to recognize my friends, colleagues, and Walden University peers for answering all my questions, encouraging me to move forward, and challenging me to think outside the box. I am so grateful for the parts you have, and continue to, played in my life. In addition, I appreciate Dr. Long and Dr. Fisher's guidance as my committee chair and member, respectively.

I thank you all, from the bottom of my heart!

Table of Contents

List of Figures

Chapter 1: Introduction to the Study

The increasing diversity in the U.S. population has warranted the need for nurses to be culturally competent. An increase in *cultural intelligence*, which is defined as the ability to identify, interpret, and understand behaviors of a group of people or a situation, has been shown to increase competence in cultural situations as well as effective health care delivery (Cultural Intelligence Center, n.d.; Thompson, 2018). To provide optimal health, ensure positive patient outcomes, and promote patient satisfaction, nurses need to provide culturally competent care (McLennon, 2019). Cultivating culturally competent behavior, decreasing biases, and demonstrating cultural competence, is the responsibility of the nurse. Governing organizations of nursing practice have commissioned standards of practice regarding culturally congruent care (American Nurses Association [ANA], 2015; The Joint Commission, 2011; Office of Minority Health, 2016). Additionally, the American Association of Colleges of Nursing (AACN, 2008) and the National League for Nursing (2016) created cultural competency curricular requirements.

The social implications of this study support nursing practice that respects and honors each individual patient and their culture, especially regarding health and wellness. In this chapter, I will discuss the background of cultural competence research, the problem statement and purpose of this study, research question, and the conceptual framework of this study. Additionally, I will cover the assumptions, delimitations, limitations, and the significance of the study, ending with a summary.

Background

Cultural competence has become a key principle in nursing practice that is intended to foster cross-cultural communication, decrease health disparities, improve access to health care, and promote equality in health care (Campinha-Bacote, 2019). The ANA (2015) decrees a set of standards of practice for nurses, one of which depicts culturally competent care as the nurse's ability to demonstrate "respect, equity, and empathy in actions and interactions with all health care consumers" (p. 69). As patient populations become increasingly diverse, it is imperative that nurses cultivate personal culturally competent practice. There is a general consensus among researchers in the field of cultural competence and health care that cultural competence needs to be improved at the bedside (Clarke, 2017; Taylor & Alfred, 2010; Young & Guo, 2020). Varied assessment tools, cultural immersion, community involvement, and education have all been suggested as interventions to improve and support cultural competence at the bedside (Garrido et al., 2019; Kovner et al., 2018; Martin et al., 2019; Schwarz et al., 2015). Self-efficacy tools are often utilized in the existing research. Using these tools, research findings indicate that practitioners believe they have the capacity to provide culturally competent care (Aboshaiqah et al., 2017; Garrido et al., 2019). Nonetheless, improvements in cultural competence are needed at the bedside (Garrido et al., 2019; Kovner et al., 2018; Martin et al., 2019; Schwarz et al., 2015; Young & Guo, 2020).

Due to the necessity to improve bedside cultural competence, this study is needed to address what is occurring at the bedside and to better understand how nurses can successfully implement cultural competence into their own practice. The gap in

knowledge that my study addressed is that what is known about the practice of cultural competence in bedside nursing care is not consistent with what is happening at the bedside. This study addressed this gap by giving nurses an opportunity to describe their perceptions of with cultural competence at the bedside.

Problem Statement

The United States is becoming increasingly diverse. According to the 2018 U.S. Census, the population was reported as 76.5% White American, 13.4% Black American/African American, 1.3% American Indian, 5.9% Asian, and 2.7% with two or more races. With the increasingly diverse population, consumers of the U.S. health care system are also becoming more diverse, placing a challenge on health care systems to meet the needs of this population (Joo & Liu, 2020). As a result, nurses must become culturally competent. Although the concept of integrating cultural competence into nursing curricula is acknowledged by academia, and nurses, the problem faced by health care systems is that culturally competent care is not consistently delivered at the bedside (Alzadeh & Chavan, 2016; Covel & Sidani, 2013; Gallaher & Polanin, 2015; Garrido et al., 2019; Kovner et al., 2018; Martin et al., 2019; McClimens et al., 2014; Young & Guo, 2020). Even with the knowledge that nurses feel they are culturally competent, some improvements, such as cultural support to increase awareness, training, and skills, as well as integrating culturally appropriate evidence-based knowledge at the bedside, are still needed (Curtis et al., 2016; McClimens et al., 2014; Oikarainen et al., 2019; Palese et al., 2019). It is unknown whether the issue lies in how academia presents cultural competence in the nursing program, or with the support, or lack thereof, available to

nurses in their practice. Exploring nurses' perceptions of cultural competence at the bedside can help to understand what is needed to support culturally competent bedside practices (Curtis et al., 2016; Debesay et al., 2014; Degrie et al., 2017; Joo & Liu, 2020; Ogbolu et al., 2018).

During the literature review, no studies were identified that address the reasons some nurses feel they are culturally competent when the level of culturally competent care has been shown to be lacking (Curtis et al., 2016; Palese et al., 2019). The results of this study provide insights into nurses' perceptions about how cultural competence is delivered in the practice setting. Additionally, knowledge from this study support future strategies for culturally competent care delivery. The aim of this study was to learn from nurses about how culturally competent care is implemented into practice, to determine if the gap lies mainly in academia, practice, or a combination of the two areas. Understanding this gap can assist in promoting cultural competence practices at the bedside. This study is unique because it addresses an under-researched area of cultural competence (Young & Guo, 2020) with a group of participants who are required to learn and implement cultural competence at the bedside (ANA, 2015; Office of Minority Health, 2016; The Joint Commission, 2011).

Purpose of the Study

The purpose of this qualitative study was to understand nurses' perceptions and application of cultural competence into practice, how they implement cultural competence into their practice, and any barriers they might perceive to this implementation. I also considered how educational methods, either formal or on the job,

might influence cultural competence in practicing nurses. Further, I explored the tools or other forms of support that foster culturally competent practice at the bedside.

Research Question

The specific research question that supports the aim of this study was as follows: What are the perspectives of acute care nurses in a midwestern state regarding the way culturally competent care is delivered at the bedside?

Conceptual Framework for the Study

Campinha-Bacote developed a model that contains five constructs of cultural competence, which include cultural awareness, cultural skill, cultural knowledge, cultural encounters, and cultural desire (Transcultural C.A.R.E. Associates, 2015). Campinha-Bacote's process of cultural competence in the delivery of health care services model focuses on the development of cultural desire as an individual engages in the process of seeking cultural encounters, gaining cultural knowledge, and becoming culturally aware while using learned cultural skills (Byrne, 2016). This framework depicts cultural competence as a continuous learning orientation in which nurses view themselves as becoming culturally competent versus already being culturally competent (Abitz, 2016). This model is an appropriate framework for this because it is geared toward health care delivery and the process nurses are encouraged to take to incorporate cultural competence into practice. The research question of this study was geared toward nurses' perceptions of the concept of cultural competence as well as how they utilize it in their practice, which is in alignment with the Campinha-Bacote framework.

Nature of the Study

The nature of this study was a basic qualitative design to understand nurses' comprehension of culture and cultural competence in practice. This research design allowed me to explore nurses' perceptions of how they implement cultural competence into practice, specific to any barriers they might perceive as well as other forms of support nurses utilize to assist them in providing culturally competent care at the bedside. Data were collected via interviews, face-to-face via videoconference (i.e., Zoom). The study focused on two health systems that serve a variety of patient populations in a Midwestern state. An email and flyer were distributed at the health systems providing a brief description of the study and asking for registered nurses to volunteer for the interviews. I audio recorded the interviews and transcribe each one. Coding was performed manually to identify major codes, then NVivo software was used to organize and identify patterns. The participants were de-identified with each interview and transcription.

Definitions

The following terms are commonly noted throughout the literature and identified as an operational definition.

Cultural awareness: The self-reflective process of becoming aware of one's own biases, including potential racism, regarding other cultures (Transcultural C.A.R.E Association, 2015).

Cultural competence: The integration of cognitive and practical skills into nursing practice (Jeffreys, 2016). Cultural competence deals with an individual's *cultural*

intelligence, which is defined as the ability to identify, interpret, and understand behaviors as a part of a group of people or a situation (Cultural Intelligence Center, n.d.).

Culturally congruent care: Health care that considers an individual's cultural believes, practices, and lifestyles when creating a plan of care (Alligood, 2018).

Cultural desire: The motivation of health care provider's desire to be knowledgeable and skilled regarding other cultures, while seeking cultural encounters to further that knowledge and skill base (Transcultural C.A.R.E. Association, 2015).

Cultural diversity: Defined as the presence of a variety of cultural or ethnic groups within a region (Oxford University Press, n.d.).

Cultural encounters: The interactions in which health care providers engage in direct contact with persons from varying cultures (Transcultural C.A.R.E. Association, 2015).

Cultural humility: Defined as personal reflection and critique regarding culture across the lifespan (Tervalon & Murray-Garcia, 1998).

Cultural knowledge: The educational process of seeking and obtaining information about culturally diverse groups of people (Transcultural C.A.R.E. Association, 2015).

Cultural sensitivity: The acknowledgement and acceptance of other cultures (Foronda, 2008).

Cultural skill: The ability to conduct a culturally based assessment of relevant data related to physical, spiritual, psychological, and medicinal problems (Transcultural C.A.R.E. Association, 2015).

Transcultural nursing: Having the ability to provide nursing care for individuals in a culturally meaningful manner by focusing on cultural care values, beliefs, and practices of individuals or groups of cultures (Alligood, 2018).

Assumptions

Assumptions are things researchers believe to be true but cannot be proven, yet they are critical to the success of the study (Simon & Goes, 2013). One assumption I made in this study was that nurses know what cultural competence is, and they understand the implications of cultural competence has on their nursing practice. Cultural competence is a concept required in nursing academia (AACN, 2008). A review of the literature indicated that nurses claimed to be taught cultural competence in their formal education (Alzadeh & Chavan, 2016; Gallaher & Polanin, 2015; Garrido et al., 2019; Kovner et al., 2018; Martin et al., 2019; Young & Guo, 2020).

Another assumption was that nurses would be honest about their level of bedside cultural competence. Cultural competence is a part of the nursing scope and standards of practice dictated by the ANA (2015), which makes it a necessity of the role. To promote honesty within the study, the participants were volunteers, and they could withdraw from the study at any time with no negative ramifications. Additionally, the participants were assured of strict confidentiality and anonymity during their participation in the study.

A subsequent assumption was that cultural competence was warranted in the region in which the study occurred. However, there was a potential that cultural competence was not implemented because the area was lacking a rich cultural diversity. Cultural diversity includes ethnicity, religion, language, nationality, sexual orientation,

class, gender, age, disability, health differences, and more (Alligood, 2018; Byrne, 2016; Jeffreys, 2016; Leininger, 1993). With this inclusion criteria, this study was conducted under the assumption that cultural competence within practice was needed in the regional nursing practice due to patient diversity. It was also assumed that, based on those same inclusion criteria, nurses have experienced cultural competency in their practice. This experience allowed the nurses to speak to their perspectives of cultural competence in practice at the bedside.

Scope and Delimitations

The scope of the study defined its extent and parameters (Simon & Goes, 2013). Cultural competence needs to be improved at the bedside and it is unknown if this is an issue stemming with academia, or instead within the practice setting. Exploring practicing nurse's perspectives of cultural competence at the bedside can help to illuminate the path in which to make improvements. It is believed that through nurse's perspectives understanding can be gained of the potential breakdown in the system that allows a nurse to provide culturally competent care at the bedside.

Delimitations of the study define the choices that were made and how this can influence the study (Simon & Goes, 2013). The population of this study is practicing, registered nurses. The region in which this study took place is in close proximity to me as well as health systems in the region. This allowed for good comparison for general nursing practice. Additionally, the two health systems provide health care access to a large population of patients, which increased the general diversity and lent creed to the cultural competence instances.

The conceptual framework that was used for this study is Campinha Bacote's model of cultural competence. This model was chosen above the other models for a variety of reasons. This is a common model noted in research, it has been validated for use with both practicing nurses and nursing students, it is relatively simplistic, and it has been used as an evaluation tool for improving cultural competence in health care (Alzadeh & Chavan, 2016; Gallaher & Polanin, 2015). The application and relevance to nursing practice was the key factor related to choosing this model. Many of the other models were specific to teaching cultural competence or self-efficacy of an individual practitioner's cultural competence. However, the focus of this study was on the application of cultural competence at the bedside, which fit best with the Campinha Bacote model of cultural competence.

The aim of the study was to understand nurse's perspectives of culturally competent care at the bedside, which make a qualitative study the best option. When applying the aim of the study to the types of qualitative studies, a general qualitative study fit best. The study did not fit the criteria for a phenomenological, ethnographic, grounded theory, case study, historical event, or narrative model.

Transferability relates to the generalizability of the research (Rubin & Rubin, 2012). Cultural competence is a requirement of nursing practice. Determining nurse's perspectives of cultural competence at the bedside can bring light to potential areas of improvement related to improving cultural competence at the bedside. Interviewing practicing nurses made it relevant to both nurses and their practice.

Limitations

The study was limited due to it only representing a specific region of a Midwestern state in the United States. Additionally, due to the rural nature of the region, the cultural perceptions can be skewed or insignificant when attempting to find common themes. More participants, particularly from various regions, utilized for this study, would help to create a clearer understanding of the results, and thus the phenomenon of cultural competence at the bedside. The overall theme of the interviews was based on perceptions of nurses' culturally competent practice, yet a clear understanding of cultural competence and the necessity of culturally competent care are also necessary. Without that foundational knowledge, the collected data could be askew. This limitation can be further explored through additional qualitative research.

Another potential limitation was related to the state of the COVID-19 pandemic. This had the potential to limit the number of participants within the study. The study was aimed at practicing nurses, but due to the nature of the pandemic, nurses were working overtime, quarantined at home, or pulled to different areas to assist and relieve the workload of the unit. These combined conditions could have made participant recruitment for the study difficult.

Significance

For this study I interviewed nurses to learn their views of cultural competency, and how it is used, or not used, in patients' care in their nursing practice. Cultural competence is a standard of nursing practice (ANA, 2015). It was believed that this could be accomplished through training programs, enhanced guidelines, increased cultural

awareness, and social determinants being culturally driven (Garrido et al., 2019; Galligher & Polanin, 2015; Kovner et al., 2018; Maiocco et al., 2019). Due to the need for improvement in culturally competent care at the bedside, the lack of which can lead to poor patient outcomes, health care professionals can benefit from understanding perceptions or practicing nurses and cultural competence. Insights from this study should aid health care professions in understanding the disconnect between learning about cultural competence and translating this knowledge into clinical practice. Additionally, the research could address barriers and facilitate support of culturally competent nursing practice, an area of patient satisfaction and patient outcomes related to cultural competence. For these reasons, positive social change can be achieved through increased cultural competence at the bedside, which improves patient care, and improved patient care could improve family life, which could result in an increased involvement in the community.

Summary

Cultural competence is recognized as an approach to work effectively across differing cultures to improve health care related to racial and ethnic group's health disparities (Moloi & Bam, 2014; Truong et al., 2014). Overall, the notion that cultural competence is necessary for improving patient outcomes, as well as the premise that it needs to be improved at the bedside, has been frequently noted in research (Alzadeh & Chavan, 2016; Gallaher & Polanin, 2015; Garrido et al., 2019; Kovner et al., 2018; Martin et al., 2019; Young & Guo, 2020). This study aimed to determine nurses' perceptions of cultural competence at the bedside as well as understanding what is

currently occurring at the bedside. Though it is noted that improvement at the bedside needs to occur, it is unclear what aspect of the culturally competent care at the bedside needs to be improved on. To better understand these areas, a literature review was conducted related to cultural competence utilizing specific search terms and key variables.

Chapter 2: Literature Review

Culturally competent care has not consistently occurred at the bedside, indicating a need for improvement (Young & Guo, 2020). The purpose of this qualitative study was to understand nurses' perceptions of how they implement culturally competent care into bedside practice. The importance of understanding this gap in knowledge could assist in promoting culturally competent care at the bedside. In this chapter search strategies, the conceptual framework, and key variables and conceptual framework are discussed.

Literature Search Strategy

The literature review was initially conducted with the search terms cultural *competenc**, *nurs**, and *implementation*. With the timeframe of 2016 to present, 82 articles were found using CINAHL plus with full text, Embase, MEDLINE with full text, and Proquest Nursing & Allied Health databases. Several of the articles discussed interventions and ways to teach students. *Implementation* was changed out for *practices or strategies or approaches*, which yielded 725 articles. Based on the inclusion criteria titles and abstracts were reviewed for eligibility. The process resulted in 227 articles that were reviewed. Databases were the only area that were searched.

Conceptual Framework

Cultural competence is the process of integrating cognitive and practical skills regarding culture into nursing practice (Jeffreys, 2016). Cultural competence deals with an individual's cultural intelligence. Culturally congruent care is health care that considers an individual's cultural believes, practices, and lifestyles when creating a care

plan (Alligood, 2018). Transcultural self-efficacy is the individual's self-confidence of providing culturally competent care (Jeffreys, 2016).

There are several nursing models used as a framework for cultural competence, and six of the major models were considered as a conceptual framework for this study. They include Leininger's (the creator of whom is considered the mother of transcultural nursing; Allgood, 2018), cultural care diversity and universality theory/model, Purnell's model of transcultural health care, Spector's health traditions model (which is an amalgamation of three other models), Campinha-Bacote's model of cultural competence, Jeffrey's cultural competence and confidence model, and Giger and Davidhizar's model of transcultural nursing (AACN, 2008). Cultural competence takes a conscious effort, should be started early on in a nursing program, and should be continued throughout practice (Alligood, 2018). Campinha-Bacote's model of cultural competence is a framework that supports the practice of culturally competent care at the bedside.

I chose the Campinha-Bacote model due to the reasonably simplistic nature of the model, as well as the direct relationship to practice (Transcultural C.A.R.E. Association, 2015). Additionally, this particular model is a common model noted in research. It has been utilized in research to examine self-reported cultural assessments, evaluate improvement to guidelines and protocols via the use of educational training, and examine the impact on practice and workflow at the organizational and community levels (Aboshaiqah et al., 2017; Garrido et al., 2019). In addition, the Campinha-Bacote model has been used to enhance cultural competence through patient experiences, both in the health care setting and using international medical mission trips to assist in decreasing

disparities (Martin et al., 2019; McClimens et al., 2014). It has also been utilized to evaluate current evidence-based practice to increase nurses' cultural competence, review national standards on cultural competence, educational programs, and the efficacy of cultural competence in the context of health care (Alzadeh & Chavan, 2016; Gallagher & Polanin, 2015; Oikarainen et al., 2019; Young & Guo, 2020).

Literature Review Related to Key Variables or Concepts

Much of the research related to cultural competence is accomplished through systematic reviews and meta-analyses. Few studies were strictly qualitative. A general search for cultural competence and nursing practice yielded 725 articles. When searching for qualitative studies, the search results went from 725 to 46 articles. When specified to nursing care, versus nursing education, the results were 16 articles, some of which, upon review, were mixed method research studies. The use of tools to measure cultural competence and self-efficacy were utilized to determine levels of cultural competence in quantitative studies. Several studies were conducted in the form of a mixed method research study, with one noted as having been stopped early due to the responses of violence during the qualitative interviews (Maiocco et al., 2019).

Previous approaches to the research of cultural competence in practice has utilized self-reflection and self-reporting of cultural competence, using a variety of tools. The strength to this approach is that it quantifies the levels of cultural competence at the bedside, which has led to the conclusion that there is need for improvement. Limitations to this approach are that individuals may have skewed perceptions of cultural competence, not understand the definition, or perceive their abilities as more or less adept

than they truly are, which can influence the quantifiable data. To this avail, mixed method research could be helpful, when not stopped early. The studies reviewed could be broken down into the following concepts when considering the elements of the Campinha-Bacote model: awareness, skill, knowledge, encounter, and desire.

Awareness

According to the Campinha-Bacote model, cultural awareness is the process of becoming aware of personal biases, prejudices, and stereotypes regarding other cultures (Transcultural C.A.R.E. Association, 2015). Most people have had or have been the recipient of unconscious biases, prejudices, and stereotypes (Abitz, 2016; Wesp, 2018). Unconscious bias can cause a lapse in cultural competence, which is why awareness is an important step to the cultural competence process. Awareness also means having a respect for cultural differences and understanding how culture influences care. This does not mean a practitioner needs to know all the values and beliefs of all cultures but rather accept the values and beliefs of others, regardless of the cultural differences (Abitz, 2016).

Supporting the practices of various cultures also fluctuate, depending on the situation. Cultural practices differ with death and dying, the birthing process, and general health and wellness. Understanding the practices and traditions in a myriad of areas can assist nurses in their cultural competence, which builds trust and rapport with patients. Establishing that rapport is vital to patient compliance and continuity of care (Wesp et al., 2018). Supporting the practices of multiple cultures in distinct situations requires nurses' active participation in providing culturally congruent care. However, to do so nurses must

be supported in their efforts to provide effective culturally competent care (Crawford et al., 2018; Jeffreys & Zoucha, 2017; Thurman et al., 2019; Wilson et al., 2019).

Several qualitative studies were aimed at analyzing levels of cultural competence (Lin et al., 2019; Moleiro et al., 2018). Cultural competence was analyzed thematically based on interviews related to background, race, religion, and sexuality (Moleiro et al., 2018). Cultural awareness and self-learning were explored for cultural differences in relation to nurses and patient viewpoints (Lin et al., 2019). Meeting the diverse needs of a patient is vital. This requires the nurse's ability to recognize cultural boundaries within a facility, as well as with patients (Crawford et al., 2018). Understanding the cultural influences on beliefs, behaviors, traditions, and customs, which can be influenced by the community, facilities, or health care providers, assists in generating culturally appropriate care interventions (Gordillo Julon et al., 2019; Goyal, 2018; McFadden & Erikson, 2020; Reed et al., 2019).

Another aspect of awareness is cultural humility. Cultural humility is an awareness of perspectives, power imbalances, and the acumen to be humble (Foronda et al., 2016). Without humility, the ability to have cultural awareness could be limited, which will hinder a nurse's capacity to provide culturally competent care. Seeking cultural humility requires self-reflection and seeking practice with culturally diverse populations (Hughes et al., 2020; Purtzer & Thomas, 2021). Awareness of biases, stereotypes, and prejudices also require support and an opportunity to self-reflect, which can occur through education or practice (Ellis Fletcher, 2016). Doing so can increase awareness and improve cultural competence (Ellis Fletcher, 2016; Foronda et al., 2016).

Skill

Cultural skill is the capacity to conduct a culturally based assessment (Transcultural C.A.R.E. Association, 2015). To have the expertise to conduct a culturally based assessment, it is important to have the skill to communicate with member from different cultures. Barriers associated with culturally competent care include communication issues, unclear or missing culturally competent care information, culturally competent training and education, and culturally competent resources (Bahreman & Swoboda, 2016; Hemberg & Vilander, 2017; Joo & Liu, 2020; Livesay et al., 2017). Proper training and education techniques related to communication are suggested to improve cultural competence at the bedside (Larsen et al., 2021; Young & Guo, 2020). Having the capability to communicate effectively allows the nurse to ask culturally appropriate questions, which will lead to the ability to conduct a cultural assessment. Ultimately, that leads to the ability to provide culturally competent care.

Various assessment tools are used for measuring cultural competence and determining areas of need. Often these tools are utilized during the educational process. It is suggested that formal education is not the only avenue in which these tools should be implemented. The nursing cultural competence scale and Purnell model of cultural competence are tools suggested to be applied in practice (Aboshaiqah et al., 2017; Chae & Park, 2018; Gozum et al., 2016; Marzilli, 2016). Tools such as these measure knowledge, skills, and abilities of nurses to provide culturally competent care. Additionally, these tools demonstrate an area in which nurses might need to improve to provide the best possible, culturally congruent care (Purnell, 2016).

Self-assessment and self-efficacy scales can also indicate areas of improvement related to cultural competence (Aviles et al., 2019; Warshawski et al., 2019). It can indicate areas of need related to assessments and culturally competent skills. Understanding cultural needs and expectations are deeply rooted in the cultural skill components of cultural competence. This is initiated by the ability to communicate and properly assesses varied cultural populations (Coleman, 2019; Malmo et al., 2020; Marrone, 2016).

Effective communication is a key aspect of the nursing process. Good communication is vital to safe and effective nursing care, especially when providing culturally competent care (Malmo et al., 2020; Marrone, 2016). Developing rapport with a patient, as well as the patient's support individuals, requires communication transactions, decision-making, and meaningful communication, which can often be influenced by some cultural component, such as gender and familial influences (Marrone, 2016; Moura de Oliveira, 2018). Effective, culturally competent communication will assist the nurse in understand what the patient needs to know and understand about their current situation (Coleman, 2019; Marrone, 2016). Nursing communication, particularly culturally competent communication, is a skill developed over time with each patient encounter (Malmo et al., 2020).

Furthermore, organizational and leadership support are required for the development of cultural skill (Manson, 2017; Zhang et al., 2019). Skill development cannot occur without the support of leadership, as well as the opportunities and training provided by the organization. Competencies and interactive teaching strategies to identify

biases, inform quality, cultural communication techniques, and create awareness are necessary (Bristol et al., 2018; Harmon et al., 2019; Phillips & Young, 2018). Professional biases and the nurse's knowledge and attitude toward certain cultures can influence a cultural encounter, which can be addressed with cultural competency training (Bristol et al., 2018; Harmon et al., 2019). Cultural knowledge can aid in the implementation of cultural skill (Transcultural C.A.R.E Association, 2015).

Knowledge

Cultural knowledge is the process of seeking and obtaining information about culturally diverse peoples (Transcultural C.A.R.E Association, 2015). Many nurses are thought to be lacking basic education associated with varying cultures (Kraus & Duhamel, 2018; Margolies & Brown, 2019; Traister, 2020; Schweiger-Whalen et al., 2018). Support for nursing should include continued training specific to regionally diverse populations. Additionally, knowledge related to societal perceptions, particularly related to generational differences, is key to cultural knowledge (Williams et al., 2018).

A review of the literature showed three overarching themes related to cultural knowledge; they are increasing knowledge via nursing curricula, increasing knowledge through experiences and encounters, and the need to understand biases and assumptions related to various cultures (Markey & Okantey, 2019; Markey et al., 2018; Ndolo, 2016; Peltzer et al., 2017; Schreiber, 2019). Nursing education should allow the nurse to develop cultural competence and start to establish a nursing process that appreciates and respects a patient as an individual, while applying their cultural needs to their care plan (Maphosa, 2017; Marion et al., 2016; Markey & Okantey, 2019). Nursing curricula is the

starting point to understand cultural differences that can lead to culturally competent care using culturally competent education by challenging established traditional perspectives and providing informational threads about various cultures (Carabez et al., 2016; Escobar-Castellanos, 2017; Peltzer et al., 2017; Woods et al., 2017).

Understanding cultural differences is largely rooted in realizing biases and assumptions related to various cultures, which leads to cultural sensitivity (Schreiber, 2019). Respect and dignity are basic human rights, which nurses need to adhere to in daily practice. Comprehending the cultural perspectives of a patient is one way to respect a patient and provide dignity, which is accomplished through considering the perceptions of the culture, how the culture might interpret illness and wellness, and grasping the differences in how cultures' view treatment options (Asmanigrum & Tsai, 2018; Truglio-Londrigan, 2016). Additionally, nurses need to have knowledge of their own biases and assumptions, as well as those of society, related to the cultures they are caring for (Campinha-Bacote, 2019; Jeffreys, 2016; Leininger, 1993; Purnell, 2016; Rising, 2017).

The final theme noted is the approach to increase cultural knowledge through experiences and cultural encounters (Crawford et al., 2017; Markey et al., 2018; Ndolo, 2016). The more nurse-patient interactions that occur, the more nurses have the opportunity to explore various cultural factors and influences related to health and illness (Crawford et al., 2017; Radix & Maingi, 2018). The nurse-patient interactions are not necessarily related to those in a health care facility. Cultural experiences are also encouraged in the form of field work and working abroad (Gol & Erkin, 2019; Nodolo, 2016).

Encounter

Kallakorpi et al. (2018) discussed the topic of nurses' experiences when treating patients from differing cultures. Perceptions, barriers, and collaborative efforts were explored in association to these types of encounters. Multiple facets, such as family dynamics and stigmas, were considered in relation to culturally competent care (Kallakorpi et al., 2018). Experiences with culturally specific health disparities, as well as the notion of illness and folk remedies were explored (Langton, 2018; Roldan-Chicano et al., 2017). Comparison of folk medicine to traditional medicine and nursing experiences with both were discussed (Langton, 2018; Murcia et al., 2016; Roldan-Chicano et al., 2017).

The review of the literature presented four overarching themes of clinical encounters, which are during initial formal education, such as in nursing school, through personal encounters and training, encounters in clinical practice, and encounters through mission work (Davis, 2020; Dos Santos Pennafort, 2018; Langton, 2018; Maiocco et al., 2019). The initial exposure to cultural encounters should start during formal education; for instance, in nursing school (Biles, 2018; Dos Santos Pennafort, 2018). Exposure and clinical encounters with indigenous peoples, as well as various cultures within a region, will help to build confidence and skills in the novice nurse (Biles, 2018; Dos Santos Pennafort, 2018).

Encounters should also occur through educational processes such as in-services, conferences, and with cultural institutions, in which personal accounts can be shared (Faught, 2016; Lin et al., 2019; Maiocco et al., 2019; McBride, 2016). Indigenous

peoples, veterans, individuals experiencing homelessness, members of the lesbian, gay, bisexual, transgender, and ally (LGBTA) community, and other various cultures can provide an insight into health disparities, perceptions, and needs that can inform the nurse for future practices (Faught, 2016; Maiocco et al., 2019). However, for this to occur, nurses must be aware of the need, resources, and availability to train and encounter these situations. Encounters in this manner also include environmental engagement. The environment or education can be stigmatized, which will then influence personal practice by coloring judgements and perceptions (Blanchet Garneau et al., 2017; Schweiger-Whalen et al., 2018).

Encounters in clinical practice will help to build culturally competent nursing practice by exposing the nurse to practice variants that have cultural influences, such as folk medicine, research programs, sensitivity in care practice, and the complexities of caring for individuals from different cultures (Gobeyn, 2018; Langton, 2018; Mendes, 2018; Nilson, 2017). Such encounters allow the opportunity to ask questions, observe the situation, and respond accordingly (Ritchie, 2018). To better serve a patient from a differing culture, it could require consulting experts in the cultural practice, which might be a scarce resource in some regions (Fowler, 2017).

The research noted various barriers to cultural competence specific to encounters with clinical practice. The barriers include, but are not limited to, language barriers, cultural manifestations and stereotypes, resources and support, and hesitancy with unfamiliar practices or cultures (Arias Murcia, 2016; Baza & Quintero, 2018; Castillo, 2019). Additionally, limited encounters with sensitive situations that are specific to

certain cultures, such as military sexual trauma, influence a nurse's ability to provide culturally competent care (Elliott, 2018).

Mission trips are also noted as a theme with cultural encounters. Mission trips help gain a deeper understanding of various cultures by creating a more emic perspective of the culture (Davis, 2020; Jarufe, 2020). Mission trips not only increase the cultural knowledge base, but also helps to build relationships with differing cultures that can maintain congruence during practice (Tsujimura et al., 2016). However, a limitation to a specific culture was noted with mission trip encounters (Davis, 2020; Tsujimura et al., 2016). Prior to engaging in an encounter, the nurse must have a desire to be culturally competent (Campinha-Bacote, 2019).

Desire

Building a rapport with a patient is an important aspect of nursing practice. Attitudes and perceptions about cultures and cultural competence can influence this process. Alpers (2018) discussed building a relationship with patients when there are cultural and language barriers. Alpers (2018) study is a good synopsis of factors that influence creating cultural competence and the relationships necessary to sustain culturally competent care.

Cultural desire on behalf of the nurse is multifaceted. Nurses must desire to seek ways to be culturally competent, reflect on personal biases and beliefs, and want to think more creatively (Hunter, 2020; Karnick, 2016; Milton, 2016). To think creatively regarding cultural practices and needs a nurse must create self-awareness and sensitivity through reflective practices (Dobrowolska, 2020; Laskowski-Jones, 2020; Uzar-Ozcetin,

2020). Through reflective practices nurses must evaluate personal biases, cultural beliefs, how they perceive the importance of cultural competence, and the value they set on diversity (Debs-Ivall, 2018; Milton, 2016; Yoder-Wise, 2018). If a nurse perceives high importance on cultural competence, they should have a willingness to employ strategies to promote cultural competence, explore diverse populations, hold a core value of awareness and inclusion, and seek ways to understand individual patients for their cultural needs, as well as the unique perspectives each patient has related to health and illness (Heaslip, 2018; Jeffreys, 2017; Karnick, 2016). Cultural desire can be added by diversity in the workplace.

Diversity in the Workforce

Due to the changes in the United States' demographics, hospital systems and providers are being encouraged to hire more diverse nursing workforce (Day-Calder, 2016; Johnson, 2016; Gregory, 2017). A key factor in reducing disparities in health outcomes for ethnic and minority communities is believed to be the lack of diversity in the nursing workforce (Johnson, 2016). Safe, quality patient care is dependent upon effective communication, a well-versed treatment team, and an understanding of the diversity within, and among, patients. A diverse health care team can develop a culturally competent treatment plan for patients, which is expected to increase understanding on behalf of the patient, as well as patient and family compliance (Day-Calder, 2016; Johnson, 2016). Additionally, patients are expected to have an increase in positive outcomes when the nursing care is culturally competent, which requires culturally knowledgeable, well informed, and diverse health care team members (Riner, 2018).

Theories

The literature also highlighted a variety of theories. Leininger's theory of cultural care diversity and universality, Campinha-Bacote's process of cultural competence in delivery of health care services, Jeffrey's cultural competence and confidence model, and Purnell's model of cultural competence were all noted frequently throughout the research. Other theories such as historical retrospective, Andrews & Boyle transcultural interprofessional practice, and structural theorizing that combined various theories were also noted. All the theories had a common thread of developing competency in cultural practices specific to care (Andrews & Boyle, 2019; Drevdahl, 2018; Lin, 2016; McFarland & Wehbe-Alamah, 2019).

Summary and Conclusion

Through the process of reviewing the literature, the need for improvement in cultural competence at the bedside, was noted a multitude of times. It is believed that this can be accomplished through the use of training programs, enhanced guidelines, increased cultural awareness, and social determinants being culturally driven (Garrido et al., 2019; Galligher & Polanin, 2015; Kovner et al., 2018; Maiocco et al., 2019). Cultural competence is recognized as an approach to work effectively across differing cultures to improve health care related to racial and ethnic groups' health disparities (Moloi & Bam, 2014; Truong et al., 2014). Overall, it is accepted that cultural competence is necessary for improving patient outcomes, as well as the need for improvement at the bedside. While it is noted that improvement at the bedside needs to occur, it is unclear what aspect of the culturally competent care at the bedside needs to be improved upon. This study

aimed to determine nurses' perceptions of, as well as what is occurring with, cultural competence practice at the bedside. Insights from this study should aid health care professions in understanding the disconnect between learning about cultural competence and translating those skills into clinical practice. Understanding what is occurring at the bedside is meaningful to understanding the perceived disconnect between the need for cultural competence and what is taking place in practice. Conducting qualitative interviews with nurses will help to bring awareness to nurses in current practice. Additionally, the research could address an area of patient satisfaction, patient outcomes, and the amount of respect patients perceive in their care related to cultural competence.

Chapter 3: Research Method

The purpose of this basic, qualitative study was to understand nurses' perceptions of how they implement cultural competence into practice as well as any barriers. The approach of this study was useful for providing a unique understanding of the context of cultural competence in nursing practice (Creswell, 2013). The participants in this study were acute care nurses who currently practice at the bedside. In this chapter, I identify the pertinent elements of, and rationale for, the research design. In addition, I restate the research question, as it supports the study; describe the role of the researcher; explain the methodology of the study; and address issues of trustworthiness. Furthermore, participants and instruments utilized during the study are discussed.

Research Design and Rationale

The specific research question that supports the aim of this study was "What are the perspectives of acute care nurses in a midwestern state regarding the way culturally competent care is delivered at the bedside?" The central concept of this study was cultural competence, which is defined as the process of integrating cognitive and practical skills into nursing practice (Jeffreys, 2016). More specifically, this study focused on the concept of cultural competence and how it is performed at the bedside. Qualitative interviews were used to explore the concept of cultural competence in acute care nurses. Understanding the perceived disconnect between the need for cultural competence and current cultural competence practices may provide opportunities for improving cultural competence in bedside nursing practice. By conducting qualitative interviews with nurses, I gained an understanding of how, and to what degree, current

cultural competence is practiced. An exploration of the themes noted in the interviews may offer insights into current practice, as well as the nurses perceived needs related to cultural competence at the bedside.

Role of the Researcher

In qualitative research, the researcher is the human instrument (Ravitch & Carl, 2016). As the researcher, my role was to collect data and safeguard the participants and the data collected. During the collection process my essential duty was to allow the participants' experiences to emerge as they were perceived by the participants, versus those of the researcher's perspectives (Creswell & Creswell, 2018). As the primary instrument of data collection and analysis, my role was also that of an observer-as-participant during the interview process (Gray et al., 2017). Observational research is used to explore the context of behaviors, attitudes, beliefs, and knowledge of the study participants while taking notes, which can improve the dependability of the study (Korstjens & Moser, 2018; Ravitch & Carl, 2016). I practiced note taking during my literature review and in my professional capacity as a committee member. I implemented these techniques during my interviews, and while coding the completed interviews.

There was no personal or professional relationship between the participants and this researcher. The participants were recruited from areas in which I do not work nor have any workplace capacity. As I was the primary instrument of collecting, coding, and analyzing the data, there was a potential bias that dictates the need to be objective and nonjudgmental in my thoughts, observations, and actions (Ravitch & Carl, 2016). The potential bias could be from my strong belief that cultural competence should be a part of

each nursing encounter, as well as be supported by health care organizations, to ensure nurses have the capabilities to practice culturally competent care. I addressed my bias by deidentifying the participants and organizations they work for as well as utilizing the transcript to be as objective as possible. Closely tracking subjectivity from the beginning of the research, versus after gathering the data, can assist in avoiding biases (Creswell & Creswell, 2018).

Methodology

Participant Selection Logic

The participants of the study were to be registered nurses who practice at the bedside and volunteered for the study. The participants were selected using purposeful sampling, which provides rich context and details of a phenomenon of interest (Ravitch & Carl, 2016). Acute care, registered nurses who practice at the bedside can provide their knowledge, experiences, and perceptions related to culturally competent practices at the bedside. A flyer as well as an email to the director of nursing from each health system were used for recruitment purposes of acute care nurses from different health care systems in a midwestern state. The flyer allowed for easier dissemination of the information necessary for recruitment purposes.

The inclusion criteria were that each participant be a current, practicing, registered nurse. This information was verified with the nurse, verbally, at the time of setting up the interview. The goal of qualitative research was to answer the research question ethically and thoroughly, whereby achieving a complex and rich understanding of the phenomenon (Ravitch & Carl, 2016). To achieve this goal, the number of

participants becomes less important than in quantitative research (Ravitch & Carl, 2016; Creswell & Creswell, 2018). The number of participants for this study were determined when saturation was attained. This was determined when the collection and analysis of the data are deemed unnecessary by recurring themes (Ravitch & Carl, 2016; Creswell & Creswell, 2018). Each participant was deidentified using a number to code to link them to the corresponding interview. The coding will include a sequential number along with the date of the interview (i.e., 1.2.14.21).

Instrumentation

The qualitative analysis was accomplished through personal interviews, face-to-face via Zoom, that was transcribed and organized for reviewal and re-reviewal to create initial codes (see Saldana, 2016). The audio recording feature of Zoom was utilized to record each interview, and NVivo was used for electronic transcription of each interview. Additionally, an interview guide was used to guide all the semistructured interviews. The semistructured interview guide was a framework of predetermined questions that were asked of each participant to support consistency of throughout the interview process (McGrath et al., 2019). The predetermined questions were designed to support the research question by gathering demographic data, along with the nurses' perceptions of cultural competence in their nursing practice. An example of the interview guide is provided in Appendix A. I asked 12 questions, the first four of which were aligned to collecting demographic data related to the credentials and roles of the nurses. A notepad was kept available for note taking and possible follow-up and clarification questions.

Due to meeting restrictions associated with the COVID-19 pandemic, the interviews took place via Zoom. Each interview was recorded, which was included in the consent form, as well as communicated to the participant. Local Zoom recordings were saved to my personal computer, which were then moved to an encrypted universal serial bus (USB) storage device (Zoom Video Communications, 2021). The audio files were then used for transcription, via the software NVivo, immediately following the interview.

Transcribing the audio files of the interview was conducted using NVivo transcription services, which could then be downloaded to my computer (QSR International, 2021). After the transcription was complete, I then played the audio recording, while reading the transcription to check for accuracy. Corrections to words or phrases that may have been incorrectly translated occurred at this time. Additionally, comparing notes made during the interview helped to facilitate my analysis of each transcript. I sent a thank you email to the participant, along with an attached copy of the transcript, asking the participant to review for accuracy.

Procedures for Recruitment, Participation, and Data Collection

Qualitative interviews were used to provide the participants' experience with cultural competence in their nursing practice (Gray et al., 2017). The data was collected through personal interviews, face-to-face via Zoom. I, as the researcher, was the interviewer. The data was then transcribed, prepped, and organized for reviewal to create initial codes (Saldana, 2016). Zoom was used to audio record the interviews (Zoom Video Communications, 2019). The audio recording was then transcribed using NVivo.

The study focused on health systems that serve a variety of patient populations in a Midwestern state. A recruitment flyer and email were sent to management and nurse educators at the different health systems as a recruitment strategy. The email contained the inclusion criteria for volunteers for this study. The flyer was also attached to the email.

The interviews continued to the point of saturation, which was determined by recurring themes (Ravitch & Carl, 2016; Creswell & Creswell, 2018). If recruitment resulted in too few participants, I planned to post flyers in the facility, with the permission of the agency. Additionally, a snowball strategy was planned as a backup strategy for recruitment. All the participants were voluntary and could decide to pull out of the study at any time.

Prior to the interviews, the participants were sent an email with the necessary information for the study. Included in the email was a consent form, instructions for scheduling and conducting the interviews, and several possible dates and times for availability. Once a date and time had been confirmed, an email was sent with a Zoom link and date and time reminder.

Data Analysis Plan

According to Miles et al. (2020) in vivo, or verbatim coding, is a good process for beginning qualitative researchers, a way to acknowledge the participant's voice, and gain an emic perspective. I analyzed each of the transcripts using Saldana's suggested method of analytical memos, first cycle coding, which will involve in vivo coding, second cycle coding, and codeweaving, which led to one or more thought lines or concepts noted

(Saldana, 2016). NVivo software was used to organize and identify patterns and then coding was performed manually to identify major codes. The codes were then reviewed and categorized into themes during the analysis process. Using memos and descriptive notes, the themes were then combined and presented in a codeweaving manner (Saldana, 2016). The participants were de-identified with each interview and transcription by assigning a number to each participant (i.e. 1.2.14.21). Personal coding was kept in a grid on a password protected USB drive.

Issues of Trustworthiness

The ability to draw accurate conclusions based on the data, which addresses *credibility*, was dependent upon an adequate amount of data collected (Ravitch & Carl, 2016). One of the potential downfalls of interviewing, and potential threats to credibility, was the lack of volunteers (Creswell & Creswell, 2018). COVID-19 had caused considerable stress for practicing individuals, which could lead to nurses not wanting to engage in an interviewing process. To address this, the interview flyers was sent out to different health systems in the region. The flyers were posted in the facilities, particularly in the breakrooms. Another threat to credibility was the selection process due to a regional sampling of nurses were utilized for this study to interview voluntary participants. The representation of nurses was purposeful among the different health systems in the area. No specific nurses or specific health systems was targeted for participation and data analysis.

Transferability refers to the research which can be applied to other contexts, and can be established with consistency, particularly related to documenting the process and

perceptions, across the data sources (Rubin & Rubin, 2012). Transferability can be related to sampling, the situation in which the study is conducted, and how the sampling and site can influence applicability of the study (Whitley & Kite, 2018). Documentation of the interview process, thick descriptions of the conversation, memos during the coding process, and thematic documentation was utilized in this study to lend creed to the applicable nature of the study (Creswell & Creswell, 2018). Transferability is attempted by gathering data from nurses at four separate health care systems, however a larger sample size of the Midwestern state could make the study truly applicable in varying contexts and situations.

Dependability refers to the notion that the data needs to be stable or dependable, which is developed through how the information is collected and how it aligns with the research question (Ravitch & Carl, 2016). The research question is to determine bedside nurse's perspectives of practicing cultural competence, which requires the participants to share their experiences. Due to this nature of inquiry, a qualitative study was the best fit for the research question. To create a comprehensive understanding of this phenomenon, triangulation was performed using multiple coding phases. Each interview was transcribed and subject to analytical memos, first cycle coding through the process of in vivo coding, second cycle coding of establishing pattern coding, and codeweaving. Additionally, an audit trail describing how the data were collected, how the coding was derived, and how decisions were made throughout the process, was established (Ravitch & Carl, 2016). For this study, interviews, transcriptions, and notes were compared to ensure trustworthiness.

Confirmability is the process of attempting to control researcher bias (Ravitch & Carl, 2016). Reflexive validating questions was applied to the data analysis to ensure personal biases are not being imposed upon the data (Ravitch & Carl, 2016). Additionally, triangulation of the data through multiple coding phases, constantly comparing the data, searching the literature for examples of the phenomenon, and rechecking the data will increase confirmability (Miles et al., 2020).

Ethical Procedures

Before data collection begins, this research study was approved by the Walden University institutional review board (IRB) to ensure the participants were protected from harm. Therefore, a signed consent form that explains confidentiality, the voluntary aspects of the study, background, procedure, nature of the study, risks, and benefits will be provided to each participant. Additionally, the specific steps to collect data, how and for how long the information is stored, as well as how it is disposed of, confidentiality agreements, potential risks and how they were minimized and managed, the informed consent, and all cooperative documentation were submitted to the Walden University IRB (Walden University for Research Quality, n.d.). While the significance of the study could impact culturally competent nursing care, the only stakeholder identified in this study was the researcher. The storage and disposal of data included storing the data on a password protected USB. I am the only individual with access to the USB and thus the information on the device. The information will be stored for five years, as is required by Walden University's IRB, the disposal of the data will be done so through secured erasing of digital data (Walden University for Research Quality, n.d.).

The respect of persons, in which privacy is maintained, as well as ensuring the participants are voluntary with no coercion, were implemented for this study. All the participants' rights were discussed and included in the consent form. Additionally, a clear statement regarding the nature of the research, time commitments, locations, and contact information were provided at the time of recruitment. If there was early withdraw from the study, I planned to place a notation in the descriptive notes, as well as in the findings and limitations of the study.

Anonymous data is preferred due to the lack of ability to link the participant with the information. De-identifiers regarding the participants and the health care system they work for were put into place. In doing so, the participants were provided a number as an identifier. Additionally, anonymous data would increase recruitment by ensuring the participants understand that no personal or professional ramifications would occur because of their involvement in the study. Part of the cultural competence process is knowing your own beliefs and biases, as well as how those might conflict with the beliefs and biases of other individuals, particularly the participants. The potential for individuals to be uncomfortable or to feel personal distress when answering questions regarding perceptions and their ability to provide culturally competent care was perceived as a potential challenge.

Summary

The qualitative study was conducted using interviews that were accomplished face-to-face, via Zoom. Participants were recruited using an email, flyer, and a purposive strategy. The participants were de-identified and the data was kept on a password

protected USB device that only I was able to access. Audio transcription with Zoom and NVivo were utilized to transcribe, organize, and identify patterns of the interviews. Coding occurred via Saldana's recommended multiple coding phases, which was used as the organizational format for the study results (Saldana, 2016).

Chapter 4: Results

This qualitative study aimed to understand registered nurses' perceptions of how they implement culturally competent care into bedside practice. Each participant's response provided unique insights that answered the following research question: What are the perspectives of acute care nurses in a midwestern state regarding the way culturally competent care is delivered at the bedside? I offered each participant an opportunity to review and clarify the information they provided by emailing them copies of the interview transcripts. This chapter discusses the interview setting, participant demographics, and data collection and analysis procedures.

Setting

I started the interview process after receiving emails from the participants stating "I consent" to the interview, as per the instructions in the recruitment email. I used Zoom, an online video conferencing platform, to conduct the interviews with nurses from two different health systems. I decided to use a video conferencing platform based on meeting restrictions because of the COVID-19 pandemic. Additionally, using Zoom allowed for flexibility with scheduling the interviews, which allowed me to be respectful of the participants' time (Rubin & Rubin, 2012). Flexibility with scheduling was significant because the participants were nurses working through a pandemic.

I used Zoom to schedule the interviews and record audio of the interviews. All the participants communicated that they were familiar with Zoom and comfortable with the audio recording for transcription purposes. Once we established a time for the interview, I scheduled a Zoom meeting. The Zoom application generated an invitation that included

the meeting access information and date and time as a reminder (Zoom Video Communications, 2019). I copied and pasted the information from the invitation into a return email to the participant. At the scheduled time of the interview, participants joined the Zoom meeting via the meeting link or via the meeting identification number, which allowed the participants to join via a weblink or an application on a mobile device.

Initially, I intended to interview acute care nurses from four different health care systems. However, only two health care systems agreed to allow me to recruit at their facility. One health care system felt this would be difficult, both for the participants and myself, due to many agency nurses present at the facility. Another facility declined to allow recruitment due to the extensive IRB process, which had a 6- to 8-month backlog.

All Zoom interviews, except for one, went as expected. One interview did not audio record due to a weather event. The participant was made aware of the technical glitch. The participant declined to repeat the interview.

Demographics

The intent of the first four questions of the interview was to obtain pertinent background information about the participants' practice and roles as a registered nurse. The 13 participants included two males and 11 females from two different health systems. The recruited participants were close to even from both health systems, with five participants from Health System A and eight participants from Health System B. All the participants work at the bedside as registered nurses. The participants' years of experience span a timeframe of 7 months to 26.5 years in practice, with most participants having 8 years or less of experience. Among the 13 participants, 10 had Bachelor of

Science in Nursing (BSN) degrees, and three had Associate Degrees in Nursing (ADN). All participants had diverse clinical backgrounds, including surgical or procedural services, labor and delivery, emergency care, medical-surgical, flight nursing, progressive care, pulmonary, and COVID-19 units. Overall, the participants brought unique and diverse perspectives to the study due to the variation in practice settings, years of experience, and educational backgrounds.

Data Collection

I collected data through personal interviews conducted face-to-face via Zoom with 13 participants. I followed a semistructured interview guide with 12 questions. The interview guide included an informative introduction about the interview process that I read before proceeding with the interview. The interview guide allowed for clarification and follow-up questions with the participants. The first four questions were designed to collect demographic information about the participants' practice and roles as a registered nurse. The remaining eight interview questions were open-ended questions designed to gain the nurses' perceptions of culture, cultural competence, and how they incorporate these concepts into their practice. Most of the interviews were completed during the week, with two interviews conducted on Sunday. I conducted the interviews between November 26, 2021 and January 30, 2022. The interview times ranged from 12 minutes to 18 minutes in length.

After receiving participant consent, I emailed participants to discern a date to conduct the interview. Participants joined the Zoom platform via the Zoom link previously sent in an email on the scheduled date and time. I logged into Zoom 5 to 10

minutes prior to the scheduled meeting time. One participant did not show up to the initially scheduled meeting and emailed later that the interview had slipped their mind. The participant rescheduled, and the subsequent encounter occurred without incident.

Once both the participant and I had joined the platform and established audio connectivity, I read the informational portion of the interview guide. I then asked participants if they agreed to continue under those circumstances. Upon participant agreement, I activated the audio recording function for the interview duration. In addition to the interview recording, I took handwritten notes to utilize during my analysis process. An MP4 recording was generated, which was downloaded to an encrypted USB. I then uploaded the audio recordings to NVivo for transcription. The transcriptions were also saved to the encrypted USB and personally reviewed for transcription accuracy.

After the interview transcriptions were verified, the transcriptions were sent to the participants for review. Interviewee transcript review is a form of validation that lends credence to both the accuracy and quality of the data and enhances researcher diligence with transcriptions (Rowlands, 2021). I sent the transcriptions to all participants for interviewee transcript review, from which I received responses from three participants, with one participant proposing clarification. The clarification was annotated on the transcript for use during the coding process. Other participants did not respond to the interviewee transcript review offer.

During one interview, an ongoing weather event caused a glitch with Zoom, which did not allow the interview to be recorded. I let the participant know the interview was not audio recorded due to a technical glitch. They asked what I wanted to do, and I

inquired about potentially repeating the interview. The participant declined, stating they did not feel they would be authentic in answering the questions, having previously heard them. I indicated that I take handwritten notes, and the participant asked if I could use those instead of doing the interview again. I agreed to this course of action. The use of this interview is discussed further in the Limitations of the Study section in Chapter 5.

Data Analysis

My data analysis occurred in three stages. I followed Saldana's (2016) suggestion of first cycle coding, which included in vivo coding, second cycle coding, and code weaving to establish themes. NVivo software was used to organize the identified patterns, which lent itself to the coding process. I used my handwritten interview notes to create memos and descriptive notes to code and theme the data. The resulting codes and themes were then combined, and code weaved into concepts. Saturation was evident after analyzing the transcripts, at which time I noted repeat concepts after the first five interviews, and no new concepts after the 13 interviews.

First Cycle Coding

For the first cycle of coding, I used in vivo coding, which utilizes the data to derive codes from the language and terminology used by participants (Saldana, 2016). I chose this coding style to reflect the perspectives and actions of the participants and create an in-depth understanding of the participants' perceptions (Saldana, 2016). The use of in vivo coding aligns with the research question of acute care nurses' perspectives regarding the way culturally competent care is delivered at the bedside. I isolated participants' answers from the transcript by question during this process to help organize

the extracted codes. I then reviewed my notes taken from each interview to add memos of the verbal and non-verbal cues noted during the interview. Such cues included laughing, silence, smiling, and shifting in their seat. Next, I reviewed the in vivo codes for patterns described by the codes. Finally, I analyzed the patterns until themes emerged.

Second Cycle Coding

The second cycle of coding involved combining the codes from all the participants. I created a table to organize the first and second level codes and the initial patterns used to theme the data. An example of table organization is provided in Appendix B. During this phase, I combined responses from individual transcripts for further analysis. I used the NVivo software to organize the code list. Using NVivo, I uploaded the transcripts and set up nodes that represent the patterns that would later become themes. Through this process, I integrated codes into the nodes in NVivo, which allowed me to re-code and categorize by pattern.

Organizing and Creating Relationships

The first and second cycles of analysis are where the code development occurred. I completed the first cycle of coding with the individual transcripts. The coding progressed into the second coding cycle by comparing one transcript to the next. I listed the generated codes in the organizing table. Through creating the table, I was able to identify patterns and relationships, which eventually emerged into themes. In interview five, I started to identify possible themes. Through transcribing, coding, and categorizing by pattern, I was able to identify the five themes, cultural knowledge, self-awareness,

barriers to cultural competency, educational process, and current culturally competent practices, described below and depicted in Figure 1.

Cultural knowledge is essential to clinical practice in that it informs clinical knowledge. The participants discussed retaining the information to apply to future practice. The participants noted this as the need for understanding varying beliefs, viewpoints, regions of origination, and support among the people they care for and within themselves. Each participant stated, in some capacity, how the different cultural information influenced how they approach care in individual patient interaction and how it might differ among people of the same culture.

Participants discussed the notion that awareness of cultural differences influenced their culturally competent care and made differences in personal views of culture and how to approach a cultural situation. Participants stated, to some degree, the necessity of self-awareness through the recognition of personal assumptions related to differing cultures. Participants perceived an open mindset as necessary for addressing cultural differences and the varying care needs when providing culturally competent care.

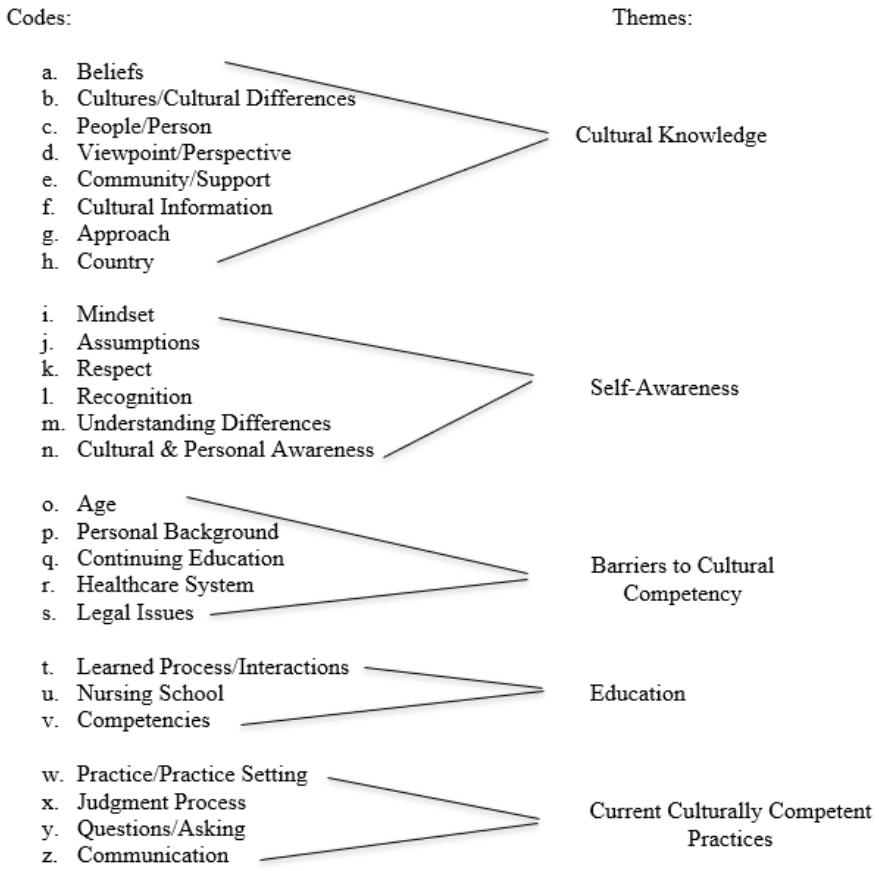
All participants discussed barriers to cultural competency, including personal backgrounds and knowledge, variations in health care systems, legality, and perceived opportunities for continuing education. All participants discussed some form of onboarding during orientation and yearly learning modules that addressed the premise of cultural sensitivity and respect for cultural diversity. However, further information about individual cultures and specific care needs are noted as areas of need to provide culturally competent care.

All participants discussed formal and experiential education concerning culturally competent care. The participants discussed formal education during nursing school and yearly education competencies related to cultural sensitivity and awareness during practice. Additionally, the participants noted perceptions of learning more about providing culturally competent care during the cultural encounters in their practice than they did during nursing school or during the education competencies.

All participants discussed their current culturally competent practices. They noted variations in practice based on the practice setting, such as in the emergency room versus obstetrics. Variations in how to communicate with patients were also noted by the participants. All participants reported asking related cultural questions of the patients, their families, and co-workers who have previously encountered the culture. Each participant stated their clinical judgment in a care situation is now perceived through the lens of cultural competence. Overall, the codes and themes from the research were consistent among the participants. Only one discrepant case was noted, in which a transcript was not generated due to a technical glitch. Without the transcription, an in-depth analysis was not possible.

Figure 1

List of Codes and Themes



Evidence of Trustworthiness

Several steps were implemented to ensure the trustworthiness of the study. The study proposal was submitted to the Walden University IRB and assigned the following approval designation number: 08-26-21-0338217. To maintain trustworthiness, my role as the researcher required me to keep an audit trail and explain the sampling, data

collecting, and analysis process (Ravitch & Carl, 2016). The following further explains my efforts to maintain credibility, transferability, dependability, and confirmability.

Credibility

The amount of data collected allowed me, as the researcher, to draw conclusions, allowing me to establish credibility (Ravitch & Carl, 2016) accurately. I interviewed 13 bedside nurses from two separate health systems, all of whom were given the opportunity to review the transcript of their interview and provide feedback. Recruitment of these nurses was on a voluntary basis using a recruitment email that contained a flyer with the study's information and the consent form. While the lack of volunteers related to the stressors COVID-19 has placed on bedside nurses was a concern, this did not present a problem in recruiting volunteers for the study (Creswell & Creswell, 2018). No specific nurses or health system were singularly targeted for participation in the data collection.

Transferability

Documentation of the interview process, thick descriptions of the conversation, memos during the coding process, and thematic documentation have allowed me to demonstrate the consistency and transferability of the research process (Creswell & Creswell, 2018; Rubin & Rubin, 2012). While I was not able to recruit from all four of the desired health systems, I was able to recruit a diverse group of bedside nurses. The participant sample spanned more than 26 years of practice, eight practice settings, both male and female nurses, and various educational backgrounds. The diversity in the participants allowed for varied contexts and situations from which the data was collected.

Dependability

I was able to demonstrate the dependability of the study by conducting virtual interviews and performing multiple coding. The multiple coding allowed for a more comprehensive understanding of the phenomenon (Ravitch & Carl, 2016). The research question looks at nurses' perceptions, making the qualitative interview an appropriate fit for the research initiative. I kept an audit trail depicting my decisions through the interview process and multiple coding cycles. Cumulatively, the interviews, transcriptions, and notes have allowed me to demonstrate dependability of the research.

Confirmability

Using multiple coding cycles, comparing the generated codes between individual transcripts, and re-reviewing the data through reflexive validating questions, has allowed me to decrease my bias (Miles et al., 2020). During the annotated memos during transcription and coding, I was able to apply the reflexive validating questions and ensure the confirmability of the data. Additionally, the use of in vivo coding in the first cycle ensured that coding was derived from the language and terminology the participants provided (Saldana, 2016).

Results

Thirteen participants were interviewed and asked 12 questions that aligned with the research question. Five themes emerged from the data analysis of the participants' responses. This section includes examples of participants' responses, codes, and categories to demonstrate thematic development.

Research Question

The following research question was created to support a basic qualitative research method and to explore nurses' perceptions of how they implement cultural competence into practice, the education they have received related to culturally competent practices, and personal insights into the concept of cultural competence.

Research question- What are the perspectives of acute care nurses in a Midwestern state regarding the way culturally competent care is delivered at the bedside?

I used a semistructured interview script with 12 interview questions to interview the participants. The first four questions were generated to collect demographic information. The remaining eight questions were utilized for data analysis. See Appendix A for the interview guide. Through the analysis process, I identified the following five themes: clinical knowledge, self-awareness, barriers to cultural competency, educational process, and current culturally competent practices. Each theme is representative of the culturally competent bedside practice insights shared by participants.

Participant Response Examples

The data collected from the participants' responses are aligned with the themes. Participants' verbatim statements guided the in vivo coding process conducted with each transcript. Each transcript was then compared to the previous transcripts, in which the generated codes were compiled in a table. The following participant responses provide context for the designated themes. The five themes are a) cultural knowledge, b) self-awareness, c) barriers to cultural competency, d) educational process, and e) culturally competent practices, which will be discussed below.

Theme 1: Cultural Knowledge

Participants described how they perceived the differences in cultures and beliefs affect the care the nurse provides and how this influences their clinical practice. For example:

- Participant A stated, “different people all over the world…have different beliefs, ideals, practices that influence their lives and their care.”
- Participant D indicated that “patients identify, and their daily life and how they perceive things and perceive pain and how they communicate.”
- Participant J reported, “someone has like a specific culture or a specific beliefs, and it’s going to change how I’m going to care for that person, I will discuss with them their beliefs and because I obviously don’t know every culture or what they like or what they dislike.”
- Participant K described the need for “respecting other people’s decisions or the fact like if you feel like they need a certain treatment and if they refuse that to be able to respect their wishes of not wanting it and not pushing it on them.”

Theme 2: Self-Awareness

Participants described their perceptions about how awareness of cultural differences and personal views influenced their culturally competent care. For example:

- Participant B stated, “I think when you become aware of a certain topic, then you see more of it in what you read or in the care that you provide.”

- Participant C indicated nurses should be “open minded that everyone else’s culture is different, that not everyone shares the same views as I do, that, you know, based on their religious beliefs for how they were raised.”
- Participant L explained that nurses must “just have that mindset where you’re open to different things, you know, different religions, different preferences to where you have that culture that you know, you talk things through, you talk with the patients, with their families, you see what they’re comfortable with, what they’re not, which way we may need to head.”
- Participant M described their perception as “when the nurse recognizes that the patient has a different thought or view and is not there to judge them but offers support and educational resources.”

Theme 3: Barriers to Cultural Competency

Participants described their perceived barriers to providing culturally competent care. They expressed the need for continued, clear explanations of cultural competence in relation to specific cultures and how a lack of information can cause the efforts of being culturally sensitive to be unintentionally misunderstood. Examples of this theme are:

- Participant D suggested that “mandatory cultural bias training, so would that be things like telling you to be culturally aware, to be culturally sensitive, but it didn’t necessarily go into the specifics.”
- Participant E indicated, “a therapeutic relations course that we could take, but it doesn’t go over like what to expect from which culture.”

- Participant F stated, “reminder that there are a lot of different cultures in our areas is important because I think we can unintentionally make our patients feel uncomfortable when that is never our intention, just because we just don’t know.”
- Participant G reported, “I think that once we get into nursing field, our education on different cultures is kind of lacking.”

Theme 4: Educational Process

Participants described their formal and experiential education, and how they perceive these have contributed to their cultural competence practices at the bedside. For example:

- Participant C stated, “I’ve had courses that have built in the cultural competence and then throughout working, seeing the variety of different cultures, you know, it helps you take a different view of how culture affects health care.”
- Participant D described, “my general practice that I have gotten better as I age, and I practice more at asking those hard questions because I think a lot of times people try to skirt around those difficult questions regarding cultural differences.”
- Participant F indicated, “I am also an older nurse coming into the profession, and so I have a lot of experience in different areas where I’ve gotten to work with a lot of different types of people and cultures to an extent, and so I think

that has helped that I had some very basic knowledge on several different cultures that I've just learned from my life experience."

- Participant G expressed, "I feel that we interact with a wide variety of cultures in bedside practice."

Theme 5: Current Culturally Competent Practices

The last theme describes the practices that nurses use that are examples of how they deliver culturally competent care. The following examples are statements that support the theme:

- Participant D indicated that to "…be aware of, just like how they communicate with that patient population and or, for instance, like you, if you had to cut their hair for some reason, that is a very sacred thing for them, that they're not going to react."
- Participant I stated, "my first degree was in journalism years ago, and I have always thought everyone has a story and I love getting to know people and how I practice it as I ask them where they are from."
- Participant J reported, "and also, like not only understanding that, but also not kind of showing any bias towards those people, I think is important for cultural competence."
- Participant M expressed, "I think it's important to be patient because it can be frustrating if the patient has like an accent or doesn't speak English, well, I think it's just a matter of being patient and offering different resources to kind of help better understand the patient."

Discrepant Cases

All thirteen participants fully participated in the interview, however, only four people participated in the interview transcript review. No participant provided feedback outside of expressing agreement with what is noted in the transcript. One case was discrepant, in the fact that a transcript was not obtainable. Due to a weather event, there was a technical glitch that caused the transcription feature to be non-functional. The participant was notified of the glitch and offered to complete the interview again. The participant declined. Notes were taken during the interview process, which were typed up and sent to the participant to review, in the event the data was needed for analysis. The participant reviewed the interview notes and sent an agreement to the presentation of the information. However, due to the lack of a transcript, an in-depth analysis is not possible.

Summary

My data analysis resulted in five main themes to answer the posited research question. The initial theme, clinical knowledge, is a culmination of professional knowledge perceived as necessary to provide culturally competent care. The next theme, self-awareness, emerged because of perceived personal characteristics necessary to provide culturally competent care. The subsequent theme, barriers to cultural competency, are the result of perceived issues that prevent comprehensive, culturally competent care. The succeeding theme, educational process, is the combination of noted academics that were previously completed and perceived as necessary moving forward. The final theme, current culturally competent practices, is the result of noted processes the participants perceive in their current practice. All five themes aligned with the

participant examples that explained their perceptions of bedside cultural competence. These codes were interpretated to include the implications for bedside, culturally competent practice, recommendations, and limitations of the study.

Chapter 5: Discussion, Conclusions, and Recommendations

Several governing nursing organizations commissioned standards of practice requiring nurses to provide culturally competent care (American Nurses Association [ANA], 2015; The Joint Commission, 2011; Office of Minority Health, 2016). Culturally competent care is necessary to promote positive patient outcomes and satisfaction as well as to ensure optimal health (McLennon, 2019). The purpose of this basic, qualitative study was to understand nurses' perceptions, implementation, and additional insights into personal cultural competence practices. Nurses know what cultural competence is and have been educated on the topic in nursing school; however, culturally competent care is not routinely occurring at the bedside (Garrido et al., 2019; Kovner et al., 2018; Martin et al., 2019; Schwarz et al., 2015; Young & Guo, 2020). The findings of this study extend the knowledge of current cultural competence bedside practices as well as identify some perceived barriers to providing culturally competent practices. The study resulted in the following five themes: clinical knowledge, self-awareness, barriers to cultural competency, educational process, and current culturally competent practices. In this chapter, I will discuss the interpretative meaning of the thematic results, correlate the interpretation of the results with the findings from the literature, discuss possible limitations to the study, and provide recommendations for future research, particularly related to the implications for positive social change.

Interpretation of the Findings

In this study, 13 nurses who, as of the time of the interview, practiced at the bedside, provided their perceptions of current cultural competence practices. The

participants were from two different health systems with varying work experiences as well as a range of years of practice. The participants' responses were analyzed in answer to the following research question: What are the perspectives of acute care nurses in a midwestern state regarding the way culturally competent care is delivered at the bedside?

The interpretation process followed Saldana's (2016) method of first cycle coding, which included in vivo coding, second cycle coding, and code weaving to establish themes. My review of the literature was organized by the conceptual framework of the Campinha-Bacote model, which informed my study. Findings from the literature were all confirmed, to some degree, by the findings of this study. I will address these confirmed areas, as well as findings from the literature that were not confirmed, through interpretation of the results that follow.

Interpretation in the Context of Conceptual Framework

The following interpretations of the results of my study are presented through the lens of the five constructs of the Campinha-Bacote model—awareness, skill, knowledge, encounter, and desire—as well as diversity in the workforce, which I will discuss further in the limitations of the study (Transcultural C.A.R.E. Associates, 2015).

Awareness

The thematic result of self-awareness aligns with the construct of awareness due to participants addressing perceptions associated with mindset, assumptions, respect, recognition, understand, and awareness. According to the Campinha-Bacote model, cultural awareness is developing an awareness of personal biases, prejudices, and stereotypes regarding other cultures (Transcultural C.A.R.E. Associates, 2015). In my

study, the participants were asked to share what culture means to them as well as how they perceive culture in bedside practice. All participants responded with some variation of need to understand different cultures as well as that not all cultures are the same as personal culture. For example, one participant stated, “making sure you understand that there’s differences in everyone’s beliefs and that there are different sides to everyone’s culture.” Although stereotypes were not mentioned by participants, the mention of biases and prejudices were present throughout the interviews. For example, a participant stated, “not only understanding that, but also not kind of showing any bias towards those people, I think is important.”

Participants also discussed the notion that cultural variations need to be recognized and addressed in a respectful manner. They indicated this is closely tied to personal mentalities, such as having an “open mind,” adjusting “assumptions,” and respecting the “mindset” of various cultures are key to cultural practice. These findings are consistent with notions of awareness posited by the authors such as Abitz (2016), Wesp et al. (2018), and Foronda et al. (2016), who suggested that differing cultural values and beliefs need to be accepted in a humble manner to establish compliance and continuity of care.

Participants of my study did not specify the need to recognize cultural boundaries, as suggested by Crawford et al. (2018). However, their responses aligned with the theorized component of recognizing cultural boundaries, such as establishing an awareness of both personal and patient viewpoints (Crawford et al.; 2018 Lin et al., 2019). For example, one participant stated, “I perceive it when the nurses recognizes that

the patient has a different thought of view and is not there to judge them but offers support and educational resources."

Skill

The thematic result of educational process aligns with the construct of skill due to participants addressing perceptions of learned processes or interactions, nursing school, and competencies related to cultural competence. According to the Campinha-Bacote model, cultural skill is the ability to conduct a culturally based assessment (Transcultural C.A.R.E. Associates, 2015). Proper training and educational techniques are necessary to improve culturally based assessment and, subsequently, care (Larsen et al., 2020; Young & Guo, 2016). In my study, when participants were asked to share how they learned culturally competent care practices, they referenced nursing school, work modules, and additional courses taken to learn about cultural care. For example, one participant stated, "book learning in class or online or different courses … or things like [facility specific module], you know, different competencies you need to take online at work."

Previous authors have noted that formal education is not the only tool to be used to support cultural skill (Chae & Park, 2018). Proper training and communication techniques support cultural skill in nursing practice (Bahreman & Swoboda, 2016; Hemberg & Vilander, 2017; Joo & Liu, 2020; Livesay et al., 2017). All the participants in my study discussed the need to ask patients about their culture, especially when the culture and practices are unfamiliar to the nurse. For example, a participant stated, "we don't necessarily have to be competent as far as like being able to take a test and check

all the boxes but being able to ask those questions and being respectful and open minded is important."

Previous authors have noted various assessment tools that are utilized to determine areas of need and measure cultural competence (Aboshaiqah et al., 2017; Chae & Park, 2018; Marzilli, 2016). Though formal cultural assessment tools were not mentioned in my study, all participants discussed various ways in which they gain information about cultural needs prior to an encounter, which included searching the internet, speaking to coworkers, and reading. For example, a participant stated, "I may do some reading for, you know, do a quick Google search or reach out to somebody that I may know." Another participant stated, "you know, before you start working with them, read a little bit about [the culture] … so that you know what you're getting into when you walk in that room."

Previous authors have stated that due to the lack of use of formal cultural assessment tools, this could be one of the reasons why cultural competence is not routinely performed (Garrido et al., 2019; Kovner et al., 2018; Martin et al., 2019; Schwarz et al., 2015; Young & Guo, 2020). Through the interview process of my study, I was not able to gain an understanding of the use, or lack thereof, of assessment tools. No participant brought this up about their current practice, or as an area of perceived need. One need that all participants of my study discussed was the need for continued education about specific cultures throughout practice. I will continue this discussion in the section on the construct of desire.

Knowledge

The thematic result of cultural knowledge aligns with the construct of knowledge due to participants addressing perceptions of beliefs, cultures or cultural differences, people or persons, viewpoint or perspective, community or support, cultural knowledge, approach, and country. Cultural knowledge is the process of not only seeking, but retaining and understanding, information about culturally diverse peoples (Transcultural C.A.R.E. Association, 2015). Additionally, previous authors Williams et al (2018) refer to knowledge related to societal perceptions, generational differences, and varied cultures should be sought. All participants of my study discussed varying cultural beliefs and perspectives, as well as the difference in peoples, support, and cultural approaches. For example, one participant stated, “not everybody is like you, and they all are either different ages, they’ve come from different states, different countries, different beliefs, different family members helping make decisions.”

In my study, the notion of personal knowledge to be applied during cultural practice was discussed with all participants. For example, one participant stated, “like knowing who the right person is to go to, like, you know, who is the standard person normally in this culture that is the lead of a family, how they react to certain situations or what their beliefs are.” Another participant stated, “patient’s identity, and their daily life and how they perceive things and perceive pain and how they communicate.” These are in alignment with the aforementioned concept of retaining and understanding information about culturally diverse individuals (Transcultural C.A.R.E Association, 2015).

Encounter

The thematic result of current culturally competent practices aligns with the construct of encounter due to participants sharing how they currently practice culturally competent care. Previous authors have noted that cultural encounters are nurses' experiences with caring for and treating people from differing cultures, as well as family dynamics and stigmas that need to be considered in relationship to culturally competent care (Kallakorpi et al., 2018). When participants in my study were asked to share examples of how they implement cultural competence in their own practice, they all mentioned a culture, that differs from their own, in practice. Participants mentioned the following cultures during the interview process: "Amish," "Indian," "African American," "Jehovah's Witness," "Native American," "Buddhist," "LGBTQ," "Polish," "Hispanic," "Middle East," "Philippines," "China," "German," and "French."

All participants of my study discussed situations in which they had a cultural encounter, such as with the birthing process and with death rituals. For example, one participant stated, "I have also had patients who choose to take their placenta home with them and plant it." Another participant stated, "a Buddhist who needed their head pointed north and feet pointed south when he passed away." Previous authors Langton (2018), Murcia et al. (2016), and Roldan-Chicano et al. (2017) stated that through differing cultural care, a nurse is tasked with exploring different treatment and practice desires, which further expands an individual's cultural competence. Overall, the participants of my study have had a variety of encounters that have proffered the opportunity to provide culturally competent care.

One area of current practice that was mentioned by most of the participants of my study was lack of time. They stated the COVID-19 pandemic has supported the idea of needing to be culturally competent but have also stated that the pandemic has hindered their cultural competence practices due to the lack of time and the inability to "have a deeper connection with a patient." In my study, one timing factor mentioned by various participants was regarding the changed expectations of nursing practice. For example, one participant stated, "you know, this day and age things that we have to kind of address and go through now as opposed to even 15, 20 years ago." Previous authors have noted time constraints could be one of the contributing factors associated with the need to improve cultural competence at the bedside (Garrido et al., 2019; Kovner et al., 2018; Martin et al., 2019; Schwarz et al., 2015; Young & Guo, 2020).

Desire

The thematic result of barriers to cultural competency aligns with the construct of desire due to the participants shared perceptions related to age, personal background, continuing education, health care system, and legal issues. Cultural desire is associated with attitudes and perceptions about a culture and how it can influence an individual's desire to be culturally competent (Alpers, 2018; Transcultural C.A.R.E. Association, 2015). Previous authors have discussed how barriers to being culturally competent can be addressed through reflective practices by the nurse (Debs-Ivall, 2018; Milton, 2016; Yoder-Wise, 2018). Additionally, these same authors have documented that an individual must reflect on personal biases, cultural beliefs, perceptions on the importance of cultural

competence, and the personal value of diversity (Debs-Ivall, 2018; Milton, 2016; Yoder-Wise, 2018).

Previous author Alpers (2018) stated perceptions can influence an individual's desire to be culturally competent. In my study, the participants provided mixed perceptions when it came to the age of the nurse in relationship to cultural desire. For example, one participant stated, "maybe the younger generation that don't get it, but…I've been a nurse for almost 25 years and have dealt with so many different ages and cultures and races and language" Another participant was in direct opposition of this by stating, "I feel that some of the younger nurses are more culturally competent, and I'm not sure if that's just because it's something that we maybe discuss more now or that we're more open about talking about now as opposed to 10-20 years ago." No clear conclusions could be gathered from these perceptions.

The ability to think creatively and create sensitivity regarding differing cultures is linked to cultural desire has been mentioned by previous authors (Hunter, 2020; Karnick, 2016; Milton, 2016). Continuous education and exploration of diverse populations is discussed as one way to foster this (Heaslip, 2018; Jeffreys, 2017; Karnick, 2016). All participants of my study discussed the need for continuing education once they have started their practice. For example, one participant stated, "I think that once we get into the nursing field, our education on different cultures is kind of lacking." Another participant stated, "mandatory cultural bias training, would be things like telling you to be culturally aware, to be culturally sensitive, but it didn't necessarily go into the specifics [for a particular culture]." The lack of continued education, that could refresh

cultural desire, the need for cultural awareness, and promote cultural sensitivity, could be one of the reasons culturally competent care needs to be improved in bedside practice, as previously mentioned by authors Garrido et al. (2019), Kovner et al. (2018), Martin et al. (2019), Schwarz et al. (2015), and Young & Guo (2020).

Another perception shared by multiple participants in my study was regarding legal issues. Several participants discussed the fact that they are were not aware of the legal precedence and ramifications of some cultural practices. Several participants discussed releasing human tissue and body parts to patients. One participant stated, “it took quite a lot of phone calls and a lot of, digging legally, to find out if the hospital could actually release that [a placenta] to her.” Another participant discussed the differences in legal age with some cultures and stated, “at 16, they’re considered legal adults, which is different.” Regarding the time, effort, and knowledge necessary to take those actions, it is easier to say, “that goes against protocol,” versus maintaining the desire to be culturally competent.

Another barrier that was noted by participants in my study was the perception of being intrusive. For example, one participant stated, “it feels like intruding on their sacred cultural practices.” Another participant discussed the notion of not wanting their patient to feel like, “they’re being interrogated every time a new nurse comes to their bedside.” These perceptions can contribute to the lack of cultural desire and subsequently, the need for improvement at the bedside.

Limitations of the Study

As with all research studies, limitations must be considered in weighing the meaningfulness and trustworthiness, through credibility, transferability, dependability, and confirmability, of the results. Limitations in my study were related to the sampling of participants from one geographic region which may introduce bias given the similarities of the types of participants and limit the transferability of the results. The limitation of representation might be addressed in future studies by recruiting participants from multiple regions of the country.

I anticipated a potential lack of participants as an issue, however this turned out not to be an issue. While I had intended to interview acute care nurses from four different health care systems, only two health care systems agreed to allow me to recruit at their facility. Even with just the two health care systems, I was able to interview 13 participants with diverse practice backgrounds and years of practice. By the fifth interview I was noting recurring concepts and had no new concepts by the thirteenth interview.

To maintain trustworthiness, I maintained documentation explaining the process of sampling, collecting data, and the analysis process (see Ravitch & Carl, 2016). This process of documentation increased the rigor of my study by demonstrating the dependability of the procedures. Due to a weather event, I was not able to transcribe and verify the information for a single interview. Due to the lack of documentation for the analysis process, it was decided not to include this interview in the coding process. While

this has been noted, additional information to analyze could have added to the interpretation of response.

While all participants of my study were provided the opportunity to review the transcript of their interview, for the purpose of clarifying or providing additional information, only one member provided a clarification. Additionally, no participant provided further feedback, which left the possibility of researcher bias, and therefore a limitation to my study.

In addition to organizing my review of the literature by the conceptual framework of the Campinha-Bacote model, I also included the concept of diversity in the workforce to inform and interpret my study. Day-Calder (2016), Johnson (2016), and Gregory (2017) noted diversity in the workforce as a key factor in reducing disparities related to health outcomes and the development of culturally competent treatment plans. I was not able to interpret any part of my study in terms of this concept because no participant discussed diversity in the workforce at any point in their interview. As previous authors note the significance of this, the lack of discussion around diversity in the workforce is a limitation of my study.

Recommendations

The literature findings support both the notion that nurses are aware of the need for cultural competence in practice and that the concept of cultural competence has been integrated into nursing curricula, however, despite these findings, culturally competent care is not provided continuously in bedside practice (Alzadeh & Chavan, 2016; Gallaher & Polanin, 2015; Garrido et al., 2019; Kovner et al., 2018; Martin et al., 2019; Young &

Guo, 2020). The findings of this study support these conclusions in relationship to nursing education and an understanding of cultural competence in nursing practice. The findings of this study noted time constraints, continued education after the start of practice, personal perceptions of being intrusive when questioning a patient about their culture, legal knowledge, and the lack of use of cultural assessment tools have all been identified as possible barriers to conducting culturally competent care.

Further studies are needed to determine the supportive tools available in the health care system, specific to cultural assessment and legal issues attached to cultural practice. Additionally, further research is recommended to determine what culture specific continuing education is available for nurses to apply to their practice. A further recommendation is to study a health care system's perceptions of the need for culture specific continuing education for practicing nurses. Further studies are recommended to measure time related to cultural assessments and correlate that to the nursing practice over time. Further research is recommended to address conducting a cultural assessment in a meaningful way that does not appear intrusive or to be interrogating a patient. A final consideration for further studies is recommended to expand this study to include more regions to gain a more comprehensive understanding of nurses' perceptions of culturally competent bedside practices.

Implications

Positive Social Change

The findings of this study provide evidence of how nurses perceive cultural competence at the bedside, but also the areas they perceive to be lacking or as a barrier to

their successful culturally competent care practices. As cultural competence is a standard of practice, it is imperative that nurses provide this type of care and continue to improve those care practices (ANA, 2015; The Joint Commission, 2011; Office of Minority Health, 2016). The implications of the findings of this study are in alignment with most of the suggested interventions to improve cultural competence at the bedside, such as cultural immersion and involvement, and education (Garrido et al., 2019; Kovner et al., 2018; Martin et al., 2019; Schwarz et al., 2015). Participants provided examples of specific cultures they have encountered, as well as specific cultural practices they have navigated in their practice. The implications of this study are beneficial to promote positive social change by identifying how to improve cultural competence at the bedside. Through this improvement, patient care, family life, and, by extension, community involvement can be further developed in a positive and constructive manner.

Recommendations for Practice

The one suggested intervention, not addressed in this study, is the use of cultural assessment tools, which was not discussed by any of the participants. This leads me to believe this is not occurring at the bedside. Providing a cultural assessment tool to be used within a health care system could improve cultural competence practices and address the perception of time constraints on behalf of the nurse (Kovner et al., 2018; Schwarz et al., 2015). Kovner et al. (2018) discuss culturally competent education, which includes changes in nurse education during active bedside practice. Incorporating continuing education could improve cultural competence practices at the bedside as well. The implications of these two recommendations for practice could promote positive

social change in the practice of nursing, which in turn, will lead to optimizing patient care and satisfaction, as well as nurses' overall perception of their practice (McLennon, 2019).

Conclusions

Health care systems are tasked with promoting optimal health, positive patient outcomes, and patient satisfaction (McLennon, 2019). Cultural competence is a key factor in optimizing health and patient outcomes (Campinha-Bacote, 2019). A professional implication of this is that nurses are bound by their professional scope and standards of practice to provide culturally competent care (ANA, 2015; The Joint Commission, 2011; Office of Minority Health, 2016). In the findings of this study, nurses described what culture and cultural competence means to them, stated current cultural practices, and identified their perceptions of culturally competent practice gaps. The results of this study revealed five themes that are in alignment with previous research, as well as the constructs of Campinha-Bacote's cultural competence model. Additionally, the results of this study added to the existing knowledge of culturally competent bedside practices, as well as suggested interventions to improve culturally competent practice at the bedside. The findings of this study are relevant to practicing bedside nurses, as well as the health care systems they work for, due to the supportive nature of these results in relation to the suggested interventions to improve culturally competent practice.

References

Abitz, T. L. (2016). Cultural congruence and infusion nursing practice. *Journal of Infusion Nursing, 39*(2), 75–79. https://doi.org/10.1097/NAN.0000000000000157

Aboshaiqah, A. E., Tumala, B., Inocian, E. P., Almutairi, A. F., & Atallah, M. (2017). Enhancing culturally competent nursing care in Saudi Arabia. *Journal of Cultural Diversity, 24*(1), 20–26.

Alligood, M. R. (2018). *Nursing theorists and their work* (9th ed.). Elsevier.

Alpers, L-M. (2018). Distrust and patients in intercultural healthcare: A qualitative interview study. *Nursing Ethics, 25*(3), 313–323. https://doi.org/10.1177/0969733016652449

Alzadeh, S., & Chavan, M. (2016). Cultural competence dimensions and outcomes: A systematic review of the literature. *Health and Social Care in the Community, 24*(6), e117–e130. http://dx.doi.org/10.1111/hsc.12293

American Association of Colleges of Nursing. (2008). *Tool kit of resources for culturally competent education for baccalaureate nurses.*

American Nurses Association. (2015). *Nursing: Scope and standards of practice* (3rd ed.).

Andrews, M. M., & Boyle, J. S. (2019). The Andrews/Boyle transcultural interprofessional practice (TIP) model. *Journal of Transcultural Nursing, 30*(4), 323–330. https://doi.org/10.1177/1043659619849475

Asmaningrum, N., & Tsai, Y-F. (2018). Patient perspectives of maintaining dignity in Indonesian clinical care settings: A qualitative descriptive study. *Journal of Advanced Nursing, 74*(3), 591–602. https://doi.org/10.1111/jan.13469

Bahreman, N. T., & Swoboda, S. M. (2016). Honoring diversity: Developing culturally competent communication skills through simulation. *Journal of Nursing Education*, *55*(2), 105–108. https://doi.org/10.3928/01484834-20160114-09

Baza, D. C., & Quintero, C. P. (2018). Nursing care experiences in an intercultural context. *Cultura de los Cuuidados*, *22*(51), 124–132. https://doi.org/10.14198/cuid.2018.51.14

Blanchet Garneau, A., Pepin, J., & Gendron, S. (2017). Nurse-environment interactions in the development of cultural competence. *International Journal of Nursing Education Scholarship*, *14*(1). https://doi.org/10.1515/ijnes-2016-0028

Biles, J. (2018). The development of Indigenous Australian cultural competence in nursing. *Australian Nursing and Midwifery Journal*, *26*(4), 40–41.

Bristol, S., Kostelec, T., & MacDonald, R. (2018). Improving emergency health care workers' knowledge, competency, and attitudes toward lesbian, gay, bisexual, and transgender patients through interdisciplinary cultural competency training. *Journal of Emergency Nursing*, *44*(6), 632–639. https://doi.org/10.1016/j.jen.2018.03.013

Byrne, D. (2016) Cultural competency in baccalaureate nursing education: A conceptual analysis. *International Journal of Human Caring*, *20*(2), 114–119. http://dx.doi.org/10.20467/1091-5710-20.2.114

Campinha-Bacote, J. (2019). Cultural compatibility: A paradigm shift in the cultural competence versus cultural humility debate-Part I. *The Online Journal of Issues in Nursing*, *24*(1). https://tinyurl.com/ojinculture

Carabez, R. M., Eliason, M. J., & Martinson, M. (2016). Nurses' knowledge about transgender patient care: A qualitative study. *Advances in Nursing Science, 39*(3), 257–271. https://doi.org/10.1097/ANS0000000000000128

Castillo, J. D. D. (2019). Faces of the vulnerable population: Inclusive practices amidst adversity. *The Florida Nurse, 67*(3), 17–19. https://www.floridanurse.org/page/TFNArchive

Chae, D., & Park, Y. (2018). Development and cross-validation of the short form of the cultural competence scale for nurses. *Asian Nursing Research, 12*(1), 69–76. https://doi.org/10.1016/j.anr.2018.02.004

Clarke, S. (2017). Cultural congruent care: A reflection on patient outcomes. *Journal of Healthcare Coordination, 2*(4), 1–3. https://doi.org/10.4172/2472-1654.100092

Coleman, D. E. (2019). Evidence based nursing practice: The challenges of health care and cultural diversity. *Journal of Hospital Librarianship, 19*(4), 330–338. https://doi.org/10.1080/15323269.2019.1661734

Covell, C. L., & Sidani, S. (2013). Nursing intellectual capital theory: Operationalization and empirical validation of concepts. *Journal of Advanced Nursing, 69*(8), 1785–1796. https://doi.org/10.1111/jan.12040

Crawford, R., Stein-Parbury, J., & Dignam, D. (2018). Culture shapes nursing practice: Findings from a New Zealand study. *Patient Education & Counseling, 100*(11), 2047–2053. http://dx.doi.org/10.1016/j.pec.2017.06.017

Creswell, J. W. (2013). *Qualitative inquiry & research design: Choosing among five approaches* (3rd ed.). Sage Publications.

Creswell, J. W. & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods* (5th ed.). Sage Publications.

Cultural Intelligence Center. (n.d.). About cultural intelligence. https://culturalq.com/about-cultural-intelligence/

Curtis, M. P., Bultas M. W., & Green, L. (2016). Enhancing cultural competency. *Online Journal of Cultural Competence in Nursing and Healthcare, 6*(1), 1–13. https://doi.org/10.9730/ojccnh.org/v6nlal

Davis, C. (2020). A Texas nurse in China: Learning more than expected. *Texas Nursing Magazine, 1*, 10–11.

Day-Calder, M. (2016). Working well in a culturally diverse team. *Nursing Standard, 31*(6), 37–38. https://doi.org/10.7748/ns.31.6.37.s42

Debesay, J., Harslof, I., Rechel, B., & Vike, H. (2014). Facing diversity under institutional constraints: Challenging situations for community nurses when providing care to ethnic minority patients. *Journal of Advanced Nursing, 70*(9), 2107–2116. https://doi.org/10.1111/jan.12369

Debs-Ivall, S. (2018). Do you value difference and embrace diversity as a strength? *Canadian Nurse, 114*(3), 44.

Degrie, L., Gastmans, C., Mahieu, L., de Casterle, B., & Denier, Y. (2017). How do ethnic minority patients experience the intercultural care encounter in hospitals? A systematic review of qualitative research. *BMC Medical Ethics, 18*(1), 2. https://doi.org/10.1186/s12910-016-0163-8

Dobrowolska, B., Gutysz-Wojnicka, A., Ozga, D., Barkestad, E., Benbenishty, J., Breznik, K., Filej, B., Jarosova, D., Kaucic, B. M., Nytra, I., Smrke, B., Zelenikova, R., & Blackwood, B. (2020). European intensive care nurses' cultural competency: An international cross-sectional survey. *Intensive & Critical Care Nursing*, *60*, 1–8. https://doi.org/10.1016/j.iccn.2020.102892

Dos Santos Pennafort, V. P., Queiroz, O., Veraci, M., Gomes, V., Lima, I., Rocha, F., & De Fatima, M. (2018). Instructional therapeutic toy in the culture care of the child with diabetes type 1. *Revista Brasileira de Enfermagem, 71*, 1415–1423. https://doi.org/10.1590/0034-7167-2017-0260

Drevdahl, D. J. (2018). Cultural shifts: From cultural to structural theorizing in nursing. *Nursing Research*, *67*(2), 146–160. https://doi.org/10/1097/NNR.0000000000000262

Elliott, B. (2018). Civilian nurses' knowledge, confidence, and the comfort caring for military veterans. *Home Healthcare Now*, *36*(6), 356–361. www.homehealthcarenow.org

Ellis Fletcher, S. N. (2016). Cultural sensibility. *Nursing Management*, *22*(10), 17. https://doi.org/10.7748/nm.22.10.17.s16

Escobar-Castellanos, B., & Paravic-Klijn, T. (2017). Transculturality, an essential element to improving health care and nursing. *Enfermeria Actual en Costa Rica, 33*, 12. https://doi.org/10.15517/revenf.v0i33.29627

Faught, D. D. (2016). Coming full circle: The old becomes new again-Cultural competence and the transgender client. *MEDSURG Nursing, 25*(4), 285–286.

https://www.researchgate.net/publication/306321228_Coming_Full_Circle_The_old_becomes_new_again-Cultural_competence_and_the_transgender_client

Foronda, C. L. (2008). A concept analysis of cultural sensitivity. *Journal of Transcultural Nursing*, *19*(3), 207–212. https://doi.org/10.111.77/1043659608317093

Foronda, C., Reinholdt, M. M., Ousman, K. (2016). Cultural humility: A concept analysis. *Journal of Transcultural Nursing, 27*(3), 210–217. https://doi.org/10.1177/1043659615592677

Fowler, J. (2017). From staff nurse to nurse consultant: Spiritual care part 3: Buddhism. *British Journal of Nursing, 26*(12), 710. https://doi.org/10.12968/bjon.2017.26.12.710

Gallagher, R. W. & Polanin, J. R. (2015). A meta-analysis of educational interventions designed to enhance cultural competence in professional nurses and nursing students. *Nurse Education Today, 35*,333–340. http://dx.doi.org/10.1016;j.nedt.2014.10.021

Garrido, R., Garcia-Ramirez, M., & Balcazar, F. E. (2019). Moving towards community cultural competence. *International Journal of Intercultural Relations, 73*, 89–101. https://doi.org/10.1016/j.ijintrel.2019.09.00s

Gobeyn, J. L. (2018). Caring for undocumented immigrants. *Nursing2018, 48*(8), 55–57. https://doi.org/10.1097/01.NURSE.0000542469.30330.13

Goi, I., & Erkin, O. (2019). Association between cultural intelligence and cultural sensitivity in nursing students: A cross-sectional descriptive study. *Collegian, 26*(4), 485–491. https://doi.org/10.1016/j.colegn.2018.12.007

Gonzalez, A., Galletta, M., Melis, P., Contu, P., Watson, J., Finco, G., Herrera, J. M. F. (2019). Cultural adaptation and psychometric validation of the caring efficacy scale in a sample of Italian nurses. *PloS, 14*(5), e0217106. https://doi.org/10.1371/journal.pone.0217106

Gordillo Julon, M. A., Llatas, J. P. B., Manchay, R. J. D., Ramirez, A. S. V., Torres, F. M. M., & Munoz, S. T. (2019). Health education and cultural practices in relation to post-vaccinal adverse reactions in the infant. *ENE Revista de Enfermeria, 13*(2), 1–13.

Goyal, D. (2018). Perinatal practices & traditions among Asian Indian women. *The American Journal of Maternal Child, 41*(2), 90–96. https://doi.org/10.1097/NMC.0000000000000222

Gozum, S., Tuzcu, A., Kirca, N. (2016). Validity and reliability of the Turkish version of the nursing cultural competence scale. *Journal of Transcultural Nursing, 27*(5), 487–495. https://doi.org/10.1177/1043659615582089

Gray, J. R., Grove, S. K., & Sutherland, S. (2017). *The practice of nursing research: Appraisal, synthesis, and generation of evidence* (8th ed.). Elsevier

Gregory, C. (2017). Effective communication for a global workforce. *Nurse Leader, 15*(6), 392–395. https://doi.org/10.1016/j.mnl.2017.09.005

Harmon, J., Summons, P., & Higgins, I. (2019). Nurses' culturally mediated practices influencing pain care provision for older people in acute care: Ethnographic study. *Applied Nursing Research, 48*, 22–29. https://doi.org/10.10/j.apnr.2019.05.010

Heaslip, V. (2018). Editorial: Diversity and culture: Threads in a golden tapestry which nurses have the privilege to enact and the responsibility to preserve. *Journal of Clinical Nursing, 27*, 3239–3240.

Hemberg, J. A. V., & Vilander, S. (2017). Cultural and communicative competence in the caring relationship with patients from another culture. *Scandinavian Journal of Caring Sciences, 31*(4), 822–829. https://doi.org/10.1111/scs.12403

Hughes, V., Delva, S., Nkimbeng, M., Spaulding, E., Turkson-Ocran, R-A., Cudjoe, J., Ford, A., Rushton, C., D'Aoust, R., Han, H-R. (2020). Not missing the opportunity: Strategies to promote cultural humility among future nursing faculty. *Journal of Professional Nursing, 36*, 28–33. https://doi.org/10.1016/j.profnurs.2019.06.005

Hunter, K. (2020). Cultural safety or cultural appropriation? *Kai Tiaki Nursing New Zealand, 26*(1), 24–25.

Jarufe, L. (2020). Medical mission trip. *New Jersey Nurse & Institution for Nursing Newsletter, 1*, 13

Jeffreys, M. R. (2016). *Teaching cultural competence in nursing and health care* (3rd ed.). New York, NY: Springer Publishing Company

Jeffreys, M. R. (2017). FITNESS for culturally congruent care. *Journal of Transcultural Nursing, 28*(5), 523. https://doi.org/10.1177/1043659617723439

Jeffreys, M. R., & Zoucha, R. (2017). The invisible culture of the multiracial, multiethnic individual: A transcultural imperative. *Journal of Cultural Diversity, 24(*1), 6–10.

Johnson, S. R. (2016). Growing the ranks of minority nurses. *Modern Healthcare, 46*(30), 0020

Joo, J. Y. & Liu, M. F. (2020). Nurses' barriers to care of ethnic minorities: A qualitative systematic review. *Western Journal of Nursing Research, 42(*9), 760–771. https://doi.org/10.1177/0193945919883395

Kallakorpi, S., Haatainen, K., & Kankkunen, P. (2018). Nurses' experiences caring for immigrant patients in psychiatric units. *International Journal of Caring Sciences, 11*(3), 1802–1811.

Karnick, P. M. (2016). Sorting it out: Cultural competency and healthcare literacy in the world today. *Nursing Science Quarterly, 29*(2), 120–121. https://doi.org/10.1177/10894318416630105

Korstjens, I. & Moser, A. (2018). Series: Practical guide to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice, 24*(1), 120–124. https://doi.org/1080/13814788.2017.1375092

Kovner, C. T., Djukic, M., Jun, J., Fletcher, J., Fatehi, F. K., & Brewer, C. S. (2018). Diversity and education of the nursing workforce 2006-2016. *Nursing Outlook, 66*(2), 160–167. https://doi.org/10.1016/j.outlook.2017.09.002

Kraus, S. (2018). Culturally competent care for older LGBTQ patients. *Nursing2018, 48*(8), 49–52. https://doi.org/10.1097/01.NURSE.0000534092.48992.7a

Langton, D. (2018). Building trust through cultural respect and sensitivity. *Nursing Leadership, 44*(2), 134–138.

Larsen, R., Mangrio, E., & Persson, K. (2021). Interpersonal communication in transcultural nursing care in India: A descriptive qualitative study. *Journal of Transcultural Nursing, 32*(4), 310–317. https://doi.org/10.1177/1043659620920693

Laskowski-Jones, L. (2020). Bridging the racial divide. *Nursing2020, 50*(8), 6. https://doi.org/10.1097/01.NURSE.0000684224.06655.ec

Leininger, M. (1993). Towards conceptualization of transcultural health care systems: Concepts and a model. *Journal of Transcultural Nursing, 4*(2), 32–40. https://doi.org/10.1177/104365969300400206

Lin, H-C. (2016). Impact of nurses' cross-cultural competence on nursing intellectual capital from a social cognitive theory perspective. *Journal of Advanced Nursing, 72*(5), 1144–1154. https://doi.org/10.1111/jan.12901

Lin, M-H., Chang, T. H., Lee, Y. H., Wang, P. Y., Lin, L. H., & Hsu, H. C. (2019). Developing and validating the nursing cultural competence scale in Taiwan. *PLOS ONE, 14*(8), 1–14. https://doi.org/10.1371/journal.prone.0220944

Lin, M-H., Wu, C-Y., & Hsu, H-C. (2019). Exploring the experiences of cultural competence among clinical nurses in Taiwan. *Applied Nursing Research, 45*, 6–11. https://doi.org/10.1016/j.apnr.2018.11.001

Livesay, K., Lau, P., McNair, R., & Chiminello, C. (2017). The culturally and linguistically diverse SPs' evaluation of simulation experience. *Clinical Simulation in Nursing, 13*(5), 228–237. https://doi.org/10.1016/j.ecns.2017.01.004

Maiocco, G., Stroupe, L. M., Rhoades, A., & Vance, B. (2019). Care of veterans in a non-veteran health administration hospital: What is the status of nursing practice after continuing education? *Journal of Clinical Nursing, 28*(3–4), 520–527. http://dx.doi.org/10.111/jocn.14641

Maori, L .M. (2017). Measuring cultural competence. *Kai Tiaki Nursing New Zealand, 23*(10), 30.

Maphosa, S. (2017). The role of spirituality in nursing part 2. *Nursing Update*, *42*(2), 40–41.

Margolies, L., & Brown, C. G. (2019). Increasing cultural competence with LGBTQ patients. *Nursing2019, 49*(6), 34–40. https://doi.org/10.1097/01.NURSE.0000558088.77604.24

Marion, L., Douglas, M., Lavin, M. A., Barr, N., Gazaway, S., Thomas, E., & Bickford, C. (2016). Implementing the new ANA standard 8: Culturally congruent practice. *Online Journal of Issues in Nursing*, *22*(1), 9. https://doi.org/10.3912/OJIN.Vol22No01PPT20

Markey, K., Tilki, M., & Taylor G. (2018). Understanding nurses' concerns when caring for patients from diverse cultural and ethnic backgrounds. *Journal of Clinical Nursing*, *27*(1-2), e259–e268. https://doi.org/10.1111/jocn.13926

Markey K., & Okantey, C. (2019). Nurturing cultural competence in nurse education through a values-based learning approach. *Nurse Education in Practice, 38*, 153–156. https://doi.org/10.1016/j.nepr.2019.06.011

Marrone, S. R. (2016). Informed consent examined within the context of culturally congruent care: An interprofessional perspective. *Journal of Transcultural Nursing*, *27*(4), 342–348. https://doi.org/10.1177/1043659615569537

Martin, T. E., Parker, L. M., & Mugambi, C. M. (2019). The impact of an international medical mission trip on the cultural competency of healthcare providers. *Journal of Cultural Diversity, 26*(2), 76–51.

Marzilli, C. (2016). Assessment of cultural competence in Texas nursing faculty. *Nurse Education Today, 45*, 225–229. https://doi.org/10.1016/j.nedt.2016.08.021

McBride, C. (2016). Untraditional nursing. *Nursing2016, 46*(5), 46–47. www.Nursing2016.com

McClimens, A., Brewster, J., & Lewis, R.. (2014). Recognizing and respecting patients' cultural diversity. *Nursing Standard, 28*(28), 45–52. http://dx.doi.org/10.7748/ns2014.02.28.28.45.e8148

McFadden, A., & Erikson, S. L. (2020). How nurses come to race: Racialization in public health breastfeeding promotion. *Advances in Nursing Science, 43*(1), E11–E24. https://doi.org/10.1097/ANS.0000000000000288

McFarland, M. R., & Wehbe-Alamah, H. B. (2019). Leininger's theory of cultural care diversity and universality: An overview with a historical retrospective and a view toward the future. *Journal of Transcultural Nursing*, *30*(6), 540–557. https://doi.org/10.1177/1043659619867134

McGrath, C., Palmgren, P. J., & Liljedahl, M. (2019). Twelve tips for conducting qualitative research interviews. *Medical Teacher, 41*(9), 1002–1006. https://doi.org/10.1080/0142159x.2018.1497149

McLennon, S. M. (2019). Predictors of hospital nurses' cultural competence: The value of diversity training. *The Journal of Continuing Education in Nursing, 50*(10), 469–474. http://dx.doi.org/10.3928/00220124-20190917-09

Mendes, A. (2018). Providing culturally sensitive dementia care in the acute setting. *British Journal of Nursing, 27*(14), 831. https://doi.org/10.12968/bjon.2018.27.14.831

Miles, M. B., Huberman, A. M., & Saldana, J. (2020). *Qualitative data analysis: A methods sourcebook* (4th ed.). SAGE

Milton, C. L. (2016). Ethics and defining cultural competence: An alternative view. *Nursing Science Quarterly, 29*(1), 21–23. https://doi.org/10.1177/0894318415614624

Moleiro, C., Freire, J., Pinto, N., & Roberto, S. (2018). Integrating diversity into therapy processes: The role of individual and cultural diversity competencies in promoting equality of care. *Counselling & Psychotherapy Research, 18*(2), 190–198. http://dx.doi.org/10.1002/capr.12157

Moloi, C. & Bam, M. (2014). Exploring cultural competence from a sociological point of view. *Mediterranean Journal of Social Sciences, 5*(3), 332–227. http://dx.doi.org/10.5901/mjss.2014.v5n3p332

Moura de Olveira, D., Expedito, A. C, Aleixo, M. T., Carneiro, N. S., de Jesus, M. C. P., & Merighi, M. A. B. (2018). Needs expectations and care production of people in street situation. *Revista Brasileira de Enfermagem, 6*, 2689–2697. https://doi.org/10.1590/0034-7167-2017-0612

Murcia, A., Eliana, S., & Lopez, L. (2016). The experience of nurses in care for culturally diverse families: A qualitative meta-synthesis. *Revista Latino-Americana de Enfermagem, 24*, 1–11. https://doi.org/10.1590/1518-8345.1052.2718

National League of Nursing [NLN]. (2016). *A vision of achieving diversity and meaningful inclusion in nurse education: A living document from the National League for Nursing*. http://www.nln.org/newsroom/news-releases/news-release/2016/02/2016/diversity-in-nursing-an-nln-vision-statement

Ndolo, N-M. (2016). Internationally educated nurses' and their contributions to the patient experience. *Online Journal of Issues in Nursing, 21*(1), 7. https://doi.org/10.3912/OJIN.Vol21No01Man05

Nilson, C. (2017). A journey toward cultural competence: The role of researcher reflexivity in Indigenous research. *Journal of Transcultural Nursing, 28*(2), 119–127. https://doi.org/10.1177/1043659616642825

Office of Minority Health. (2016). CLAS A-Z: A practical guide for implementing the national standards for Culturally and Linguistically Appropriate Services (CLAS) in health care. https://www.minorityhealth.hhs.gov/omh/content.aspx?ID=2954

Ogbolu, Y., Scrandis, D. A., & Fitzpatrick, G. (2018). Barriers and facilitators of care for diverse patients: Nurse leader perspectives and nurse manager implications. *Journal of Nursing Management, 26*(1), 3–10. https://doi.org/10.1111/jonm.12498

Oikarainen, A., Mikkonen, K., Kenny, A., Tomiettto, M., Muomikoski, A-M., Merilainen, M., Mielttunen, J., & Kaariainen, M. (2019). Educational interventions designed to develop nurses' cultural competence: A systematic review. *International Journal of Nursing Studies, 98*, 75–86. https://doi.org/10.1016/j.inurstu.2019.06.005

Oxford University Press (n.d.). Cultural diversity. Oxford Languages. Retrieved October 15, 2020, from https://tinyurl.com/oxfordculture

Palese, A., Tommasini, C., DiFalco, A., Mulloni, G., Rissolo, R., Sanson, G., Bressan,V., & Papastavrou, E. (2019). Developing policies and actions in response to missed nursing care: A consensus process. *Journal of Nursing Management, 27*, 1492–1504. https://doi.org/10.1111/jonm.12835

Peltzer, J. N., Teel, C., & Pierce, J. D. (2017). Culturally competent nursing care: A descriptive study of Kansas nurses and pre-licensure and RN-BSN programs. *The Kansas Nurse Journal, 92*(3), 11–12.

Phillips, J. M., & Young, J. A. (2018). Strategies for integrating global awareness and engagement into clinical practice. *Journal of Continuing Education in Nursing, 49*(5), 203–205. https://doi.org/10.3928/00220124-20180417-04

Purnell, L. (2016). Are we really measuring cultural competence? *Nursing Science Quarterly, 29*(2), 124–127. https://doi.org/10.1177/0894318416630100

Purtzer, M. A., & Thomas, J. J. (2021). What Native Americans want nurses to know: Attitudes and behaviors desired in client/nurse relationships. *Public Health Nursing*, *38*(2), 176–185. https://doi.org/10.1111/phn.12810

Radix, A., & Maingi, S. (2018). LGBT cultural competence and interventions to help oncology nurses and other health care providers. *Seminars in Oncology*, *34*(1), 80–89. https://doi.org/10.1016/j.soncn.2017.12.005

Ravitch, S. M. & Carl, N. M. (2016). *Qualitative research: Bridging the conceptual, theoretical, and methodological.* Sage Publications

Reed, S. J., Callister, L. C., Kavaefiafi, A., Corbett, C., & Edmunds, D. (2019). Honoring motherhood. *The American Journal of Maternal Child*, *42*(3), 146–152. https://doi.org/10.1097/NMC.0000000000000328

Riner, M. E. (2018). Global health nursing: Making connections by embracing the other. *The Journal of Continuing Education in Nursing*, *49*(3), 99–100. https://doi.org/10.3928/00220124-20180219-01

Rising, M. L. (2017). Truth telling as an element of culturally competent care at end of life. *Journal of Transcultural Nursing*, *28*(1), 48–55. https://doi.org/10.1177/1043659615606203

Ritchie, L. (2018). Navigating my bicultural journey. *Kai Tiaki Nursing New Zealand*, *24*(4), 34.

Roldan-Chicano, M. T., Fernandez-Rufete, J., Hueso-Montoro, C., del Mar Garcia-Lopez, M., Rodriguez-Tello, J., & Flores-Bienert, M. D. (2017). Culture-bound syndromes in migratory contexts: The case of Bolivian immigrants. *Revista*

Latino-Americana De Enfermagem, 25 (e2915). http://dx.doi.org/10.1590/1518-8345.1982.2915

Rowlands, J. (2021). Interviewee transcript review as a tool to improve data quality and participant confidence in sensitive research. *International Journal of Qualitative Methods, 20,* 1–11. https://doi.org/10.1177/16094069211066170

Rubin, H. J. & Rubin, I. S. (2012). *Qualitative interviewing: The art of hearing data* (3rd ed.). Sage Publications

QRS International. (2021). NVivo transcription. https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/about/nvivo/modules/transcription

Saldana, J. (2016). *The coding manual for qualitative researchers* (3rd ed.). Sage Publications

Schreiber, M. L. (2019). Tattoos and piercings: Considerations for nursing practice. *MEDSURG Nursing, 28*(2), 130–134.

Schwarz, J. L., Witte, R., Sellers, S. L., Luzadis, R. A., Weiner, J. L., Domingo-Snyder, E., & Page, J. E. (2015). Development and psychometric assessment of the healthcare provider cultural competence instrument. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing, 52*, 1–8. http://dx.doi.org/10.1177/0046958015583696

Schweiger-Whalen, L., Noe, S., Lynch, S., Summers, L., & Adams, E. (2018). Converging cultures: Partnering in affirmative and inclusive health care for members of the lesbian, gay, bisexual, and transgender community. *Journal of the*

American Psychiatric Nurses Association, 25(6), 453-–466. https://doi.org/10.1177/1078390318820127

Simon, M. K., & Goes, J. (2013). Dissertation and scholarly research: Recipes for success (2013 ed.) Dissertation Success, LLC. www.dissertationrecipes.com

Taylor, A. & Alfred, M. V. (2010). Nurses' perceptions of the organizational supports needed for the delivery of culturally competent care. *Western Journal of Nursing Research*, *32*(5), 591–609. http://wjn.sagepub.com/content/32/5/591

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, *9*(2), 117–125. https://provider.bcbsil.com/pdf/education/guest_speaker_cultural_sensitivity.pdf

The Joint Commission. (2011). Patient-centered communication standards for hospitals. *R^3: Requirement, rational, reference*, 1, 1–4. www.jointcommission.org

Thompson, R. (2018). A qualitative phenomenological study of emotional and cultural intelligence of international students in the United States of America. *Journal of International Students*, *8*(2), 1220–1255. http://dx.doi.org/10.5281/zenodo.1250423

Thurman, W. A., Johnson, K. E., & Sumpter, D. F. (2019). Words matter: An integrative review of institutionalized racism in nursing literature. *Advances in Nursing Science*, *42*(2), 89–108. http://dx.doi.org/10.1097/ANS.0000000000000265

Traister, T. (2020). Improving LGBTQ cultural competence of RNs through education. *Journal of Continuing Education in Nursing*, *51*(8), 359–366. https://doi.org/10.3928/00220124-20200716-05

Transcultural C.A.R.E. Associates. (2015). The process of cultural competence in the delivery of healthcare services. http://transculturalcare.net/the-process-of-cultural-competence-in-the-delivery-of-healthcare-services/

Truglio-Londrigan, M. (2016). Shared decision making through reflective practice: Part II. *MEDSURG Nursing*, *25*(5), 341–345.

Truong, M., Paradies, Y., & Priest, N. (2014). Interventions to improve cultural competency in healthcare: A systematic review of reviews. *Biomedical Central Health Services Research*, *14* (99). https://doi.org/10.1186/1472-6963-14-99

Tsujimura, M., Ishigaki, K., Yamamoto-Mitani, N., Fujita, J., Katakura, N., Ogata, Y., Mochizuki, Y., Okamoto, Y., & Shinohar, Y. (2016). Cultural characteristics of nursing practice in Japan. *International Journal of Nursing Practice*, *22*, 56–64. https://doi.org/10.1111/ijn.12440

U.S. Census Bureau. (2018). Quick facts. Retrieved from https://www.census.gov/quickfacts/fact/table/US/PST045218

Uzar-Ozcetin, Y. S., Tee, S., & Kargin, M. (2020). Achieving culturally competent cancer care: A qualitative study drawing on the perspectives of cancer survivors and oncology nurses. *European Journal of Oncology Nursing*, *44*, 1–9. https://doi.org/10.1016/j.ejon.2019.101701

Warshawski, S., Itzhaki, M., & Barnoy, S. (2019). Nurse and nurse student attitudes and perceived self-efficacy in use of information and communication technologies: Professional and cultural differences. *Computers, Informatics, Nursing, 37*(1), 20–28. https://doi.org/10.1097/CIN.0000000000000470

Wesp, L. M., Ruiz, A., Weitzel, J., Kako, P. M., & Mkandawire-Valhmu, L. (2018). An emancipatory approach to culturally competency: The application of critical race, postcolonial, and intersectionality theories. *Advances in Nursing Science*, *41*(4), 316–326. http://dx.doi.org/10.1097/ANS.0000000000000230

Whitley, B. E., & Kite, M. E. (2018). *Principles of research in behavioral science* (4th ed.). Routledge

Williams, B. M., Wright, C., Leigh, K., Armstrong, B., & Kelley, S. (2019). Do we practice what we preach? Tattoos in nursing. *Journal of Christian Nursing, 36*(1), 38–41. https://doi.org/10.1097/CNJ.0000000000000496

Wilson, L., Mendes, I. A. C., Klopper, H., Catrambone, C., Al-Maaitah, R., Norton, M. E., & Hill, M. (2016). 'Global health' and 'global nursing': Proposed definitions from the global advisory panel on the future of nursing. *Journal of Advanced Nursing*, *72*(7), 1529–1540. http://dx.doi.org/10.1111/jan.12973

Woods, D. L., Mentes, J. C., Cadogan, M., & Phillips, L. R. (2017). Aging, genetic variations, and ethnopharmacology: Building cultural competence through awareness of drug responses in ethnic minority elders. *Journal of Transcultural Nursing*, *28*(1), 56–62. https://doi.org/10.1177/1043659615606202

Yoder-Wise, P. S. (2018). The importance of culture. *The Journal of Continuing Education in Nursing*, *49*(5), 195–196. https://doi.org/10.3928/00220124-20180417-01

Young, S. & Guo, K. (2020). Cultural diversity training: The necessity of cultural competence for healthcare providers and in nursing practice. *The Health Care Manager*, *39*(2), 100–108. http://dx.doi.org/10.1097/HCM.0000000000000294

Zhang, Y-P., Liu, W-H., Yan, Y-T., Porr, C., Zhang, Y., & Wei, H-H. (2019). Psychometric testing of the evidence-based practice nursing leadership scale and the work environment scale after cross-cultural adaptation in mainland China. *Evaluation & the Health Professions*, *42*(3), 328–343. https://doi.org/10.1177/0163278718801439

Zoom Video Communications. (2019). Features. https://zoom.us/feature

Zoom Video Communications. (2021). Getting started with recording. https://support.zoom.us/hc/en-us/articles/360059781332-Getting-started-with-recording

Appendix A: Interview Guide

Interview Script

Researcher: Hello [insert participant's name] I appreciate you agreeing to this interview. The purpose of my study is to understand nurses' perceptions and application of cultural competence into practice, how they implement cultural competence into their practice, and any barriers they might perceive to this implementation.

You have received my previous email regarding consent and have consented to this interview. As a reminder, I will be recording our conversation using the Zoom platform, audio recording function, as well as the transcription function of the NVivo platform. At the end of the interview, I will review the interview to be sure there were not any technical difficulties. In the event we are disconnected, you can call back or log on with to our Zoom meeting using the link and meeting identification information included in the email. At the end of this interview, I will transcribe our conversation, using NVivo to create a verbatim transcript that I can use for data analysis. I will email you a copy of the transcript, for you to review. You are welcome to provide additional insight or clarify any part of the transcribed conversation.

Prior to beginning this interview, it is important that you are in a safe, quiet place and have at least 30 to 45 minutes to answer the questions. If you are not able to meet the time and safety conditions at this time, we could reschedule.

Are you able to continue under these stipulations?

Participant response:

Researcher: Do you have any questions prior to beginning the interview?

Participant response:

(Allow for Researcher follow-up if needed)

Researcher: Okay, if you have no other questions, are you alright getting started?

Participant response:

Researcher: Great! These first few questions are just to obtain a little pertinent background information about your practice and role as a registered nurse. After which, we will go right into the questions related to cultural competence.

(Allow for affirmation or understanding prior to starting the questions)

Researcher: Question 1, How long have you been a registered, bedside nurse?

Participant response:

Researcher: Question 2, What are your professional nursing and educational credentials?

Participant response:

Researcher**:** Question 3, What setting do you work in?

Participant response:

Researcher**:** Question 4, What is your role in this setting?

Participant response:

Researcher**,** Question 5, Please share what culture means to you.

Participant response:

Researcher: (Allow for follow-up or clarification) Thank you for your answer.

Researcher: Question 6**,** How do you perceive culture in bedside practice?

Participant response:

Researcher: (Allow for follow-up or clarification) Thank you for your answer.

Researcher: Questions 7**,** Please tell me what cultural competence is to you and how you define it.

Participant Response:

Researcher: (Allow for follow-up or clarification) Thank you for your answer.

Researcher: Question 8, How do you perceive cultural competence in bedside practice?

Participant Response:

Researcher: (Allow for follow-up or clarification) Thank you for your answer.

Researcher, Question 9, Please share how you learned culturally competent care practices.

Participant Response:

Researcher (Allow for follow-up or clarification) Thank you for your answer.

Researcher**,** Question 10, Please share some examples of how you implement cultural competence in your practice.

Participant response:

Researcher: (Allow for follow-up or clarification) Thank you for your answer.

Researcher, Question 11, What other insights would you like to share about your perceptions of cultural competence in your practice?

Participant response:

Researcher: (Allow for follow-up or clarification) Thank you for your answer.

Researcher, Question 12, Do you have any questions for me?

Participant response**:**

Researcher: I want to thank you again for your participation. You have my contact information. Please reach out to me if you have any other thoughts or insights that you would like to share. I will follow up with you, by email, in the coming week to provide you with a transcript of this interview.

Enjoy the rest of your day! Goodbye!

Appendix B: Example of Coding and Categorizing Table

In Vivo	First Cycle	Second Cycle	Theme
Interview 1: "…different people all over the world…have different beliefs, ideals, practices that influence their lives and their care." "…just like with any job, you're either competent or you're not competent." "Have a certain patient set or certain race or religion or culture or age and knowing what works and what didn't work and asking the patient as well."	• Varying beliefs • Cultural understanding • Cultural competence • Recognizing cultural differences • Patient types	Beliefs Competence Recognition	Cultural knowledge Educational process Self-awareness
Interview 2: "…can mean a different, a lot of different things, it can be the culture of the profession, it can be the culture of the patient, it can be the culture of the institution." "…cultural nursing at **college**, which really gave me an insight on different things that different cultures experience." "…like knowing who the right person is to go to, like, you know, who is the standard person normally in this culture that is the lead of a family, how, how they react to certain situations or what their beliefs are."	• Cultural differences • Learning about cultures • Understanding cultural differences	Recognition Education; Educational needs Competence	Self-awareness Educational process Educational process

Interview 3: "…I have to keep an open mind…" "And in that aspect, you can't let that affect your judgment…" "…I feel like everyone is more open minded, especially with the fact that they are trying to make sure they're giving patients the best possible care, especially when we're seeing a lot of hold for patients…"	• Open minded • Judgment processes • Open minded	Mindset Process Mindset	Self-awareness Current culturally competent practices Self-awareness