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Educating About Military Culture: Lived Experiences of Nurse Educators

Jennifer C. Dodge
Walden University

Walden University

College of Nursing

This is to certify that the doctoral dissertation by

Jennifer C. Dodge

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Review Committee
Dr. Mary Martin, Committee Chairperson, Nursing Faculty
Dr. Elizabeth Diener, Committee Member, Nursing Faculty

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

Walden University
2025

Abstract

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by

Jennifer C. Dodge, MSN, RN

MSN, Purdue Global University, 2019

BSN, Kaplan University, 2016

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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November 2025

Abstract

Despite national initiatives designed to expand healthcare programs and resources for veterans, there is a lack of knowledge about military culture and health problems specific to this demographic among registered nurses who serve in a role to impact the suicide rate among the veteran population. The purpose of this qualitative study, guided by Leininger's culture care theory and Benner's novice to expert model, was to understand the lived experiences of associate degree in nursing (ADN) nurse educators in non-Veterans Health Administration-affiliated programs regarding teaching undergraduate nursing students about military veteran culture. Fifteen ADN nurse educators, selected through purposeful sampling, participated in focus groups guided by open-ended questions and conducted using the Zoom platform until data saturation was reached. Thematic analysis revealed four themes to answer the research question: (a) personal experience and level of knowledge, (b) current education practices, (c) barriers to education, and (d) recommendations. Results indicated that while many of the published veteran competencies are taught within ADN nursing programs, they are not connected with the veteran's demographics. Barriers to providing veteran-centric education included faculty inexperience with veteran content and a lack of time. Future studies are needed to assess the implementation of veteran culture within nursing curricula and evaluate the impact on the cultural competence of practicing nurses. The development of veteran-centric resources and the intentional incorporation of veteran sharing of experiences related to specific concepts may affect positive social change by arming future nurses with the knowledge, skills, and attitudes necessary to provide care for this demographic.

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Dedication

I dedicate this study to my family. To my mother, Carol Kramer, thank you for supporting me through my journey as a veteran, a nurse educator, and as a dreamer who wanted to change the world. To my father, Tom Kramer, if it weren't for you, I wouldn't have joined the Navy and become the person I am today. You saved me. I love you both more than words could ever express. To my daughters, Kaylyn and Quincy, thank you for loving me as I figured out who I wanted to be when I grow up. To my family members who I lost during my journey to PhD, I hope I've made you proud.

This study is also dedicated to Micah Ecumenical Ministries. Through my work with Micah, I met "Lonnie," although that was not his actual name. Lonnie was a veteran suffering from PTSD, who eventually shared his experiences from serving in the military with me. The more Lonnie shared, the more layers of his trauma were peeled back, revealing a wonderful human being. It made me think of vidalias, a sweet variety of onion. Perhaps the most damaged humans are like vidalias, just waiting to be discovered under layers of life. Lonnie's greatest wish was to be granted visitation with his daughter; however, despite many petitions to the courts, this wish was never granted. Lonnie became one of the veterans we lose each day to suicide. The experiences of working with clients supported by Micah changed my life, and I am grateful beyond words.

Finally, this project is dedicated to all veterans and active-duty servicemen and women. I'm proud to be a part of your culture and honor you with my work.

Acknowledgments

To Dr. Mary Martin and Dr. Elizabeth Diener, words cannot express the level of gratitude I feel for your guidance and support. You were there for me when I stumbled and celebrated every victory with me as I took each step on this journey. Your thoughtful feedback helped me grow as a scholar, researcher, and nurse.

To Dr. Angela Sheaffer, thank you for being a mentor to me as a nurse, a nurse educator, and a lifelong scholar.

To the nurse educators who volunteered to participate in my study, thank you for providing your time and valuable insights. I am grateful to you and all nurse educators striving to shape the future of our profession.

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Chapter 1: Introduction to the Study

Introduction

Suicide rates among military veterans in the United States are increasing. In 2022, suicide was the second leading cause of death in veterans under the age of 45 (U.S. Department of Veterans Affairs, 2024). The suicide rate for veterans is over double the rate for civilians, with a rate of 34.7 per 100,000 veterans compared to a rate of 17.1 per 100,000 in the civilian population (U.S. Department of Veterans Affairs, 2024). Currently, there are over 18 million living veterans residing in the United States, and of those veterans, more than 50% receive healthcare outside of the Veterans Health Administration (VHA; Zychowicz et al., 2022), indicating a need for prelicensure nursing faculty to educate students on providing culturally competent care to this demographic. Despite national initiatives, including Joining Forces and Have You Ever Served, that have raised awareness of the needs of the veteran population, studies have indicated that civilian nurses lack the capacity to provide culturally competent care to veterans (Bonzanto et al., 2019; Elliott et al., 2024; Simoni et al., 2024). To address the problem of a lack of knowledge about military veteran culture among civilian nurses, it is essential to examine how veteran culture is taught within prelicensure nursing programs not affiliated with the VHA.

In this chapter, I provide an overview of the study. I begin with the background of the problem, including a review of the literature that approaches the identified problem from three angles: veteran needs in the healthcare environment, prelicensure education about military veteran culture, and registered nurse perceptions of their capacity to

provide culturally competent care to veterans. The purpose of the study is explained, and the research question is presented. I introduce how the study is grounded in Leininger's culture care theory (McFarland, 2019; Alligood, 2021) and Benner's novice to expert model (McEwen & Wills, 2022) as well as the concepts of cultural competence and healthcare disparities. The decision to design a qualitative study with an interpretive descriptive approach is explained. I also explain the rationale for using focus groups for data collection as well as the process for analyzing the data. Additionally, I describe my choices for the parameters of inclusion and exclusion, along with the rationales for these choices. To ensure clarity for readers, I have provided definitions of terms used throughout the study as well as discuss the perceived limitations of the study. The significance of the study and its potential to enhance the health outcomes of veteran patients is then described.

Background

Military veterans represent a demographic with characteristics that differ from those of their civilian counterparts, leading to the development of veteran-specific competencies for healthcare providers (Elliott et al., 2021). Veteran culture encompasses beliefs and practices related to organizational structure, social components, help-seeking behaviors, and healthcare practices (Derefinko et al., 2019; McCaslin et al., 2021; Shankle et al., 2023). Studies that explored perceptions of practicing nurses regarding caring for veteran patients included differences in establishing nurse-patient relationships with military veteran patients compared with civilian patients, perceived barriers to providing culturally competent care to military veterans, and educational needs to

empower nurses to provide care for the veteran demographic (Elliott et al., 2024; Maiocco et al., 2019; Mushale & Bakerjian, 2021).

Preparing prelicensure nursing students to care for patients from diverse cultural backgrounds involves a combination of didactic, simulation, and clinical experiences. Published studies that examined how veteran culture is presented within prelicensure nursing textbooks found that within nursing fundamentals textbooks, content surrounding cultural competence focused primarily on race and ethnicity as well as language barriers, noting that the simplification in presentation of diversity leads to generalization and not focusing on patients as individuals and that within medical surgical textbooks, the knowledge, skills, and attitudes necessary to provide culturally competent care to veterans were poorly addressed (Carmack & Jannat, 2025; Chargualaf et al., 2021). Faculty tasked with preparing prelicensure students assess themselves as culturally aware, a step below culturally competent, and noted barriers to providing education about cultural competence include a lack of diversity within the classroom and lower prioritization of educating students about cultural competence (Chen et al., 2020). An expanded search to determine student perceptions of veteran cultural competence education indicated limited data from this angle; however, studies that explored nursing student perceptions of learning activity that included veteran-centric simulations disclosed that participants reported increased knowledge regarding veteran culture, increased confidence in their ability to provide culturally competent care to this demographic, empathy development for veterans, and understanding of the complex healthcare needs of veterans (Byrne, 2020; Flores et al., 2021).

Practicing nurses report feeling unprepared to provide adequate care for their veteran patients, stating that while they understood that veterans require specialized treatment plans, they felt they lacked the skills required to care for patients who are military veterans and noted fear of triggering posttraumatic stress disorder (PTSD) episodes as a barrier to assessing veteran status in their patients (Claus et al., 2020). Communication is an area identified by veterans as one of the biggest challenges they face when transitioning to civilian life (Derefinko et al., 2019; McCaslin et al., 2021), noting a perceived need for healthcare providers to identify veterans and ask about their military experiences, promotion of autonomy, anticipation of cultural differences, and treating veterans as individuals (Borah et al., 2022).

There is limited published data regarding how military veteran culture is taught within nursing programs in the United States. A 2017 study explored the impact of the Joining Forces initiative on nursing programs, finding that 15% of programs had incorporated some form of veteran-centric education into their curriculum. Approximately 50% of nursing programs located within 50 miles of a VHA facility reported greater inclusion of veteran criteria into their curriculum (Elliott et al., 2024). There is a lack of current published data regarding how nurse educators prepare their students with the knowledge, skills, and attitudes encompassing veteran competencies. In the current study, I explored this through the lived experiences of prelicensure nurse educators from nursing programs not affiliated with the VHA, including current practices, perceived barriers, and the needs of faculty to empower them to provide this education. .

Problem Statement

Adverse health outcomes in veteran patients have been attributed to a deficiency in knowledge among healthcare providers and failure to provide culturally competent care (Borah et al., 2022). Research regarding how future nurses are prepared to meet the healthcare needs of the veteran demographic indicated deficiencies in academic resources and faculty preparedness to provide education (Chargualaf et al., 2021; Chen et al., 2020). The concept of communication is at the heart of forming trusting nurse-patient relationships and leads to positive patient outcomes (Afriyie, 2020). This ties directly to the veteran demographic because veterans report that one of their most significant challenges is communicating with civilians about their military experiences, leading to a sense of isolation and reluctance to share their experiences (Giesler & Juarez, 2019; McCaslin et al., 2021), indicating a greater need for nurses to broach the subject of military service and bridging the divide in order to build trust.

Limited exposure and education about veteran culture can create insecurity in nurses and inhibit their ability to provide appropriate care to veteran patients (Elliott et al., 2024). Cultural competence in nursing students is best achieved through a combination of lectures, simulation, role-playing, simulation, and exposure (Nkhoma et al., 2023). Medical-surgical textbooks are insufficient to provide education that addresses veteran competencies (Chargualaf et al., 2021). Faculty reported that they are unprepared to educate prelicensure students about cultural competence in general (Flores et al., 2021), and prelicensure students and practicing nurses reported feeling unprepared to provide care for veteran patients (Elliott et al., 2024; Mushale & Bakerjian, 2021).

Published studies that explored nursing student perceptions of learning activities that included veteran-centric simulations disclosed that participants reported increased knowledge regarding veteran culture, increased confidence in their ability to provide culturally competent care to this demographic, empathy development for veterans, and understanding of the complex healthcare needs of veterans (Byrne, 2020; Flores et al.; 2021; Roe et al., 2019).

Researchers have explored best practices for developing cultural competence in prelicensure nursing students; however, a gap exists in how nursing programs not affiliated with VHA facilities are incorporating these practices into their programs. The current state of nurse knowledge, skills, and attitudes regarding the care of veteran patients indicates a need to understand why the problem exists, informing the education of future nurses.

Purpose of the Study

The purpose of this study was to explore the lived experiences of faculty from non-VHA-affiliated programs in preparing nursing students to provide nursing care to military veterans. Nursing faculty are the best source for current educational practices within their respective programs, providing realistic data on how nurses are prepared to deliver culturally competent care to veteran patients. Exploring the lived experiences of nurse educators will generate data regarding when and how veteran content is presented within nursing programs as well as the consistency among programs in delivering education about this demographic to better understand current practices in educating future nurses about military veteran culture.

Research Question

The following research question guided this study: What are the lived experiences of associate degree in nursing (ADN) nurse educators in non-VHA-affiliated programs regarding teaching undergraduate nursing students about military veteran culture?

Theoretical and/or Conceptual Framework for the Study

This study was underpinned by Leininger's (1966) culture care theory and Benner's (1982) novice to expert model as well as the concepts of cultural competence and health disparities. An in-depth analysis of the relationships between these theories and concepts in the study will be presented in Chapter 2.

Leininger's (1966) culture care theory is based on the understanding that cultural philosophies, beliefs, and practices are interrelated with health, illness, and wellness in patients, and influence the healthcare practices of individuals within their respective cultures. Leininger stipulated in the tenets of this theory that, in order for nurses to provide culturally congruent care, the cultural beliefs and values of the patient need to be incorporated appropriately into that patient's plan of care (Alligood, 2021; McFarland & Wehbe-Alamah, 2019).

Benner's novice to expert model encompasses the concepts of knowledge, skill acquisition, competence, and experience in relation to skill acquisition through five stages, progressing from novice to expert (McEwen & Wills, 2022). In the model, Benner noted that new graduate nurses are at the level of advanced beginner, with basic knowledge and skills, and require additional support to fulfill their roles (Murray et al., 2019; Silva et al., 2021).

In Chapter 2, I present an in-depth analysis of the existing literature surrounding the concepts of cultural competence and health disparities as they relate to this study. These concepts relate to the problem of a lack of knowledge among nurses today because they underpin cause and effect: A lack of knowledge in practicing nurses results in patients, particularly military veterans, receiving care that is not equal to the care received by members of other cultural groups. The interview questions presented to focus group participants were open ended and focused on current practices in academia.

There is a gap in knowledge regarding how nursing programs not affiliated with VHA facilities are incorporating these practices into their curricula. The concept of cultural competence is one of the building blocks of Leininger's culture care theory, specifically that cultural competence in nursing incorporates the healthcare beliefs and practices of individuals and groups into the plan of care to promote optimal health (Sharifi et al., 2019; Vasli et al., 2024). Nurses are tasked with establishing trusting relationships with veteran patients to promote health outcomes. Published studies have indicated that nurses often feel unprepared to provide culturally competent care to their veteran patients (Elliott et al., 2024).

The concept of health disparity is described as preventable differences in healthcare opportunities due to imbalances in interpersonal and systemic constructs (Downey & DiBenedetto, 2021). A lack of knowledge prevents nurses from providing culturally competent care to veteran patients by inhibiting their ability to establish therapeutic nurse-patient relationships through communication, thus presenting a preventable difference in healthcare opportunities for the veteran population.

Nature of the Study

I employed a qualitative, interpretive, descriptive approach in this study. The study was designed to help nurse educators identify how veteran content is currently presented in nursing programs not affiliated with the VHA, identify gaps in current practices, and inform future academic practices. The selected design enabled me, as the researcher, to explore the experiences of the study participants regarding the education of nursing students within the context of their program(s). I conducted focus groups via the Zoom platform to generate data for the study. The use of focus groups in qualitative studies centered on healthcare research have increased in popularity over the past few decades, and I selected this methodology due to its collaborative nature and noted capacity to promote spontaneous discussions and gather more robust data (see Gundumogula, 2020). I conducted thematic analysis with the assistance of ATLAS.ti software for word frequency identification, coding, and linking codes to participant quotations (see Kalpokas & Radivojevic, 2022).

Definitions

Cultural competence: The ability of a healthcare professional to provide care specific to a demographic's specific beliefs, values, and practices (Robaina Castillo, 2022).

Nursing care: Actions that assist others in the process of healing and becoming well, and culture refers to shared values, norms, and practices shared by a group of individuals that guide the thought processes and actions of the group (Hadadian-Chaghaei et al., 2022; McFarland & Wehbe-Alamah, 2019).

Nursing faculty: Individuals who provide education to nursing students in didactic, simulation, and clinical settings (Labrague et al., 2020).

Veteran culture: A set of values, beliefs, and traditions that guide the practices and behaviors of a collective or individual. These values include a chain of command that serves under an authoritarian leadership structure, which ensures the readiness of those who serve to complete missions and protect national interests (Heward et al., 2024).

Assumptions

I assumed that participants were honest in their responses to eligibility questions for participation in the study. Another assumption was that participants were open and honest in their responses and interactions with other participants in the study. Additionally, I assumed that participants had a vested interest in the study because of the spirit of inquiry that drives nurse educators as lifelong learners

Scope and Delimitations

The scope of this qualitative study encompassed nurse educators from prelicensure ADN programs that are not affiliated with the VHA, located across the United States, who had at least 1 year of teaching experience within their respective programs. Participants represented a range of expertise in nursing, including years of experience as a registered nurse in diverse areas of healthcare, as well as various specialties. The Accreditation Commission for Education in Nursing (ACEN) includes culture, diversity, and healthcare disparities in Standard 4 (Chargualaf et al., 2021), and faculty from prelicensure programs were familiar with this because each program strives to maintain accreditation. The current study generated data from registered nurse

prelicensure programs that would be beneficial to educators in similar programs across the country, informing future curriculum development.

Because the purpose of the study was to explore the lived experiences of nursing faculty from non-VHA-affiliated programs, a qualitative study was appropriate (see Pyo et al., 2023). A quantitative study would have provided statistical data surrounding the problem (e.g., the number of prelicensure programs that include veteran culture into their curriculum); however, a quantitative approach would not have provided the in-depth data regarding where within programs this content is taught. The sampling method used for the study was purposive because participants selected through this method have experienced the phenomenon being studied (see Doyle et al., 2020). Nursing faculty from prelicensure programs not affiliated with the VHA have experience with how their curriculum prepares nursing students to provide culturally competent care to military veterans. I sought to understand how programs not affiliated with the VHA are incorporating military culture into their educational practices as well as any challenges they may be experiencing in providing this education.

I did not include nurse educators with less than a year of experience teaching within their programs because participants needed to have adequate knowledge about their program curricula. Research has indicated that the duration of mentorship for new faculty spans between 6 and 12 months (Busby et al., 2022). Additionally, practical nursing faculty were excluded from this study due to the condensed nature of education for practical nurses (see Taylor et al., 2023).

Limitations

A potential limitation for this study was achieving data saturation. A systematic review aimed at assessing saturation found that saturation typically occurs in 12 to 20 participants or four to eight focus groups (Hennink & Kaiser, 2022). I initially estimated that the sample size for this study would be 15 participants engaging in a minimum of four focus group discussions and planned to adjust that number if data saturation had not occurred by that point. I determined that data saturation occurred after completing four focus groups, each comprising between two and six participants, totaling 15 participants.

Researcher bias was a second potential limitation of this study. I incorporated planned strategies to avoid or limit bias, including reflexivity, excluding participants with whom I have a personal or professional relationship, and maintaining transparency throughout the resource process through journaling and remaining open to emerging data. Additionally, I incorporated member checking to ensure the accuracy of the transcribed data.

Significance

As nurse educators, improvement is needed in how future nurses are prepared to care for veteran patients. The suicide rate among veterans is nearly twice that of civilians (U.S. Department of Veterans Affairs, 2023). Veterans report difficulty communicating about their military experience with civilians (Derefinko et al., 2019; McCaslin et al., 2021), and nurses reported feeling that they lacked the skills required to care for patients who are military veterans and noted fear of triggering PTSD episodes as a barrier to assessing veteran status in their patients (Claus et al., 2020). A need for education

regarding how to communicate with veterans was expressed by registered nurses (Mushale & Bakerjian, 2021).

The findings of this study have the potential to impact the health outcomes of military personnel and veterans by providing insight into the current state of nursing education in relation to military culture and informing changes to enhance content delivery. Empowering future nurses with skills to provide culturally competent care to active military and veteran patients addresses the communication challenge that veterans report facing when sharing their experiences with civiliansand assists in the creation of therapeutic nurse-patient relationships that are essential for healthy outcomes through identification of patients who are at risk or who are experiencing suicidal ideation as well as reducing the sense of isolation that veterans perceive as a result of a divide between military and civilian cultures (Giesler & Juarez, 2019; McCaslin et al., 2021).

Best practices involve combining lectures with active learning strategies and immersive experiences, such as those with the military (Nkhoma et al., 2023). I conducted this study to determine whether and how prelicensure programs are implementing these best practices, and if not, why. By understanding current practices, nurse educators can identify areas for improvement and implement changes. These changes will reduce nurses' trepidation about triggering PTSD in veteran patients by asking about their military background and experiences, bridging the gap between civilians and veterans through communication.

Summary

Veterans make up 6% of the population within the United States; however, suicide rates among military veterans in the United States are increasing and are nearly twice as high as suicide rates among civilians (U.S. Department of Veterans Affairs, 2023). Prelicensure nursing programs are not meeting the benchmarks set forth by national initiatives, including Joining Forces and Have You Ever Served (Bonzanto et al., 2019; Elliott et al., 2024; Simoni et al., 2024). To address the lack of knowledge regarding military culture among nurses, it was necessary to examine how veteran culture is taught within prelicensure nursing programs not affiliated with the VHA and identify areas for improvement.

Chapter 2: Literature Review

Introduction

The importance of educating prelicensure nursing students about veteran culture was indicated in a report published by the U.S. Department of Veterans Affairs (2023), which noted that the suicide rate for veterans is 33.9 per 100,000 compared with a rate of 16.7 per 100,000 in the civilian population. In 2012, the American Association of Colleges of Nursing endorsed the Joining Forces Initiative, a White House Initiative designed to support veterans, their families, and caregivers with transitioning to civilian culture through support in areas that include employment, education, and health (Elliott et al., 2024; Tayyeb, 2024). Following the Joining Forces Initiative, a set of veteran competencies was outlined in various publications to guide the education of nurses to prepare them to provide culturally competent care to military veterans (Elliott et al., 2021).

There is a lack of knowledge among nurses about military/veteran culture and health problems specific to this demographic. The purpose of this study was to explore the lived experiences of nursing faculty preparing nursing students to provide clinical care to military veterans using Leininger's theory of cultural care and Benner's novice to expert model. I conducted a literature review that approached the topic of educating prelicensure nurses about military veteran culture from three different angles: the healthcare needs of veteran patients and their perception of care provided by civilians, prelicensure education about military veteran culture, and the capacity of registered nurses to provide culturally sensitive care to veterans. Despite extensive research, I

identified a gap in the literature regarding where, within prelicensure nursing programs that incorporate clinicals within civilian healthcare facilities, students are taught about military veteran culture. Researchers have studied faculty and student perceptions regarding cultural competence in general, with a focus on veteran competencies within medical-surgical textbooks, the capacity of practicing nurses to provide culturally competent care to veteran patients, and veteran perceptions of patient-centered care that addresses the unique needs of their culture. Missing from the literature, however, is research that focuses on how prelicensure nursing programs prepare students to meet the healthcare needs of veteran patients.

In the following sections, I share the approach I took to search for literature for the review, provide an analysis of Leininger's (1966) culture care theory and Benner's (1982) novice to expert model, discuss the concepts of cultural competence and healthcare disparities, and present a review of literature related to key concepts.

Literature Search Strategy

I conducted an extensive review of the literature surrounding the problem of interest, utilizing the databases and search terms listed below. Search engines and databases accessed for the literature review included CINAHL and MEDLINE Combined Search, CINAHL Plus with Full Text, and Cochrane Database of Systematic Reviews. My review of literature began with CINAHL and MEDLINE Combined Search and CINAHL Plus with Full Text, using the search terms of *comparison of veteran and civilian healthcare needs, perceived challenges to including veterans' health in prelicensure nursing programs, student perceptions of prelicensure nursing curriculum*

and ability to provide culturally competent care to military veterans, teaching veteran health to undergraduate nursing students, incorporating military veteran health issues into prelicensure nursing curriculum, veteran experiences with civilian healthcare providers and nurses, novice nurse perceptions of ability to provide culturally competent care to veterans, faculty perceptions of veteran cultural competency in prelicensure nursing programs, perceived challenges to providing prelicensure nursing students with clinical experiences that foster military veteran cultural competence, and *novice nurse perceptions of ability to provide culturally competent care to veterans.*

I consulted with a Walden University librarian for guidance to ensure that all potential sources of published peer-reviewed literature were identified in order to examine existing data regarding the identified topic of interest. After meeting with the librarian, I incorporated new strategies to identify further relevant articles by incorporating veteran competencies into the search terms and using citation chaining in Google Scholar. Search terms used in Google Scholar included *United States veteran competencies for healthcare providers, veteran competencies in civilian nurses non-VA facilities, veteran cultural competence in prelicensure nursing programs, prelicensure nursing students prepared to care for veteran health issues, Joining Forces initiative for civilian providers, cultural competence within nursing programs in United States, transcultural nursing education,* and *veteran competencies in civilian nurses non-VA facilities.*

Theoretical Foundation

The theories that grounded this study included Leininger's (1966) culture care

theory and Benner's (1982) novice to expert model. The problem that the project addressed focuses on the lack of knowledge about military culture, beliefs, and healthcare practices, which hampers nurses' ability to provide care to veterans in a manner that aligns with their belief systems. I selected Leininger's culture care theory for this study based upon published studies that identified military veterans as a unique culture with beliefs and practices that set them apart from other cultures (Derefinko et al., 2019; Elliott, 2019; Heward et al., 2024; McCaslin et al., 2021; McMillan et al., 2022). Benner's novice to expert model was selected for this study due to the nature of preparing prelicensure students to enter the healthcare workforce.

Culture Care

The origin of Leininger's (1966) culture care theory stemmed from work as a pediatric mental health specialist. During that time, Leininger determined that established treatment modalities did not adequately consider the cultural beliefs and practices of patients and were thus ineffective (Alligood, 2021). Leininger introduced the beginnings of the theory as part of her doctoral dissertation, in which the population of two villages in New Guinea, the Akuna and the Arona, were studied and compared, noting that the researcher, when focusing on specific circumstances, can identify aspects of how a cultural group responds individually and as a group within those circumstances. Leininger presented the comparison of the Akuna and the Arona within her dissertation, noting the social makeup of each group; physical setting of each group that included number of times the village moved; roles and interactions among members within the groups; conflict resolution; spiritual beliefs; and ceremonial practices for specific events

that included births, marriages, and funerals. Incorporating Leininger's culture care theory into the plan of care for a member of the Akuna tribe would differ from the plan of care for a member of the Arona tribe, addressing the unique beliefs and practices of each culture to promote healthy outcomes.

Within the United States, the military veteran culture has been explored and data has been published in multiple studies. The study of U.S. military veterans as a culture indicates that this demographic is characterized by a chain of command and an authoritarian leadership structure. Members from all branches of the U.S. military describe their culture with terms that include patriotism, honor, discipline, team/unit, and pride (Heward et al., 2024; McCaslin et al., 2021). Also prevalent in military/veteran culture is self-stigma for help-seeking behaviors, which are viewed as a sign of weakness and inability to perform within the context of a team, and studies have indicated a higher risk of suicide related to self-stigma and a decreased incidence of suicide among military veterans who connect with other veterans (Cacace et al., 2022; Decker, 2025; Heward et al., 2024; Kranke et al., 2019). Studies that explored the perceptions of nurses who work with military veteran patients indicated that differences that exist between caring for military veteran patients and civilian patients include additional time necessary for forming trusting relationships with veteran patients as well as differences in dynamics regarding when to lead and when to follow (Elliott, 2019; McMillan et al., 2022).

Leininger's culture care theory combines the concepts of culture and caring, and the practice of culturally competent care is grounded in this theory (Alligood, 2021; McFarland & Wehbe-Alamah, 2019). Leininger's purpose in creating the theory was to

empower nurses to provide care through the lens of holism, aligning with the cultural beliefs of individual patients to promote health. Caring is defined as actions that assist others in the process of healing and becoming well, while culture refers to the shared values, norms, and practices of a group of individuals that guide their thought processes and actions (Alligood, 2021; McFarland & Wehbe-Alamah, 2019). Leininger's culture care theory is based on the understanding that cultural philosophies, beliefs, and practices are interrelated with health, illness, and wellness in patients and influence healthcare practices within individual cultures. Leininger stipulates in the tenets of this theory that, in order for nurses to provide culturally congruent care, the cultural beliefs and values of the patient need to be incorporated appropriately into that patient's plan of care (Alligood, 2021; McFarland & Wehbe-Alamah, 2019).

In culture care theory, Leininger (1966) posited three constructs to guide the nursing care of patients: culture care preservation and maintenance, culture care accommodation or negotiation, and culture care repatterning and/or restructuring. The construct of culture care preservation and/or maintenance refers to tailoring nursing care to align with the cultural values of that individual (Alligood, 2021; McFarland & Wehbe-Alamah, 2019). Among the terms veterans use to describe their culture are pride and team/unit (McCaslin et al., 2021; McCormick et al., 2019), and when combined with published data supporting a decrease in suicide risk among veterans who connect with other veterans, a plan of care to encompass those values would include ensuring the veteran knows that they are part of the healthcare team and taking advantage of opportunities for the veteran patient to interact with other veterans. The construct of

cultural care accommodation and/or negotiation guides the care of patients by encouraging providers to help patients from different cultures adapt to or work with others to restore or maintain their health or address significant health issues, including disability and death (Alligood, 2021; McFarland & Wehbe-Alamah, 2019). There are numerous examples of how this construct is addressed today, including the use of musical instruments to restore motor function in the upper extremities of stroke patients (Grau-Sánchez et al., 2020). The final construct, culture care repatterning and/or restructuring, guides the area of nursing that focuses on assisting patients in modifying behaviors (Alligood, 2021; McFarland & Wehbe-Alamah, 2019). Self-stigma leads to a sense of isolation, which can be addressed in the veteran population by connecting veteran patients with other veterans through support groups or veteran-centric organizations, for example, the Veterans of Foreign Wars (Decker, 2025).

Leininger's culture care theory was reinforced in the Institute of Medicine *Crossing the Quality Chasm* report*,* in which patient-centered care was defined and reinforced to guide the care of patients from diverse backgrounds, stating that cultural competence and incorporation of patient values and beliefs into planning care are necessary for improving the quality of healthcare (Stubbe, 2020). Faculty teaching future nurses, along with students from other disciplines in the healthcare arena, have been tasked with preparing students to provide culturally appropriate care for diverse patient populations. The ACEN requires nursing programs seeking accreditation to include aspects of culture, ethnicity, and social differences into programs of study in nursing (Chargualaf et al., 2024). Prelicensure nursing faculty report understanding the

importance of teaching cultural competence; however, they note a lack of priority in providing this education (Chen et al., 2020).

Leininger's culture care theory has been a foundational concept in published studies conducted in both academic and practice settings. In a qualitative descriptive study grounded in theories, including Leininger's culture care theory, researchers explored home health nurses' perceptions of how they incorporate cultural sensitivity and patient-centered care into their practice (Narayan & Mallinson, 2022). Participants expressed the belief that assessing the cultural values of patients is a crucial step in planning care and described the strategies they incorporate to ensure that they provide culturally competent care to patients. These strategies were organized by the themes of relationship-building, assessment, and care planning (Narayan & Mallinson, 2022).

Leininger's culture care theory relates to the current study in that military veterans represent a culture that is not adequately taught within prelicensure programs in the United States, evidenced in previous studies that evaluated content regarding the knowledge, skills, and attitudes related to military veteran culture within medical-surgical nursing textbooks (Chargualaf et al., 2021) and evaluation of the capacity of registered nurses to provide culturally appropriate care to military veteran patients (Bonzanto et al., 2019; Simoni et al., 2024). The purpose of the current study was to explore the lived experiences of prelicensure nurse educators regarding educating students about military veteran programs to inform future education practices.

Novice to Expert Model

Benner's novice to expert Model encompasses the concepts of knowledge, skill

acquisition, competence, and experience in relation to skill development through five stages, progressing from novice to expert (McEwen & Wills, 2022). Competence refers to an individual's ability, grown through education and training, to perform specific tasks (Mrayyan et al., 2023). In 1984, Benner developed this model by tailoring the Dreyfus model of skill acquisition to make it specifically applicable to nursing, incorporating aspects of clinical judgment and interventions. Benner described the achievement of skill acquisition through stages and processes that include exposure to new knowledge in the classroom and experiential learning (McEwen & Wills, 2022). In the model, Benner (2021) noted that new graduate nurses are at the level of advanced beginner, with basic knowledge and skills, and requiring additional support to fulfill their roles (Murray et al., 2019).

The novice to expert model has been a key focus of nursing education and practice in the United States. In a phenomenological study grounded in Benner's novice to expert model, researchers investigated student nurses' perceptions of competence development (Munangatire & McInerney, 2021). Their results indicated that students perceive competence in five areas: completing assignments or tasks, passing tests, applying theory to practice, acting as a nurse in accordance with regulations, and providing care that leads to positive health outcomes.

The current study focused on the lived experiences of prelicensure nursing faculty regarding how they educate students about military veteran culture. Data were collected through focus groups, and questions centered on participants' self-perception of knowledge, skills, and attitudes related to military veteran culture. Nursing faculty who

participated in a mixed-methods study that explored their perspectives regarding their own level of cultural competence and how they incorporate culture into their courses scored themselves as culturally aware, a step below culturally competent, which is a potential barrier to providing education regarding diverse cultures within the classroom setting (Chen et al., 2020). Chargualaf et al. (2021) found that medical-surgical nursing textbooks do not provide sufficient material to address the knowledge, skills, and attitudes necessary to meet the veteran care competencies, indicating a need for nursing faculty to supplement the material with simulation and active learning strategies. The questions I designed for this study explored faculty perceptions of their knowledge of military veteran culture based on Benner's novice to expert model as well as lived experiences and perceived barriers to educating prelicensure students about this demographic.

Conceptual Framework

This study was grounded in the concepts of cultural competence and health disparity. In nursing textbooks, culture is defined as "a shared system of beliefs, values, and behavioral expectations that provides social structure for daily living" (Taylor et al., 2023, p. 96).

Cultural Competence

The concept of cultural competence is one of the building blocks of the culture care theory, in which Leininger noted that cultural competence in nursing incorporates the healthcare beliefs and practices of individuals and groups into the plan of care to promote optimal health (Alligood, 2021; Sharifi et al., 2019). When asked what veteran

culture means to them, veterans who participated in a qualitative study used terms that included pride, team/unit, and honor (Heward et al., 2024; McCaslin et al., 2021; McCormick et al., 2019). There are multiple studies in which civilian nurses caring for veterans described the unique characteristics and needs of veteran patients that set this demographic apart from their civilian counterparts (Decker, 2025; Elliott, 2019; McMillan et al., 2022). When describing challenges faced during the transition to civilian life, the most common issue reported by veterans is communicating with civilians about their military experience (Derefinko et al., 2019; McCaslin et al., 2021). This presents a challenge to nurses striving to establish trusting relationships with veteran patients. Nurses who care for this demographic have noted that more time is required to form a therapeutic relationship with their veteran patients (McMillan et al., 2022). The purpose of the current study was to explore the lived experiences of prelicensure nurse faculty in teaching students about military veteran culture, including faculty perceptions regarding their own cultural competence regarding this demographic, and inform future education strategies to empower future nurses.

Health Disparity

The concept of health disparity is described as preventable differences in healthcare opportunities due to imbalances in interpersonal and systemic constructs (Downey & DiBenedetto, 2021). Within nursing textbooks, health is defined holistically as a state of well-being that encompasses the physical, mental, and spiritual dimensions of human beings (Taylor et al., 2023). The healthcare field tends to think about vulnerable populations, or populations with limited resources, when studying health

disparities, and veterans are often not included in this thinking due to the existence of the VHA; however, greater than 50% of veterans receive healthcare from providers outside of the VHA (Bonzanto et al., 2019; Chargualaf et al., 2024; Derefinko et al., 2019; Sheehy & Schwartz, 2021). Defining attributes of the concept of health disparities include preventable inequities in the delivery of healthcare to populations (Downey & DiBenedetto, 2021).

The problem I addressed is a lack of knowledge among healthcare providers regarding military culture and the unique characteristics of the veteran population, particularly in relation to healthcare beliefs and practices. This lack of knowledge prevents nurses from communicating effectively with military veteran patients and providing culturally competent care to veteran patients by inhibiting their ability to establish therapeutic nurse-patient relationships, thus presenting a preventable difference in healthcare opportunities for the veteran population. Published data indicated that 25% of nurses providing care within civilian healthcare facilities possess the knowledge, skills, and attitudes necessary to deliver culturally competent care to veteran patients (Bonzanto et al., 2019; Elliott et al., 2024; Simoni et al., 2024).

This concept aligns with the current study's purpose because published data indicated a lack of knowledge about military veteran culture among practicing nurses today (Bonzanto et al., 2019; Claus et al., 2020; Elliott et al., 2024; Simoni et al., 2024). There is an inconsistency in the identification of veteran status among patients presenting to non-VHA facilities, with nurses who participated in the study citing a lack of

confidence in their ability to communicate effectively with military veterans (Maiocco et al., 2019; Sheehy & Schwartz, 2021).

Literature Review Related to Key Variables and/or Concepts

Key concepts addressed in this literature review include culture, cultural competence, and health disparity. I conducted a review of the literature for each of these concepts as they relate to the education of prelicensure nursing students about military veteran culture. Limited research regarding the education of nursing students about military veteran culture was found during my review of published data.

Culture

Leininger defined culture as values, norms, and practices shared by a group of individuals that guide the thought processes and actions of the group (Alligood, 2021; McFarland & Wehbe-Alamah, 2019). There is evidence within the literature to support military veterans as a unique culture that is recognized as having beliefs and practices in relation to organizational structure, social components, and beliefs surrounding help-seeking behaviors and healthcare practices (Decker, 2025; Derefinko et al., 2019; Elliott, 2019; Heward et al., 2024; McCaslin et al., 2021; McCormick et al., 2019). The transition from active duty is a challenge for many veterans, who cite the most prevalent issue they face as communicating with civilians about their military experience (Derefinko et al., 2019; McCaslin et al., 2021). Military culture encompasses a set of values, beliefs, and traditions that guide the practices and behaviors of a collective or individual. These values include a chain of command and an authoritarian leadership structure that serves the purpose of ensuring readiness of those who serve to complete missions and protect

national interests (Heward et al., 2024; McCaslin et al., 2021; McCormick et al., 2019). Veterans, when asked to describe the terms used to describe military culture, used terms that included patriotism, honor, discipline, team/unit, and pride (McCormick et al., 2019).

When considering how these terms and understanding of military culture affect the provision of healthcare to veteran patients, researchers explored civilian home health and hospice nurses' lived experiences in the care of veterans, including facilitators and barriers to providing care as well as the differences and similarities between veteran and civilian populations (Elliott, 2019; McMillan et al., 2022). When discussing care of military veteran patients, civilian nurses endorsed challenges coordinating care, additional time required to build a nurse-patient relationship compared to establishing a nurse-patient relationship with civilian patients, understanding that military service impacts veteran worldview, ensuring safe home environments, following veteran cues regarding when to lead and when to follow, and giving back to veterans with a sense of honor (Elliott, 2019).

Derefinko et al. (2019) explored veteran perceptions regarding challenges to transitioning from military to civilian life. The results of their study indicated that the most common issue veterans face as they transition from military to civilian life is communicating their service experiences to civilians. During the transition from active duty, veterans often face loneliness as they leave a community with defined roles, social structure, and a sense of purpose that is often achieved through collectively working towards goals or missions (Norman et al., 2020).

Veterans report that the most common issue they face as they bridge from military to civilian life is communicating with civilians about their experiences from service, noting that when returning to civilian life they were perceived by family, friends, and their community negatively, leading to a sense of isolation and reluctance to share their experiences with civilians (Derefinko et al., 2019; Giesler & Juarez, 2019; McCaslin et al., 2021). Additionally, over 50% of veterans experience a physical alteration in health within 1 year after discharge and a higher rate of mental health disorders compared with civilians (Geraci et al., 2023). Veterans representing the Army, Navy, and Marines emphasized the need for healthcare providers to identify veterans and ask about their military experiences, promote autonomy, anticipate cultural differences, and treat veterans as individuals (Borah et al., 2022).

Cultural Competence

The culturally appropriate nursing care of military veteran patients requires knowledge about the healthcare beliefs and practices common in military veteran culture. Elliott et al. (2021) synthesized a list of veteran care competencies for nurses and nurse educators after reviewing available literature and included among those competencies are military/veteran culture, PTSD, traumatic brain injury, substance use disorders, suicide, trauma/amputation and assistive devices/wound care, military sexual trauma, pain, exposures, homelessness, end of life, VHA, access to healthcare and resources, and care of the military family. These competencies share several aspects, including the importance of understanding veteran culture and incorporating the values and beliefs of veterans into care, advocating for veterans and their families, addressing mental and

physical health alterations related to military service, and providing holistic care to the veteran and their family (Chargualaf et al., 2021).

Because communication is a challenge between veteran and civilian cultures (Derefinko et al., 2019; McCaslin et al., 2021), it is essential to educate prelicensure students about military veteran culture, including strategies to enhance communication with veteran patients. Analysis of medical-surgical textbooks for content addressing the knowledge, skills, and attitudes required for culturally competent nursing of veteran patients revealed that these areas were poorly addressed within the textbooks (Chargualaf et al., 2021). Chargualaf et al. (2021) conducted a qualitative analysis of nursing textbook literature to identify gaps in knowledge, skills, and attitudes outlined in veteran competencies. A component of the research process included analyzing the depth of content, learning assignments, and teaching recommendations for content. Results from their study indicated inconsistency in content delivery, and that while the knowledge domain was adequately covered within the textbooks, skills and attitudes were not.

A mixed-methods study that explored faculty perceptions regarding teaching cultural competence to prelicensure nursing students indicated that while participants noted the importance of educating students to communicate appropriately with patients from diverse backgrounds, modeling culturally competent care for students, and incorporation of classroom activities to practice providing culturally competent care, they experienced barriers to educating students about diverse culture that included lack of diversity within the classroom and lower prioritization of educating students about cultural competence (Chen et al., 2020). This study examined faculty perceptions

regarding teaching students about cultural competence in general. A further literature review did not yield studies that explore faculty perceptions of educating students about military veteran culture or current practices regarding the education of prelicensure nursing students about military veteran culture within their curriculum.

An expanded search to determine student perceptions of veteran cultural competence education indicated limited data from this angle; however, studies that explored nursing student perceptions of learning activity that included veteran-centric simulations disclosed that participants reported increased knowledge regarding veteran culture, increased confidence in their ability to provide culturally competent care to this demographic, empathy development for veterans, and understanding of the complex healthcare needs of veterans (Byrne, 2020; Flores et al., 2021; Roe et al., 2019).

Qualitative and quantitative studies that explored the capacity of nurses working in non-VHA hospitals indicated a lack of capacity to provide culturally sensitive care to this population. A quantitative study evaluating the competency of 612 civilian nurses in providing culturally competent care to military veterans and their families found that 25 participants, or 4%, met the benchmark (Bonzanto et al., 2019). A web-based survey of 541 nurses aimed to assess their ability to provide culturally competent care to post-9/11 veterans in civilian healthcare facilities revealed gaps in knowledge regarding veteran healthcare needs, underscoring the need for increased education on health issues affecting the veteran demographic (Simoni et al., 2024). This was echoed by registered nurses, who emphasized the need for education on how to communicate effectively with veterans (Mushale & Bakerjian, 2021). Nurses in a West Virginia hospital who completed

mandatory continuing education with a focus on mental health needs of veterans reported uncertainty regarding how to communicate with veterans and adapt care to meet the needs of this demographic (Maiocco et al., 2019). This indicates the importance of expanding education within prelicensure programs and continuing education to include communication and training to empower current and future nurses to provide culturally competent care to veterans.

Health Disparity

In the Healthy People 2030 plan, health disparities were defined as differences in healthcare related to a lack of social, financial, or environmental resources. (Levine, 2021). The Centers for Disease Control and Prevention expanded this definition to note that the differences are preventable (Downey & DiBenedetto, 2021). Veterans have been identified as a vulnerable population in academic literature, with factors of greater risk of homelessness in military veterans compared with civilians as well as the prevalence of mental illness and suicide contributing to the demographic being designated as vulnerable (Thurston, 2022; Zychowicz et al., 2022).

Currently, the VHA is utilized for primary care by less than half of the veterans within the United States (Zychowicz et al., 2022). In a study that explored the prevalence of 10 self-reported morbidities in U.S. military veterans compared with the prevalence of those morbidities in civilians between 2003 and 2019, results indicated a significantly higher rate of eight of the morbidities in veterans (Betancourt et al., 2021). Other studies indicated that civilian providers do not consistently screen primary care patients for veteran status (Detert et al., 2019; Roberts et al., 2021). In a mixed-methods study

conducted to assess the perceptions of medical-surgical nurses working in non-VHA hospitals, findings indicated that participants noted that while they understood that veterans require specialized treatment plans, they felt they lacked the skills required to care for patients who are military veterans and noted fear of triggering PTSD episodes as a barrier to assessing veteran status in their patients (Claus et al., 2020).

The cultural divide between military veterans and civilians can be attributed to communication gaps related to negative experiences veterans report when attempting to share their military experiences with civilians (Derefinko et al., 2019; Giesler & Juarez, 2019; McCaslin et al., 2021). Added to the communication struggles that military veterans face is the prevalence of self-stigma among veterans regarding help-seeking behaviors (Cacace et al., 2022). Awareness of these factors, paired with education regarding military veteran culture as well as strategies to foster therapeutic nurse-patient relationships, will potentially improve the health outcomes of military veteran patients.

Summary and Conclusions

Despite the emphasis for nursing students to be prepared to provide culturally competent care to military veterans in the United States, there is a lack of prelicensure nursing education about military/veteran culture and health problems specific to this demographic. After performing an extensive review of the literature surrounding the healthcare needs of veteran patients and their perception of care provided by civilians, prelicensure education about military veteran culture, and the capacity of registered nurses to provide culturally-sensitive care to veterans, I identified a gap in the literature regarding where within prelicensure nursing programs that incorporate clinicals within

civilian healthcare facilities students are taught about military veteran culture. I designed the current study, grounded in Leininger's culture care theory, Benner's novice to expert model, and the concepts of cultural competence and health disparity, to explore the lived experiences of nursing faculty preparing nursing students to provide care to military veterans in an effort to understand current practices and inform future education.

In Chapter 3, I describe aspects of the data collection and analysis I performed for this study in detail, including my role as the researcher, research design, methodology, participant selection, and ethical considerations. Additionally, I hare details about how I followed best practices for conducting focus groups using the Zoom platform.

Chapter 3: Research Method

Introduction

The purpose of this study was to explore the lived experiences of nursing faculty from programs not affiliated with the VHA in preparing nursing students to provide culturally competent care to military veterans using Leininger's theory of cultural care and Benner's novice to expert model. In this chapter, I discuss aspects of the study related to data collection and analysis, including the research design, methodology, participant selection, instrumentation, and my role as researcher.

Research Design and Rationale

Qualitative research designs glean subjective data through the lens of the participants' experiences surrounding a topic of interest (Johnson et al., 2020). My goal in designing this study was to investigate whether and where, within prelicensure nursing programs not affiliated with the VHA, students are being taught about military veteran culture. I used focus groups for data collection. The use of focus groups in qualitative studies in the healthcare field has increased over the past few decades. While not aligned with any specific qualitative methodology, focus groups provide researchers with more robust data generated through spontaneous interactions among participants compared to data obtained through one-on-one interviews (Gundumogula, 2020). I selected this methodology to explore whether and how schools are incorporating veteran culture into their curricula through discussions among nurse educators in a focus group setting due to the collaborative nature of this approach.

Kaizens are processes that bring together members from multiple disciplines to improve a process or aspect of work (Shatrov et al., 2021). While planning this study, I recalled participating in a kaizen while working as an emergency room technician in northern Virginia. What stood out from that memory was the collaboration between frontline members from multiple disciplines, who brought their experiences to the process and worked together to solve a problem. There is published data supporting the use of kaizens in healthcare as a method of continuous improvement with a focus on a specific area (Danese et al., 2023). The varied experiences and perspectives generated by those who participated in the kaizen enabled us to explore the problem from multiple aspects. Because of the success of the kaizen I participated in and experiencing the benefit of multiple perspectives in problem-solving during the kaizen event, I decided to gather data from focus groups of nurse educators because focus groups allowed me to bring together educators from multiple ADN nursing programs with perspectives from their experiences that are centered around educating prelicensure students about military veteran culture. I believe that this relates to what I was trying to accomplish with this study in that I wanted to gather data from representatives from multiple schools in order to understand the problem that I have identified: a lack of knowledge about unique characteristics of healthcare practices of military veterans among nurses (see Bonzanto et al., 2019; Claus et al., 2020; Mushale & Bakerjian, 2021; Simoni et al., 2024).

This study addressed the following research question: What are the lived experiences of ADN nurse educators in non-VHA-affiliated programs regarding teaching undergraduate nursing students about military veteran culture? To investigate the

underlying problem of a lack of knowledge about military veteran culture among registered nurses, I gathered data from the lived experiences shared by prelicensure nurse educators. An interpretive descriptive approach was employed in the study because it enables the researcher to identify recurring themes among the experiences of study participants (see Thompson Burdine et al., 2021, Thorne, 2016). An interpretive descriptive approach enables researchers to gain insight into specific issues (Doyle et al., 2020). This approach enabled me, as the researcher, to explore the experiences of participants regarding the education of nursing students within the context of their program(s) to learn more about current practices incorporated in the education of nursing students to inform future education practices.

Role of the Researcher

My role as a researcher for this study included project design, data collection, interpretation, and analysis, with full participation in each aspect of the project. Research quality can be influenced by both intrinsic and extrinsic factors of the researcher, including their racial and ethnic background, culture, knowledge related to the study topic, and language proficiency (Yoon & Uliassi, 2022). As a veteran of the U.S. Navy and a prelicensure nurse educator, I recognized that these identities could impact my research and incorporated personal reflexivity by disclosing my background as well as how it may have influenced the decisions I made (see Olmos-Vega et al., 2022). I did not include participants with whom I have a professional or personal connection or did I include any participants with whom I have a supervisory or collegial relationship. Participants for this study were recruited from two professional organizations, the

Organization for Associate Degree Nursing (OADN) and the National League for Nursing (NLN), as well as social media groups for nurse educators. I belong to both groups as a member and do not hold a supervisory role in either group. To reduce the risk for bias, exclusion criteria for participant selection included faculty who work at the same college as me. Participation was voluntary, without coercion or fear of retaliation. Additionally, I incorporated interpersonal, methodological, and contextual reflexivity throughout each stage of the research process to maintain transparency and openness to the data that emerged. To ensure the accuracy of data collected, I used member checking, in which participants were asked to review the transcripts of the focus group interviews for accuracy (see Motulsky, 2021).

As an instrument, I facilitated focus groups using open-ended research questions and follow-up questions to clarify or elaborate on participants' responses. I ensured that each participant fully took part in the study and that the setting demonstrated safety, allowing participants to feel comfortable sharing their viewpoints and that mutual respect was prevalent in all interactions.

I prepared for my role as a researcher by completing an advanced qualitative reasoning course through Walden University. During this course, I developed questions related to my topic of interest and conducted practice interviews, which helped me become more comfortable with qualitative interviewing techniques. Additionally, I completed a qualitative interviewing course through Walden University, which included skills modules focused on crafting qualitative interview questions, conducting focus groups, and transcription. I met with Walden University's qualitative methodologists

during the proposal stage to guide the research planning and completed the Qualitative Data Analysis and Coding Research Readiness Module through Walden University.

Ethical considerations were addressed in all stages of the research process. I obtained informed consent from participants by emailing each participant a Walden University consent form, which included the purpose of the study, details of how the study would be performed, along with sample questions, risks, and benefits to participants, how privacy would be maintained, and the rights of each participant to withdraw consent from participation in the study at any time. The confidentiality of participants was maintained through the assignment of pseudonyms. The data collected during the study were stored on a password-protected device that I alone know the password for and have access to. The focus groups were conducted via Zoom, and confidentiality was maintained in this format by turning off participant video and using pseudonyms for each participant. I used Zoom as the platform to host practice qualitative interviews for an assignment in advanced qualitative reasoning to determine the feasibility of the application for this study, with noted success.

Methodology

Participant Selection

Interpretive descriptive studies enable researchers to identify themes gleaned from the shared subjective experiences of participants (Thompson et al., 2021). Purposive sampling was appropriate for this study because participants selected using this sampling method have experienced the phenomenon being studied (see Doyle et al., 2020). The purpose of the study was to explore the lived experiences of ADN nursing faculty from

nursing programs not affiliated with the VHA in preparing nursing students to provide culturally competent care to military veterans using Leininger's theory of cultural care and Benner's novice to expert model. Participant recruitment consisted of purposive sampling of nurse educators who are members of the OADN and the NLN, as well as members of social media groups for nurse educators. The ACEN (n.d.) is an organization that utilizes peer-review processes to ensure the quality of nursing education. ACEN Standard 4 addresses curriculum within prelicensure nursing programs, and the criteria within Standard 4 require nursing programs to educate students about culture, ethnicity, diversity, inclusion, and the social determinants of health (Chargualaf et al., 2024). Nurse educators from accredited schools have knowledge of accreditation criteria and the ability to provide data for the study regarding current practices within their institution regarding how students are educated about military veteran culture, including information about where within their programs this concept is taught, methodology of instruction, and any facilitators or barriers to providing the education. These faculty have the lived experience of educating prelicensure students and have provided data regarding those experiences, specifically, how they are or are not providing education about military veteran culture. Purposive sampling has the potential to limit the available population due to geographical considerations (Doyle et al., 2020). To overcome this limitation, I collected data through the facilitation of focus groups conducted through Zoom, which enabled me to recruit participants without the barrier of geographical location.

Maximum variation refers to a broad spectrum of participants to identify patterns that emerge from responses (Doyle et al., 2020). To achieve maximum variation, the

inclusion criteria for participants consisted of a minimum of 1 year of teaching experience within their current institution, with no maximum length of experience required. Additionally, I recruited participants from institutions across the United States, and they participated in virtual focus groups facilitated using the Zoom platform. Participants described and provided examples of how and where, within their programs, nursing students are educated about military veteran culture, based on their experiences.

It is not easy to predetermine a sample size for qualitative studies. Saturation is defined as the point in research at which no new data or insights are gained from further data collection (Hennink & Kaiser, 2022). A systematic review aimed at assessing saturation found that saturation typically occurs in nine to 17 interviews or four to eight focus groups (Hennink & Kaiser, 2022). For this study, the sample consisted of 15 participants who participated in four focus group discussions, each comprising between two and six participants. I determined that data saturation had occurred by the end of the fourth focus group, after noting redundancy in the data generated by the third focus group, and no new data were generated in the fourth focus group.

Recruitment strategies for participants included posting a digital flyer to the previously indicated social media groups and emailing it to the OADN, NLN, and Walden University participant pools once Walden University Institutional Review Board (IRB) approval was obtained. The flyer contained information about the study, including criteria for participation and details on how to participate. I included my Walden University email address so that potential participants could contact me. The inclusion criteria for participants consisted of three factors: participants must be prelicensure nurse

educators from an associate's-level nursing program, participants must have at least 1 year of teaching experience within that program, and the participant's respective nursing program must not be affiliated with the VHA. Participants were screened for inclusion criteria by responding by email to questions that determined their eligibility to participate in the study. Once a potential participant reached out expressing interest in the study, I responded by asking the following questions:

1. What level of prelicensure nursing education are you currently teaching: practical nursing (PN), ADN, bachelor of science in nursing (BSN)?
2. How long have you taught within your program?
3. Is your program affiliated with the VHA?

Participants who met the inclusion criteria were emailed an informed consent form generated using the Walden University Informed Consent template for review and response. They were asked to complete the form and indicate their consent by typing the words, "I consent," if they wished to participate in the study. Those who did not meet the criteria were respectfully excluded from the study. I notified participants that the Zoom interviews were going to be audio recorded for transcription purposes and that the transcripts would be forwarded to them for verification of accuracy. Participants were reminded that they could withdraw their consent to participate in the study at any time. Participants were also provided with information regarding the date and time of the focus group as well as instructions for accessing the Zoom platform, including a link to the platform and an alphanumeric identifier to use to maintain anonymity throughout the focus group discussion.

Instrumentation

As a researcher for the study, I was the data collection instrument. The analytic framework in research encompasses the researcher's knowledge, which stems from experience and existing theories and research surrounding a topic of study (Thompson Burdine et al., 2021). My experiences and background as a military veteran and a nurse educator have enhanced my ability to serve as a data collection instrument, providing valuable insights (see Thompson Burdine et al., 2021). I used a screening guide to determine the eligibility of study participants. I facilitated Zoom focus group meetings with audio recording and transcript generation features. Best practices for conducting focus groups via Zoom were incorporated, including the identification of opportunities to ask follow-up or probing questions from participants; advising participants of technical requirements early in the process of scheduling the Zoom meetings; encouraging participants to refrain from responding through the chat feature or, in instances when participants do use the chat feature ensuring that what is written in the chat is read aloud so that it can be recorded and transcribed; and creating a list of participants (Gray et al., 2020; Santhosh et al., 2021). Interview questions were open-ended to facilitate robust responses from participants and addressed the research question that guided the study: What are the lived experiences of ADN nurse educators in non-VHA-affiliated programs regarding teaching undergraduate nursing students about military veteran culture?

The interview questions were formulated using best practices for qualitative interviews, including ensuring that questions align with the study's purpose, avoiding leading questions, and designing questions that are broad in nature to encourage

participants to provide data on what they feel is important regarding the study's topic (see Roberts, 2020). I conducted a practice qualitative interview with volunteers as part of an advanced qualitative reasoning course at Walden University, during which I used questions I had crafted to develop my qualitative interview skills, which were applied in this study.

The focus group sessions for this study were conducted using Zoom, and audio recordings were incorporated. The recorded interviews were transcribed, and I carefully compared the Zoom-generated transcripts with the audio recording for accuracy. The transcripts were emailed to participants for member checking for accuracy, followed by coding and identifying emerging themes.

Procedures for Participation and Data Collection

I facilitated Zoom focus groups from a room in my home where I was the only person present. It is recommended that when using a Zoom format for focus groups that a waiting room is employed, allowing approximately 5 minutes from the scheduled start of the session for participants to join the session (see Santhosh et al., 2021).

I began each focus group with an introduction that provided background information on the study and the value of their responses in informing nursing education practices. I explained that the session would be audio recorded and how the confidentiality of participants would be maintained. Participants were allowed to withdraw from the focus group if they did not wish to consent to be audio recorded. I asked participants not to use the chat feature of Zoom and, instead, to use the raise hand feature to engage in discussion.

Once the introduction was complete, I began asking the questions prepared for the focus group discussion (see Appendix A). I maintained an inclusive and respectful environment within the Zoom platform, giving each participant the opportunity to answer questions individually and respond to one another through the use of the raise hand feature in Zoom. Open dialogue between participants was encouraged to gather robust data for the study. Once I had finished asking all my questions, I provided the opportunity for further discussion.

I planned to conduct four to eight focus groups based on a systematic review that assessed sample sizes for saturation in qualitative studies (see Hennink & Kaiser, 2022). The focus groups were estimated to take approximately 1 hour. During the debriefing at the end of the focus groups, participants were encouraged to share any information related to the topic that had not been covered during the focus group session. They were also informed that the identities of participants and the information shared would be kept confidential. Following the focus group and transcription of audio recordings, participants were sent transcripts digitally for member checking, an acknowledged practice to ensure rigor of qualitative studies (see Johnson et al., 2020).

Data Analysis Plan

Data from the qualitative focus groups were collected through audio recording of the Zoom sessions and handwritten notes. I used the transcription feature of Zoom and downloaded the transcriptions into a Microsoft Word document. Afterward, I compared the transcription with the audio recordings and handwritten notes to ensure accuracy. I ensured that all responses were included in the transcription. Once I had completed a

review of the transcripts, I then forwarded them to the participants for member checking, a process in which validation of the data is sought from respondents (see Motulsky, 2021).

Data analysis and coding were performed using ATLAS.ti software. ATLAS.ti is a qualitative data analysis software program used by researchers in various aspects of the data analysis process, including creating memos as a research diary for transparency, identifying word frequencies, coding, and linking codes to quotations from participants (Kalpokas & Radivojevic, 2022). ATLAS.ti was used by researchers conducting a qualitative study to explore patients' perspectives on readiness to use E-Oral Health technologies (Jagde et al., 2021). The researchers identified four themes that aligned with three types of readiness recognized as benchmarks. Banerjee (2022) used ATLAS.ti in the analysis of interviews conducted with psychiatric nurses and nutritionists regarding emotional strength and challenges experienced in working with patients who experience alterations in mental health. Findings gleaned using ATLAS.ti indicated factors were linked to the challenges faced by participants in the study (Banerjee, 2022).

For the current study, I uploaded the transcribed audio recordings into ATLAS.ti for the identification of word repetition to assist in identifying codes. From there, I used the program's feature to organize the codes and identify themes supported by direct quotes from participants. I used the memo feature of ATLAS.ti to keep a journal of my actions for transparency.

Issues of Trustworthiness

Trustworthiness in qualitative research is characterized by credibility, transferability, dependability, and confirmability (Adler, 2022). Credibility can be achieved using triangulation or the use of multiple sources of data (Ahmed, 2024). Credibility can be established by ensuring adequate time is spent with participants to build rapport and fully understand their experiences with the subject matter, using triangulation, and by maintaining reflexivity (Ahmed, 2024). To achieve transferability, I have incorporated detailed descriptions of my research process, methodology, and participants, allowing readers to determine the applicability of the findings to other contexts. I have ensured that I address dependability by maintaining an audit trail, which discloses to readers any changes in methodology and analysis, and presents transparency regarding any potential biases (see Ahmed, 2024). Confirmability in this study was addressed through member checking and reflexive journaling throughout the study.

Ethical Procedures

Qualitative research focuses on data collection from human participants, requiring the researcher to maintain practices that respect human rights. Ethical considerations not only protect study participants but also lend to the trustworthiness of the study by fostering a relationship between researcher and participant that encourages the sharing of honest information (Nii Laryeafio & Ogbewe, 2023). Ethical challenges faced by researchers in data collection center around the researcher–participant relationship, data interpretation, and the research design, with overarching issues of informed consent and confidentiality or privacy (Nii Laryeafio & Ogbewe, 2023). For this study, I followed the

Walden University IRB process and was granted the approval number of 03-06-25-1050848 for this study.

Informed Consent

Once I received approval from the Walden University IRB, I obtained informed consent from prelicensure nurse educators who met the criteria to participate in the study. I used the Walden University IRB consent form template, including criteria for participation; the purpose of the study; and procedures, including sample questions, the right of participants to withdraw at any point during the study, risks and benefits, details regarding how participant privacy will be maintained, the voluntary nature of the study, and my contact information. I notified participants in the informed consent that the focus group sessions would be audio recorded. There was a space on the informed consent document for each participant to sign and date.

Privacy and Confidentiality

Each participant was assigned an alphanumeric identifier to maintain confidentiality, and these identifiers were used during the Zoom sessions. Participant names were not visible during Zoom sessions, in the transcripts, or in the published study. I obtained IRB approval for audio recording of the focus group sessions. Best practices for using the Zoom platform to conduct qualitative interviews and focus groups include sending password-protected electronic invitations to ensure the privacy of the focus group sessions (Santhosh et al., 2021). The current study does not include any statements or information that would identify participants.

I incorporated ethical considerations into every stage of the research process. I completed the CITI Program's Human Subjects Protection Training Module, as recommended by Walden University, and submitted my completion document to the Walden University IRB. Participant confidentiality measures were disclosed as part of the informed consent process and during the introduction of each focus group. Additionally, at the beginning of each focus group, I provided an introduction, explaining the purpose of the study, describing how the collected data would be used, and advising participants that they had the right to withdraw their consent from participation in the study at any time. I reminded the participants that the focus group session would be audio recorded and provided the opportunity for those who did not wish to be audio recorded to leave the session at that time.

Data collected, including audio recordings, transcripts, and hand-written notes, have been kept in a locked file cabinet or on a password-protected laptop belonging to me. No other person has access to this laptop. Documents required by the Walden University IRB are stored with the Walden University IRB.

Summary

In this chapter, I described my rationale for the study design, including why a qualitative approach was the most appropriate for generating data regarding the research topic. Additionally, I explained details regarding my role as the researcher as well as my process for data collection and analysis, including how I have addressed ethical considerations for the study, such as the measures taken to ensure confidentiality of each

participant and how transparency of the processes was maintained to eliminate researcher bias. In Chapter 4, I will present detailed results from the focus groups.

Chapter 4: Results

Introduction

The purpose of the study was to explore the lived experiences of prelicensure ADN nursing faculty from non-VHA-affiliated programs in preparing nursing students to provide nursing care to military veterans. The research question guiding the study was: What are the lived experiences of ADN nurse educators in non-VHA-affiliated programs regarding teaching undergraduate nursing students about military veteran culture?

To answer this research question, I explored ADN nurse faculty experiences with how they individually present content surrounding veteran competencies as well as how their nursing program presents the content and any barriers they experienced with incorporating the content into their respective curriculum. Nurse educators were selected because they could provide their experiences regarding current practices within academia. This study was needed because there is limited published data surrounding how nursing programs that are not affiliated with the VHA are preparing students to provide culturally competent care to veteran patients.

I used a qualitative, interpretive, descriptive design with thematic analysis conducted using ATLAS.ti software. Data were collected from participants through focus groups conducted using the Zoom platform. I asked open-ended questions to encourage participants to share their experiences and posed follow-up questions to clarify their responses. Common themes and codes were identified from information shared by participants, which enabled me to understand and share current practices in academia regarding the education of future nurses about military veteran culture.

Setting

Twenty-four prospective participants met the criteria to participate in the study. Once it was determined that a candidate met the eligibility criteria, I sent an email with scheduling details for the focus groups, including an invitation and instructions for participating via the Zoom platform. Fifteen candidates participated in one of the four Zoom focus groups, with group sizes ranging from two to six participants. Of the remaining nine prospective participants, one did not meet the eligibility criteria due to her program's affiliation with the VHA. Four prospective participants did not attend the scheduled focus groups, and four were unable to attend due to scheduling conflicts. Zoom audio recording and transcription were used for each of the focus groups. I reviewed each transcript and compared it with the audio recording, editing the transcripts when needed for accuracy.

Demographics

Study participants consisted of nurse educators from ADN programs across the United States. Of the 15 participants who took part in focus groups, 13 were female and two were male. The years of teaching experience in nursing education ranged from 1 to 18 years. Five participants reported having less than 5 years of teaching experience, five participants reported having between 5 and 10 years of teaching experience, and five participants reported having more than 10 years of teaching experience.

The 15 participants represented several areas of education within their respective programs, including fundamentals of nursing, medical-surgical nursing, care of the older adult, pharmacology, pathophysiology, assessment, critical care concepts, mental health,

and maternal/newborn nursing. In addition to serving as didactic faculty, six of the participants reported providing education within the lab, simulation, and clinical environments. Two participants described serving in leadership positions at some point during their careers in nursing academia. One participant noted serving as a skills lab coordinator in addition to her role as didactic faculty at the time of the focus group. One participant noted having served in the roles of dean of nursing for one program and later as a director of nursing at a community college.

Data Collection

Once approval from the Walden University IRB was obtained, I posted the digital flyer approved by the IRB within social media Facebook groups for nurse educators. Included in the flyer was my Walden University email address, providing prospective participants with the opportunity to contact me to express interest as well as the anticipated duration of the focus groups and the purpose of the study. Additionally, details regarding the study were posted in the Walden University Participant Pool for participant recruitment, and an invitation to participate was included in the NLN newsletter, along with my contact information for those interested in taking part in the study. Only ADN faculty with a minimum of 1 year of teaching experience within their respective programs were recruited for the study. The requirement of at least a year of teaching experience within their program was essential to the study because participants were asked not only about their personal experiences with providing education centered around veteran competencies but also about program practices in providing the education.

Before data collection, each participant was emailed a consent form with study details. Additionally, I screened each prospective participant for eligibility by emailing them three questions with their consent form:

1. What level of prelicensure nursing education are you currently teaching?
2. How long have you taught within your program?
3. Is your program affiliated with the VHA?

Once a prospective participant provided consent to participate in the study and indicated, through their answers to the screening questions, that they were eligible, I emailed them the details for the upcoming focus groups.

Before the focus group, each participant was assigned an alphanumeric identifier and provided with instructions for logging in to Zoom, including registration using the alphanumeric identifier to maintain the confidentiality of each participant's identity. During the introduction to each focus group, participants were allowed to withdraw their consent to participate at any time.

Focus groups were conducted between April 13 and May 29, 2025. Each focus group lasted approximately 60 minutes and was facilitated using the Zoom platform. Participants were encouraged to engage in discussions surrounding each question presented to generate more robust data. I used open-ended questions to enable participants to freely share their experiences and perceptions regarding the education of future nurses about veteran culture. I also asked follow-up questions to clarify participant responses when my understanding of the response was unclear. I was careful to maintain

objectivity in my questioning of participants, avoiding the incorporation of my personal views or leading questions that might influence a participant's response.

I used the audio recording and transcription features of Zoom for each of the focus groups. Additionally, notes were taken to ensure that every participant had the opportunity to respond to each question posed during the focus group. After each focus group, I compared the audio recording with the transcript generated by Zoom for accuracy. I then emailed the participants the transcript with their responses highlighted for member checking and accuracy verification. During the focus group, I indicated to participants that I would email them the transcripts and requested that they review them for accuracy. Of the 15 participants, six responded after receiving the transcripts, and all indicated that the transcript accurately represented their responses.

There were no variations in the data during the conduct of this study; however, several unusual circumstances arose during the data collection process. One participant was unable to access the Zoom focus group and contacted me to report this, indicating that she would like to participate in the next group. I provided her with the information for the next focus group, and she was able to join that group and participate successfully. One prospective participant was unable to attend any of the focus groups due to health issues that arose. Another participant experienced connectivity issues during the focus group, which occasionally caused her audio to be inconsistent. This was addressed by asking the participant follow-up questions to generate responses that were clearly recorded.

Data Analysis

Data saturation in research occurs when no new data or insights are gained from further data collection (Hennink & Kaiser, 2022). I noted that redundancy in the content of participant responses began to happen in the second focus group, and by the fourth focus group, no new data were generated. Once I determined that I had reached data saturation, I began the process of data analysis using a systematic approach based on Braun and Clarke's (2006) six-step framework for thematic analysis (see Ahmed et al., 2025). I uploaded the transcripts from the focus groups into ATLAS.ti and used a combination of features of the program to identify codes. After reviewing the transcripts and codes, I was then able to categorize the codes into themes that addressed the research question that guided this study.

Codes to Themes

The first step in thematic analysis is familiarization with the data (Ahmed et al., 2025). I accomplished this by carefully reading through the transcripts no fewer than three times. I then proceeded to the second step of thematic analysis, generating initial codes, or labels that the researcher assigns to data with recurring similar features and that relate to the research question (see Ahmed et al., 2025). I first used the feature of the program ATLAS.ti that identified word frequency; however, I found it did not help with coding the transcripts. The transcripts uploaded to ATLAS.ti were then manually reviewed and the program's manual coding feature was used to identify relevant codes. I was also able to highlight participant quotes and categorize them by identified code. I followed the best practices in thematic analysis set forth by Braun and Clarke's

framework, using a systematic approach in the coding process (see Ahmed et al., 2025). The responses to each question posed to participants were coded separately. I performed this coding process twice on separate days to ensure that the assigned codes accurately represented the data in relation to the research question.

Once I finished coding the transcripts, I began Step 3 of thematic analysis, searching for themes by organizing the codes into themes using the code family feature of ATLAS.ti. Themes are words or short phrases that can be thought of as categories and may be developed at any stage of the research process (Mishra & Dey, 2022). After coding the transcripts from the focus groups, I then proceeded to Steps 4 and 5 of Braun and Clarke's framework, reviewing themes and defining and naming themes. I carefully reviewed all the codes to ensure that they were inclusive of all data obtained during the focus groups. I referred to the questions I developed for the focus groups when reviewing the themes I had identified during Step 3, noting that the questions aligned with the themes in which I organized the codes. Each question was designed to gather information from different angles surrounding the research question, providing comprehensive knowledge about the topic of interest. The study was designed to help develop an understanding of current practices in academia surrounding the education of future nurses about military culture, including faculty experiences with members of the military/veteran demographic, individual faculty practices in education, respective program practices, perceived barriers to providing this education, and recommendations. Four themes emerged from the analysis:

1. Personal experience and level of knowledge

2. Current education practices
3. Barriers to education
4. Recommendations

In Step 6 of the thematic analysis framework, writing the report, the researcher compiles the data collected in the study into a report. I completed this by creating an in-depth analysis of the data, including direct quotes from the participants aligned with the themes identified, to create a report that reflects the data collected and provides an understanding of current practices in academia.

Evidence of Trustworthiness

Credibility

I noted in Chapter 3 that I would establish credibility in this study by employing best practices outlined by Ahmed (2024), including spending adequate time with participants to build rapport and fully understand their experiences with the topic as well as employing triangulation and reflexivity. At the beginning of each focus group, I designed a question to serve as an introduction to each participant's overall experiences as a faculty member and to facilitate interactions among participants during the study. I devoted time at the beginning of the focus group to introducing myself and providing participants with information about my background. I presented each question to participants with an open, nonjudgmental attitude. Each question was posed in a manner that did not sway participants' responses, and I accepted each member's feedback as presented.

Triangulation in qualitative research refers to the use of multiple data sources (Donkoh, 2023), which I achieved through conducting focus groups with audio recordings, member checking of transcripts for accuracy, and taking notes during and immediately after the focus groups. When discussions occurred among participants related to a specific response during the focus groups, I would make a note of this. For example, when Participant 2D noted that due to the population of students in his program, he would need to issue a trigger warning prior to broaching topics related to military culture, Participant 3H responded,

> I'm glad you mentioned that because this just shows the differences of the geographic areas of the United States, and how the populations are very different. You had mentioned the immigrant population, especially those that have been in the refugee camp. And I, you know again, not having that lived experience, I can't even imagine. You mentioned that trigger warning, and that really, yeah, that really hits home there, because that would probably be very challenging and upsetting for a lot of them based on some of the experiences they've had.

I incorporated reflexivity in the current study by maintaining a study journal during each step of the study to ensure my personal biases did not impact the outcomes of the study.

Transferability

Transferability refers to the researcher providing sufficient data about the study to determine how the study findings can be applied to other areas of interest through the concepts of applicability, resonance, and theoretical engagement (Stalmeijer et al., 2024). To ensure transferability, I have included detailed descriptions of my research process,

methodology, and participants, allowing readers to assess the applicability of the findings to other contexts.

The topic of this study is the current practices in the education of prelicensure nursing students regarding military veteran culture. In previous studies, practicing nurses reported a lack of skills required to provide care for veteran patients (Claus et al., 2020). To understand this lack of knowledge, it was necessary to explore the lived experiences of nurse educators regarding how nursing programs prepare students to care for this demographic. The findings from the current study have the potential to inform future education practices of U.S. ADN programs.

Dependability

I collected data for this study through the use of audio-recorded focus groups conducted on the Zoom platform. I carefully compared the Zoom-generated transcripts from each focus group with the audio recording and corrected the transcripts for accuracy. The edited transcripts were then compared with the audio recording a second time. I emailed the transcripts to each participant for member checking. Using ATLAS.ti, I manually coded the transcripts and then performed thematic analysis using Braun and Clarke's framework. According to Ahmed (2024), the dependability of a study can be established through the creation of an audit trail, or a log of the researcher's steps and decisions throughout the study. I achieved this through maintaining a study journal as well as using the memo feature in ATLAS.ti to track all actions.

Confirmability

Confirmability refers to the objectivity of study findings (Ahmed, 2024). I addressed this through member checking and reflexive journaling throughout the study. I created open-ended questions for the focus groups and presented each question with an open mind, ensuring that my verbal and nonverbal communication did not influence participant responses. Every step of my research process was documented, and I used self-reflection frequently to ensure that my personal biases did not impact any aspect of this study.

Results

The four themes that emerged from the process of manual coding and organizing the data from the focus group transcripts (i.e., personal experience and level of knowledge, current education practices, barriers to education, and recommendations) provided an answer to the research question in the responses from the participants.

Theme 1: Personal Experience and Level of Knowledge

Participants provided background information regarding their experiences, both personal and professional, with members of the military/veteran population. Among the personal experiences with military veterans shared were having family members who are veterans or are currently serving. Participant 1B shared, “Well, my father, brothers, uncles, cousins, aunts, were all from military different branches: Army, Navy, Air Force, Marines, and so we were exposed to family who were military.” Participant 4U disclosed that she has a child who was serving at the time of the focus group, stating, “I became a

military mom about 4 years ago." Other participants described personal experiences working with veterans as colleagues or students. Participant 3H stated,

> As a faculty member, most of my interaction is with students who have served in the military, whether it's active duty, full reserves, whatever, and that are now maybe using some GI benefits, or maybe they're serving in the reserves while they're going to nursing school.

Participant 4H noted, "I work in the operating room with several veteran nurses and certified registered nurse anesthetists (CRNA). As an instructor, I've had several students that were active duty, and I've got a few right now that are." One of the participants, 4W, disclosed that she is a veteran, stating, "I'll start that I'm a Navy veteran, so I have had a lot of experience with veterans."

Participants also described caring for veteran patients. Participant 5B noted,

> When I was working on my bachelor's degree in psychology, I volunteered for a crisis hotline that serviced, I think, a fairly large veteran population, so I didn't know them, but they would identify themselves as veterans through conversation, and it was, mostly like a suicide hotline and then I worked for as a hospice nurse for about I think, 8 years or so, and again I was kind of the one that was designated to work with the veteran patients, because that was a population that I just felt very passionate about.

When asked about how they assessed their level of knowledge regarding military/veteran culture, participants described their level of knowledge ranging from

basic to proficient. Most participants rated their level of knowledge between basic/novice to intermediate. Participant 2G stated,

> I think I have a basic novice to intermediate level of understanding, sort of about the way benefits work, and how patients can access their benefits, and sort of the overall sense for how a lot of veterans will react.

The majority of participants, except for Participant 4W, who disclosed that she is a Navy veteran, reported having limited knowledge about military culture. Participant 4C stated, “I do have a lot of family members that have served in different branches and a lot of friends, but I still feel my knowledge is pretty lacking.” Participant 4P noted that her knowledge surrounding military culture centers around a specific time frame in history, stating, “I feel like I can get along really well with the Iraq and Afghanistan Arab veterans because that was what my husband did.”

Participants were asked to describe characteristics of the veteran demographic. The top two characteristics identified by participants were hierarchy and time-oriented, which were noted by nine of the participants. Participant 2D stated, “I think they’re disciplined, and they”re people that go by a hierarchy structure.”" Participant 4P described veteran students, stating, “I think of them as like my very silent but strong students, respectful, always on time. Those are never my late to clinical.” Eight of the participants described veterans as professional. Participant 4W responded, "I would say that veterans, culture, or the military characteristics of the demographic would be that they’re stoic, intelligent, capable, professional, and respectful, because those are the parts of the military that are mostly built into veterans.” Seven participants used the term

respectful when describing veterans. Participant 4N stated, “Resilience, loyalty, strong allegiance for their country and their comrades, and respect for authority, the familiarity with hierarchical structures, and being service-oriented in general, even just not in active duty or veteran community.” Other characteristics of veteran culture pointed out by participants included, but were not limited to leaders, organized, quiet, reserved, self-protection, and stoic.

Theme 2: Current Education Practices

Participants were shown the following list of published veteran competencies (Elliott et al., 2021) and asked to describe how they individually and their respective program educates future nurses about military culture:

- military/veteran culture
- PTSD
- traumatic brain injury
- substance use disorders
- suicide
- trauma/amputation
- assistive devices
- wound care
- military sexual trauma
- pain
- exposure
- homelessness

- end of life
- VHA
- access to healthcare resources
- care of the military family

When describing individual practices in educating future nurses about military/veteran culture, nine of the participants were able to describe incorporating military veteran culture into their curriculum. Participant 5Y noted, “I teach most of these competencies. I don’t know that I tie them all into military I do generally tie the PTSD, trauma, and amputation a lot of times into that.” Participant 5B described facilitating a veteran-centric simulation for students:

> I have a virtual simulation where the patient is a veteran with a traumatic brain injury, and we thread the ideas of suicide and PTSD in there. And I teach quite a bit on trauma-informed care, diversity, equity, and inclusion in my program, and the veteran population is one that I try to put at the front for the students, because we have a lot of veterans around here, and they’re caring for them.

Six of the participants described teaching concepts found on the list of veteran competencies; however, they noted that these concepts do not specifically tie them to the veteran population. Participant 3H stated,

> You know, as I look at the topics that you have there, I mean, there’s a lot of things that are there for fundamentals, but I cover them more generally, not necessarily with an emphasis, or even sometimes even mentioning military.

When describing how their nursing program addresses educating students about veteran competencies, eight of the participants were unable to specify where within their program veteran competencies are addressed; however, they noted that many of the competencies are presented within their program. Participant 4C stated,

> We do include the majority of these competencies. I don't necessarily know how they do it. You know, other instructors tie things in. I do know that they're talked about, but a lot of some of this stuff is done in 1st Level, which I don't teach, so I'm not 100% sure how, but I do know that it's in there somewhere.

Participant 5Y added, "I don't think we do it anywhere else; specifically, we just intertwine it into our processes." Seven participants were able to provide specific examples of how veteran competencies are incorporated into their curriculum. Two of the participants noted that education about veteran culture and veteran competencies was facilitated by nursing faculty who were veterans in the past, but this was no longer happening due to those faculty members leaving. Participant 1B reported,

> When we had our nurse educator, who was a retired Lieutenant Colonel, teaching, she was primary, and she was also program chair, so she did a little bit of everything. She was also the mental health instructor, and during that time, she would come to me and talk about what we could do in simulation. And so since she's been retired actually having something related to veterans has not occurred. We continue the mental health piece in every simulation, but not the veterans piece in every simulation, or in any simulation.

Two participants noted using digital resources with veteran content. Participant 3H described using Lippincott resources that include veteran material:

> The one resource that our program uses is the Lippincott complete package, and one of the things that's in there: They have a really neat resource in their Lippincott cultural perspectives, and pretty much any type of cultural group, from homeless to deaf to Iranian to Russian. Anything is really in there, but they do have a section that talks about military culture. So I do make it a point to show them that, because when they go to clinical and they start looking at the psychosocial characteristics of their assigned patient, I want them to use that resource.

Theme 3: Barriers to Education

Participants described the perceived barriers to providing education about military culture from both personal and program-centered perspectives. The most frequently cited barriers were faculty inexperience with the content and lack of time. Participant 2G stated, "I would say it's a lack of faculty experience. And so I think that when you have faculty who are experienced in this area or have some knowledge, they like to infuse that into the program." Participant 4U added, "Barriers are probably teachers who feel a little bit of a lack of expertise to be able to speak thoughtfully about it, and also the content-laden curriculum." Participant 4V noted that her program was in the process of redesigning its curriculum and that part of the process involved removing units, stating, "We don't have enough time to do everything we need to do." Two participants shared that a barrier they have encountered is the prioritization of veteran content within their

program. Participant 2D stated, “I think for our program, it’s really identifying the need, and I don’t know if that’s necessarily a barrier, but it hasn’t been brought up.” Participant 4U expressed a concern with incorporating veteran competencies into the curriculum:

> I’m thinking of a coworker that actually was post retired military that brought it up to me that, you know, there seems to be a fine balance. He was concerned about talking about veterans at increased risk for some of these things, but it almost seemed also to reinforce negative stereotypes.

Theme 4: Recommendations

Participants shared recommendations for educators and programs to improve education about the veteran demographic. The most frequent recommendation from participants was resources about veterans. Participant 4U stated,

> I would say that nurse educators need more resources. I went to the OADN Conference. Some of you are probably familiar with that, and there was a speaker that is retired military who’s working on improving health care on the civilian side of veterans. But he gave a number of links that I was curious about, and I know the VA medical system, for example, has a link. I can’t tell you what it is right now, but if you put in the conflict or the situation in which somebody served it will talk about the potential exposures to environmental deterrents, like Agent Orange or the burn pits, things like that. So just even putting some of those resources out there that people can kind of follow their curiosity, I think, would be helpful and just some of those resources for nurse educators.

Intention was a recommendation from four participants. Participant 5B shared,

> I think also, intention is huge. I think a lot of people don't see the veteran population as fitting into the idea of diversity, equity, and inclusion. And so, people are teaching on that or just person-centered care. If there's more intention, we might be able to see that more often.

Participant 2D added,

> Understanding how the veterans, especially our baby boomers, their beliefs and practices towards healthcare in that kind of tone or a conversation, I think we'd be really successful with it, because to me it's no different than any other conversation about interdisciplinary teams. Right? You know, this is a subset of the population, part of our culture that we are caring for.

Four participants recommended incorporating veteran sharing into their lesson plans. Participant 5B stated,

> I think lived experiences are really important. You have students interact with veterans. Even if you don't have the time or ability or capability to do that, doing something like finding content creators that are sharing their experiences and having students kind of watch. Those might be helpful.

Discrepant Case

One of the participants, 2D, noted that military veteran culture is a difficult topic to incorporate into their program due to the makeup of the student body, stating:

> I've switched a whole lot of how I present information, not only for the military folks, but we have a high immigrant population and students that have spent time

> in refugee camps. So I'm more aware now than I think I ever have about triggering, sensitive topics.

By the end of the focus group, Participant 2D had a recommendation for those who have similar experiences with their student body:

> Knowing the population of students that I have, if we were to bring up the military in a classroom, a lot of my students who have had negative experiences with the military from their home country, or even the police in our area, a trigger warning conversation would have to be announced.

Summary

In this chapter, I have provided an in-depth description of the processes used to collect data for the study, including the setting, participants, analysis of data, and results to answer the research question. The use of focus groups comprised of ADN nurse educators with a range of experience and specialty backgrounds to gather data to answer the research question generated data that may not have been shared in a different setting through discussions between participants centered around topics broached. Most participants indicated that they and/or their program cover many veteran competencies within their curriculum; however, they do so without connecting those competencies to the veteran demographic. A lack of veteran-centric resources and time were the most commonly noted barriers to providing education about veteran culture to prelicensure nursing students. Recommendations for incorporating veteran content into nursing programs included developing a bank of resources surrounding veteran competencies, providing opportunities for students to interact with veterans by encouraging veteran

students and faculty members to share their experiences, and intentionally incorporating this culture into various aspects of nursing education. In Chapter 5, I provide an interpretation of the findings, implications for social change, limitations of the study, and recommendations.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to explore the lived experiences of faculty from non-VHA-affiliated programs in preparing nursing students to provide nursing care to military veterans. The suicide rate for veterans is nearly double the rate for civilians (U.S. Department of Veterans Affairs, 2023); however, despite national initiatives established to enhance the care of veteran patients, civilian nurses lack the capacity to provide culturally competent care to veterans (Bonzanto et al., 2019; Elliott et al., 2024). Prior to conducting this study, little was known regarding how ADN nursing programs not affiliated with the VHA are teaching published veteran competencies to students. To understand the problem of lack of knowledge about military veteran culture among civilian nurses, it was important to examine how veteran culture is taught within prelicensure nursing programs in a manner that harkens to the first step of the nursing process taught within prelicensure programs across the United States, assessment, or the gathering of data that occurs prior to planning interventions (see Hants et al., 2023).

I conducted a qualitative, descriptive study and thematically analyzed the collected data using Braun and Clarke's (2006) framework. Participants consisted of faculty from ADN programs not affiliated with the VHA who had greater than 1 year of experience teaching within their programs. The study findings revealed four key themes: personal experience and level of knowledge, current educational practices, barriers to education, and recommendations.

Interpretation of the Findings

My findings introduced new knowledge regarding how veteran-centric content is presented in prelicensure nursing programs. I selected Leininger's (1966) culture care theory and Benner's (1982) novice to expert model to underpin this study due to veterans representing a culture with unique beliefs and healthcare practices and the necessity of preparing nurses to provide culturally competent care to veteran patients. Prior to this study, research had indicated that veterans represent a culture with unique characteristics and healthcare practices (Elliott et al., 2021). Within academia, veteran content in medical surgical textbooks poorly addresses the knowledge, skills, and attitudes necessary to care for this demographic (Chargualaf et al., 2021). These factors, combined with published data indicating that registered nurses lack the skills to provide culturally competent care to veterans (Bonzanto et al., 2019; Simoni et al., 2024), suggested a need to understand current practices in the education of prelicensure nursing students regarding the care of the veteran population.

Participants in my study represented a range of experiences, including both their familiarity with veteran culture and their role as educators tasked with presenting content to prelicensure nursing students. The majority of participants expressed that they present content surrounding veteran competencies and shared examples of how they incorporate veteran-centric content within their curriculum. A lack of knowledge surrounding veteran culture and time constraints was noted to present a challenge to providing education related to military culture; however, participants shared recommendations for improving content within nursing curricula.

Theme 1: Personal Experience and Level of Knowledge

Leininger's (1966) culture care theory was based on the understanding that cultural philosophies, beliefs, and practices are interrelated with health, illness, and wellness in patients and influence the healthcare practices of individuals within their respective cultures. Previous studies have indicated that military culture encompasses a set of values, beliefs, and traditions that guide the practices and behaviors of both the collective and the individual and that these values include a chain of command and an authoritarian leadership structure that serves the purpose of ensuring readiness of those who serve to complete missions and protect national interests (McCormick et al., 2019).

Participants in the current study described veteran characteristics using the following terms: hierarchy, time-sensitive, disciplined, professional, leaders, stoic, respectful, resilient, loyal to their country and comrades, reserved, and self-protection. The participants in this study represented a diverse range of experiences with members of the veteran demographic, including working with veteran colleagues and students as educators, having veteran family members, and serving in the military themselves. Despite the range of experience, the majority of participants felt that their knowledge of military culture was limited. This aligns with the findings of a study in which faculty rated themselves as culturally aware, a step below culturally competent, when assessed for knowledge surrounding cultural competence in general as well as education practices related to culture in nursing in the didactic setting (Chen et al., 2020). Chargualaf et al. (2021) analyzed veteran content within medical-surgical textbooks and found that the content poorly addressed the knowledge, skills, and attitudes necessary to care for the

veteran population, indicating a need for nurse educators to provide additional instruction to prepare future nurses to provide competent care to veteran patients. This presents a challenge for educators who perceive that their knowledge of veteran culture is limited.

Theme 2: Current Education Practices

Prior to this study, there were limited published data surrounding how nursing faculty educate prelicensure students about veteran culture. Benner's novice to expert model encompasses the concepts of knowledge, skill acquisition, competence, and experience in relation to skill acquisition through five stages, progressing from novice to expert (McEwen & Wills, 2022). Benner postulated that new graduate nurses are at the level of advanced beginner, with basic knowledge and skills, and requiring additional support to fulfill their roles (Murray et al., 2019); however, registered nurses are not meeting benchmarks when assessed for competency in caring for veteran patients (Bonzanto et al., 2019; Simoni et al., 2024). Prelicensure nursing students reported increased knowledge regarding veteran culture, increased confidence in their ability to provide culturally competent care to this demographic, empathy development for veterans, and understanding of the complex healthcare needs of veterans after participating in veteran-centric learning activities (Byrne, 2020; Flores et al., 2021; Roe et al., 2019). This finding reinforces the impact that nurse educators have on the ability of new graduate nurses to provide culturally competent care to veteran patients.

I designed the focus group questions presented to participants in this study to gather data about current education practices being used by the participants as individuals as well as what their program is implementing. This study revealed inconsistencies in the

presentation of veteran-centric content in nursing programs represented by the participants in this study. From an individual standpoint, responses varied from presenting the competencies in general without linking them to any culture to facilitating veteran-centric simulations. Nine of the participants noted that they cover topics from the veteran competencies; however, not all the nine connect those topics with the veteran demographic. The way participants incorporated veteran culture into their content varied. Two participants noted that their programs incorporate digital veteran-centric resources, including Lippincott and NLN unfolding case studies. One participant shared that they facilitate a veteran-centric simulation. One participant noted presenting didactic material with a veteran as the focus of the content. This study also revealed that, similar to individual presentation of veteran competencies, most programs represented cover many of the published veteran competencies in general, without linking the content to the veteran population. Eight of the participants were unable to specify where within their programs the veteran competencies are taught.

Theme 3: Barriers to Education

The responses from participants in this study echoed those of faculty participants in a mixed methods study by Chen et al. (2020) in which participants noted the importance of educating students to communicate appropriately with patients from diverse backgrounds, modeling culturally competent care for students, and incorporation of classroom activities to practice providing culturally competent care. Their participants experienced barriers to educating students about diverse culture that included lack of diversity within the classroom and lower prioritization of educating students about

cultural competence. Participants in the current study identified barriers to providing veteran content, noting that a lack of expertise surrounding veteran culture as well as time constraints due to an already content-laden curriculum are the most common barriers they face. When discussing how their respective programs incorporate veteran content into their curricula, participants representing programs that employ veterans as faculty or administrators indicated that veteran culture has been incorporated into the curriculum as long as the institution employs the veteran faculty member or administrator; however, this integration is not maintained when those individuals leave. Multiple participants noted that their nursing program is in the process of curriculum revisions, and among those participants, one noted that the revisions to her program required removing content. Prioritization of veteran content was a barrier shared by two participants, noting that their program had not identified the need to present material surrounding veteran culture.

Theme 4: Recommendations

Most participants expressed a desire to incorporate veteran content into their curriculum and recommended strategies to improve educational practices. Several participants recommended increasing resources for veteran content educators. One participant described attending a presentation about veterans at a nurse educator conference and finding the content valuable, recommending that more options be provided to link educators to resources. Another participant recommended that when discussing patient populations with students that veterans should be included as a demographic that they may encounter. Four participants recommended incorporating intention to link veteran culture into their curriculum and inviting veterans to share

experiences related to content being presented, noting the value of having students interact with veterans.

Limitations

I identified three limitations related to this study. Participants in this study were nurse educators from ADN programs. This is a limitation because the study did not expand knowledge regarding how BSN and PN programs educate their students to provide culturally competent care for the veteran demographic. Another limitation was that the study only included faculty participants. Program administration may have been able to provide more specific details regarding where content is presented in areas of the nursing program outside of the area taught by faculty. The final limitation of the study is that it did not include questions regarding whether each school represented by a participant had a Veteran Resource Department. Participant 4V shared that their school has a Veterans Resource Center that presents annually to nursing students. The existence of a Veteran Resource Center in the school offers a resource that may be available to assist with presenting content surrounding veteran culture to students.

I carefully ensured the trustworthiness of this study by focusing on participant responses, interactions between participants and me, and the participants' lived experiences shared in their own words, which I used to interpret the data and answer the research question guiding this study. Transcripts from each focus group were mailed to participants for member checking to ensure accuracy. I also maintained a study diary and used the memo feature of ATLAS.ti to maintain transparency and reflect on my own

feelings in order to maintain objectivity and prevent bias from affecting participant responses and the study outcomes.

Recommendations

The data from this study support that colleges with ADN programs not affiliated with the VHA implement professional development opportunities for faculty to become more familiar with veteran culture. Each participant in this study identified exposure to veterans in various aspects of their lives; however, they indicated that their knowledge of military culture was limited. Providing opportunities for nursing faculty to interact with veterans and learn strategies for communicating with them as well as aspects of veteran culture would foster confidence in their knowledge levels surrounding this culture. I noted in the limitations for this study that I did not include a question to determine if the college represented by the participant had a Veterans Resource Center. I encourage colleges that have a Veterans Resource Center to partner with that department for faculty development and assist with introducing aspects of veteran culture to students.

Additional studies are needed to determine how veteran content is presented in BSN and PN programs as well as advanced practice nursing programs. Additionally, a study to compare the capacity to care for veteran patients between new graduate nurses from schools affiliated with the VHA compared with those from schools not affiliated with the VHA is supported by the findings from this study.

Implications

This study has the potential to positively impact social change if its findings are utilized by leaders within ADN programs to provide professional development activities

centered on veteran culture for faculty and to modify respective curricula to incorporate veteran culture. I stated in Chapter 1 that nurse educators can do more to prepare future nurses to care for veteran patients. This was echoed in the recommendations from participants in this study. The suicide rate among veterans is nearly twice that of civilians (U.S. Department of Veterans Affairs, 2023), and nurse educators have the potential to positively impact that rate through educating themselves and their students about veteran culture, thus fostering a bridge between civilians and veterans.

The data generated by this study increases understanding of current education practices among ADN programs. To address a problem, it must first be understood. In this study, I focused on the problem of a lack of knowledge about military culture and health problems specific to this demographic among practicing nurses. Empowering future nurses with skills to provide culturally competent care to active military and veteran patients addresses the communication challenge that veterans report facing when sharing their experiences with civilians and assists in the creation of therapeutic nurse-patient relationships that are essential for healthy outcomes through identification of patients who are at risk or who are experiencing suicidal ideation as well as reducing the sense of isolation that veterans perceive as a result of a divide between military and civilian cultures (Giesler & Juarez, 2019; McCaslin et al., 2021).

Conclusion

In 2022, 6,407 veterans committed suicide, and that number is increasing (U.S. Department of Veterans Affairs, 2024). The U.S. Department of Veterans Affairs (2024) reported suicide as the second leading cause of death in veterans under the age of 45.

Compared with their civilian counterparts, the rate of suicide in the veteran population is over twice that of civilians (U.S. Department of Veterans Affairs, 2024). As practitioners of person-centered care, nurses are tasked with fostering therapeutic nurse-patient relationships; however, practicing nurses are not meeting the benchmarks for the knowledge, skills, and attitudes necessary to provide culturally competent care to veteran patients (Bonzanto et al., 2019; Simoni et al., 2024). Qualitative studies that explored nurses' perceptions of providing care to veterans indicated uncertainty among participants regarding communicating with and tailoring care for veteran patients (Claus et al., 2020; Mushale & Bakerjian, 2021).

This study provides new data that expands knowledge of how prelicensure nursing students are prepared to care for veterans through the words and lived experiences of nurse educators from ADN programs across the United States. Fifteen nurse educators participated in focus groups, sharing their personal and program practices in providing education surrounding published veteran competencies. The results indicated that while the majority of programs represented by educators in this study present concepts found within the veteran competencies, they are often presented in a general manner without linking them to the veteran demographic. Less than half of the participants were able to identify specific instances in which they provide education linked to veterans. Notably, faculty from programs with veterans employed as faculty, staff, or administrators, reported curricula that include learning activities specifically tailored to the veteran population, particularly when these faculty or administrators are within the educational system.

Participants discussed barriers to providing education, with knowledge about the content and limited time within the program as the most frequently cited obstacles they encounter. Despite describing experiences with veterans that included working with veteran students, caring for veteran patients, having veterans within their families, and being veterans themselves, when asked to evaluate their level of knowledge about veteran culture, the majority of participants noted that their knowledge is novice to intermediate. Time constraints due to an already content-laden curriculum was a barrier noted by multiple participants. The participants recommended expanding veteran-centric resources for educators, increasing the intention to include veteran content within their programs through veteran sharing related to concepts being presented, and fostering interactions between students and veterans.

Empowering future nurses with skills to provide culturally competent care to active military and veteran patients addresses the communication challenge that veterans report facing when sharing their experiences with civilians (Derefinko et al., 2019; Giesler & Juarez, 2019; McCaslin et al., 2021) and assists in the creation of therapeutic nurse-patient relationships that are essential for healthy outcomes. The findings of this study can be used to inform future education practices and prepare future nurses to have a positive impact on the healthcare of veterans.

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Appendix A: Focus Group Questions

What level of prelicensure nursing education are you currently teaching?
Please provide a brief overview of your experiences in general as a nursing faculty member.
What experiences have you had with veterans or active-duty members of the military in the past?
How would you describe your level of knowledge surrounding military/veteran culture?
When you think about military/veteran culture, what characteristics do you associate with this demographic?
What experiences have you personally had with educating undergraduate nursing students about veteran culture?
How does your nursing program educate prelicensure nursing students about veteran culture?
What experiences have you had with barriers to providing education about veteran culture within your program?
Based on your experiences, what should be done to improve the teaching of undergraduate nursing students about military culture, specifically, veteran healthcare beliefs and practices?
Is there anything else you would like to add regarding educating nursing students about veteran culture?